Audit, Risk and Assurance Committee

Tue 12 November 2024, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. Preliminary Matters

v2 Audit Risk and Assurance Committee Agenda 12.11.24. V11.pdf (3 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 12th September 2024

Attached *Chair*

1.4 Audit Risk and Assurance Committee Minutes 12.09.24.pdf (9 pages)

1.5. Committee Action Log and Matters Arising

Attached *Chair*

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

09:30 - 09:30
0 min

2. Items for Approval/Ratification/Decision

2.1. To Approve the Closing Position of the Audit Recommendations Tracking Report

Attached *Director of Corporate Governance*

2.1 Internal_External Audit Recommendations Cover Report November ARAC (1).pdf (7 pages)
2.1 Appendix A 22 Revised deadlines (1).pdf (4 pages)
2.1 Appendix B 3 Overdue Recommendations (1).pdf (1 pages)
2.1 Appendix C 17 Completed Recommendations (1).pdf (3 pages)
2.1 Appendix D Recommendations Exceeding Extension Threshold.pdf (5 pages)

2.2. To Approve the Use of Single Tender Action

Attached *Assistant Finance Director*

2.2 Single Tender Action Report - 30.08.2024 - 18.10.2024.pdf (3 pages)
2.2 Appendix 1 Single Tender Action 30.08.2024 - 18.10.2024.pdf (1 pages)

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

Attached *Assistant Finance Director*

1. Recovery of Overpayments to Employees
2. Accounts Payable

- 2.3 Finance Governance Report 12.11.2024.pdf (8 pages)
- 2.3 Appendix 1 ABUHB_Finance_0238 FCP Accounts Payable_Final.pdf (23 pages)
- 2.3 Appendix 2 ABUHB_Finance_0559 Recovery of Overpayments to Employees_Final.pdf (17 pages)
- 2.3 Appendix 3 - NHS Wales - No Purchase Order-No Payment Policy 2024.pdf (11 pages)
- 2.3 Appendix 4 - All Wales Recovery of Overpayments Procedure Oct 24.pdf (25 pages)
- 2.3 Appendix 5 - No PO No Pay Exceptions - Briefing.pdf (2 pages)

09:30 - 09:30
0 min

3. Items for Discussion

3.1. Report of Losses and Special Payments

Attached *Assistant Finance Director*

- 3.1 Losses Report Sept 24.pdf (5 pages)

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

Attached *Clinical Director of Pharmacy*

- 3.2 Assurance Note Template - community pharmacy data matching.pdf (4 pages)
- 3.2 Appendix 1.pdf (4 pages)

3.3. Update Report on Consultant Job Planning

Attached *Medical Director*

- 3.3 Consultant Job Planning SBAR (1).pdf (9 pages)
- 3.3 071124 Appendix 1 Job Planning Action Plan.pdf (8 pages)

3.4. Receive the Private Practice Policy

Attached *Medical Director*

- 3.4 Policy Consultant Private Practice Cover Report.pdf (4 pages)
- 3.4 Appendix 1 - Policy - Consultants Private Practice (2).pdf (12 pages)

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

Attached *PPV Manager*

- 3.5 PPV Mid-Year 24-25 Board and Committee Report.pdf (5 pages)
- 3.5. ABUHB Mid-Year 2024-2025.pdf (1 pages)

3.6. Committee Risk & Assurance Report to include an Update on Implementation of the Risk Management Framework

Attached *Director of Corporate Governance*

- 3.6 Strategic Risk and Assurance Report Cover Report_Nov 2024.pdf (7 pages)
- 3.6 Appendix A_ Strategic Risk Register Database.pdf (7 pages)
- 3.6 Appendix B Strategic Risk Dashboard and Assessments.pdf (40 pages)

3.7. Receive Internal Audit Progress Report

Attached *Head of Internal Audit*

- 3.7 ABUHB November 2024 Audit Committee Progress Report.pdf (9 pages)

3.8. Receive Internal Audit Reports

3.8.1. Energy Management - Reasonable Assurance

Attached *Head of Internal Audit*

3.8.1 ABU-SSU-2425-27 Energy Management Final Report.pdf (23 pages)

3.8.2. NHH Reinforced Autoclaved Aerated Concrete

Attached *Head of Internal Audit*

3.8.2 ABU-SSU-2425-26 Nevill Hall RAAC - Final Report.pdf (20 pages)

3.8.3. Providing Care to Asylum seekers and Refugees

Attached *Head of Internal Audit*

3.8.3 ABUHB 2324-16 Providing care to Asylum seekers and Refugees Final Report.pdf (13 pages)

3.8.4. Newport East Health & Wellbeing centre

Attached *Head of Internal Audit*

3.8.4 SSU_ABUHB_05 Newport East HWC 2023-24 Final Audit Report.pdf (38 pages)

3.8.5. Facilities Stock

Attached *Head of Internal Audit*

3.8.5 ABUHB 2024-25 - Final Facilities Stock Report v2.pdf (6 pages)

3.9. Receive External Audit Progress Report

Attached *Performance Audit Lead, Audit Wales*

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

3.10. Final Annual Accounts Memorandum

Attached *Finance Audit Lead, Audit Wales*

3.10 4508A2024_ABUHB_Audit of Accounts Report Addendum_final.pdf (10 pages)

09:30 - 09:30
0 min

4. Items for Information

4.1. Committee Programme of Business

Attached *Director of Corporate Governance*

4.1 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (4 pages)
4.1 Appendix A ARA_Committee Work Programme 2024-25 Final.pdf (6 pages)

09:30 - 09:30
0 min

5. Other Matters

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

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting: Tuesday 18th February 2025

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Tuesday 12th November at 09:30**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 12 September 2024	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Approve the Closing Position of the Audit Recommendations Tracking Report	Attached	Director of Corporate Governance
2.2	To Approve the Use of Single Tender Action	Attached	Assistant Finance Director
2.3	To Receive the Report on Financial Governance and Reporting and Ratify Changes to Financial Control Procedures (FCPs) • Recovery of Overpayments to Employees • Accounts Payable	Attached	Assistant Finance Director
3	**ITEMS FOR DISCUSSION**		
3.1	Report of Losses and Special Payments	Attached	Assistant Finance Director

3.2	Assurance Note on the Implementation of the Actions from the Audit Wales Community Pharmacy Data Matching Report	Attached	Clinical Director of Pharmacy
3.3	Update Report on Consultant Job Planning	Attached	Medical Director
3.4	Receive the Private Practice Policy	Attached	Medical Director
3.5	Receive a Mid-Year update in respect of Post-Payment Verification Activity	Attached	PPV Manager
3.6	Committee Risk & Assurance Report to include an Update on Implementation of the Risk Management Framework	Attached	Director of Corporate Governance
3.7	Receive Internal Audit Progress Report	Attached	Head of Internal Audit
3.8	Receive Internal Audit Reports • Energy Management • NHH Reinforced Autoclaved Aerated Concrete • Providing Care to Asylum seekers and Refugees • Newport East Health & Wellbeing centre • Facilities Stock	Attached	Head of Internal Audit
3.9	Receive External Audit Progress Report	Attached	Performance Audit Lead, Audit Wales
3.10	Final Annual Accounts Memorandum	Attached	Finance Audit Lead, Audit Wales
4	**ITEMS FOR INFORMATION**		
4.1	Committee Programme of Business	Attached	Director of Corporate Governance
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair

5.3	**Date of the Next Meeting: Tuesday 18th February 2025**

Motion to Exclude Members of the Public and the Press

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

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

MINUTES OF THE AUDIT RISK & ASSURANCE COMMITTEE

DATE OF MEETING	Tuesday 12 September 2024
VENUE	Microsoft Teams

PRESENT	Iwan Jones	Committee Chair – Independent Member
	Richard Clark	Committee Vice Chair - Independent Member
	Neil Patrick	Independent Member
IN ATTENDANCE	Rani Dash	Director of Corporate Governance
	Rob Holcombe	Director of Finance and Procurement
	Gareth Lavington	Head of Counter Fraud
	Gareth Lewis	Head of Financial Services & Accounting
	Stephen Chaney	Head of Internal Audit, NWSSP
	Muray Guard	Senior Auditor, Internal Audit, NWSSP
	Sara Utley	Perfoance Audit Lead, Audit Wales
	Nicola Prygodzicz	Chief Executive *(joined at 10:15)*
	Leeanne Lewis	Assistant Director Quality & Patient Safety
	Lucy Windsor	Head of Corporate Risk and Assurance (Secretariat)
OBSERVING	Heulwen Griffiths	Head of Business Systems & Governance
APOLOGIES	Dafydd Vaughan	Independent Member
	Dr James Calvert	Medical Director
	Julie Rees	Finance Audit Lead – Audit Wales

Minute Reference	Preliminary Matters
ARAC 1209/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting and welcomed Gareth Lavington, Head of Counter Fraud, to the Health Board and Committee.
ARAC 1209/02	**Apologies for Absence** Apologies were noted.
ARAC 1209/03	**Declarations of Interest** There were no declarations of interest raised to record.

ARAC 1209/04	**Minutes of the previous meeting** The minutes of the meeting held on the 09 July 2024 were agreed as a true and accurate record.
ARAC 1209/05	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due. The Committee **AGREED** that completed actions could be removed from the Action Log.
	ITEMS FOR APPROVAL / RATIFICATION / DECISION
ARAC 1209/06	**Audit Recommendation Tracking Procedure** Lucy Windsor (LW), Head of Corporate Risk and Assurance presented the Committee with the updated Audit Recommendation Tracking Procedure which incorporated comments from the July meeting and noted that the updated procedure had been reviewed by internal and external audit. Iwan Jones (IJ) Committee Chair, raised a query about handling risks raised by external audits where actions could not be completed, suggesting the need for mitigating controls. Rani Dash (RD) Director of Corporate Governance reassured IJ that further work was needed to align audit outcomes with the risk management system, and this was a priority for the Corporate Governance Directorate. The Committee **APPROVED** the Audit Recommendation Tracking Procedure.
ARAC 1209/07	**Audit Recommendations Tracker** Lucy Windsor (LW), Head of Corporate Risk and Assurance reported on the status of audit recommendations as of 31 August 2024, noting that 24 recommendations were completed, deadlines for 30 were revised, and 3 remained overdue. Neil Patrick (NP), Independent Member enquired about the report's purpose, to which LW responded that it served to assure the Committee that recommendations were being monitored and implemented, as well as to oversee any outstanding recommendations that required additional scrutiny. Iwan Jones (IJ), Committee Chair, acknowledged the substantial progress that had been made with progressing recommendations particularly the backlog of longstanding recommendations. The Committee **APPROVED** the closing position of the Completed recommendations.

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ARAC 1209/08	**Use of Single Tender Action (STA)** Gareth Lewis (GL), Head of Financial Services & Accounting presented the report on STAs approved between March and August 2024. The Committee noted that some STAs from the previous financial year had been missed but were now captured. Iwan Jones (IJ) Committee Chair queried whether control measures had been implemented to prevent similar issues in the future, to which Robert Holcombe (RH) Director of Finance and Procurement confirmed that actions had been taken. Neil Patrick (NP), Independent Member, enquired about the use of the STA for the Acorn Project, valued at £800k, and requested sight of the STA. The proforma would be shared by RH. **ACTION: Director of Finance and Procurement** The Committee **APPROVED** the Single Tender Action Report.
ARAC 1209/09	**Financial Governance Report and Charges to Financial Capital Procedures (FCP)** Gareth Lewis (GL), Head of Financial Services & Accounting updated the Committee on financial governance, including the approval of two financial control procedures relating to salary sacrifice and out-of-area referrals. The Committee also received an update on technical accounting issues, compliance with the public sector payment policy, and payments exceeding £100,000, including the approval of a significant Chepstow lease purchase which had been approved by Welsh Government The Committee **NOTED** the contents of the Financial Governance Report and **APPROVED** changes to the Salary Sacrifice and Out-of-Area Referrals FCPs.
	ITEMS FOR DISCUSSION
ARAC 1209/10	**Mid-year Report on the delivery of the Clinical Audit Plan** Leeanne Lewis (LL), Assistant Director Quality & Patient Safety presented an interim report on clinical audits, noting significant progress but also acknowledging areas requiring improvement. Iwan Jones (IJ), Committee Chair raised several concerns regarding the level of assurance which could be taken from the report; specifically • how the number and scope of completed audits compared to those planned;

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	• how the plan ensured the appropriate coverage of clinical areas; • the prioritisation and timeliness of audit actions – most audit actions did not appear to be prioritised and were overdue LL explained that ongoing work was focused on tracking overdue actions and improving governance. LL sought clarity on the remit and frequency of reporting to the Committee. Rani Dash (RD), Director of Corporate Governance, explained that the ARAC focused on the plan and its delivery, while the Patient Quality, Safety and Outcomes Committee (PQSOC) focused on the outcomes, risks, issues, and learning from the clinical audits. RD advised that Lucy Windsor (LW), Head of Corporate Risk and Assurance, would create and share a document outlining the reporting schedules and focus of reports for both committees. **ACTION: Head of Corporate Risk and Assurance** The Committee **NOTED** the Mid-year Report on the delivery of the Clinical Audit Plan but was not able to take the necessary assurance that the plan was on track and delivering improvements.
ARAC 1209/11	**Counter Fraud Quarterly Update** Gareth Lavington (GLa), Head of Counter Fraud Lavington provided the Committee with a progress report on counter fraud activities for noting a significant number of referrals and ongoing investigations. GLa highlighted the success of staff awareness programmes, with over 10,000 staff completing the mandatory Counter Fraud e-learning module on ESR. The Committee **NOTED** the Counter Fraud Quarterly Update for Assurance. ***Nicola Prygodzicz joined the meeting.***
ARAC 1209/12	**Committee Programme of Business** Rani Dash (RD), Director of Corporate Governance presented the Committee Forward Work Programme noting that committee business was on track, with all items scheduled to date having been received by the Committee The Committee **NOTED** the Committee Programme of Business for Assurance.

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ARAC 1209/13	**Implementation of the Governance Priorities set out within the IMTP 2022-25** Rani Dash (RD), Director of Corporate Governance presented the report stating that progress against the previously established three-year governance priorities was continuing and advised that certain actions would remain ongoing as the governance system evolved. Neil Patrick (NP), Independent Member, acknowledged the challenges that were reported regarding the implementation of the Once for Wales RL Datix Risk Module and enquired whether arrangements had been made for both migration and non-migration situations. Lucy Windsor (LW), Head of Corporate Risk and Assurance, stated that a recent meeting highlighted disparities in risk management processes among health bodies and stated that a unified system for all of Wales might not be the way forward and that consideration of a customised system to meet specific organisational requirements could be more suitable. The Committee was informed that there was a growing consensus to extend the use of Datix Web until 2027 while evaluating alternative options was the favourable option amongst health bodies. LW had committed to providing an update report when there was a clearer position and way forward. **ACTION: Head of Corporate Risk and Assurance** The Committee **NOTED** the progress against the Implementation of the Governance Priorities set out within the IMTP 2022-25 for Assurance.
ARAC 1209/14	**Bi-annual Report on Compliance with Ministerial Directions and Welsh Health Circulars (WHCs)** Rani Dash (RD), Director of Corporate Governance presented the report and advised that the Annual Governance Statement typically included compliance with ministerial directions and Welsh health circulars. The Committee noted that the Corporate Governance Directorate was working to establish a regular updating and oversight process, similar to the audit tracking process. Efforts were being made to attach time frames to actions outlined by WHCs, aiming to address existing gaps. The Committee **NOTED** the Bi-annual Report on Compliance with Ministerial Directions and Welsh Health Circulars (WHCs) report for Assurance.

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ARAC 1209/15	**Committee Risk & Assurance Report** Lucy Windsor (LW), Head of Corporate Risk and Assurance provided an update on the Health Board's strategic risks, noting that six risks remained outside the Board's risk appetite. Iwan Jones (IJ), Committee Chair asked whether the controls in place would bring these risks within acceptable levels, to which LW explained that due to the complexity of certain risks, they may remain high despite mitigations. Rani Dash (RD) Director of Corporate Governance emphasised the importance of committees assessing the breadth of actions related to risks and provide recommendations to the Board. RD stated that committees needed to adopt a more focused and detailed approach to risk review and suggested that the risk item evolve into a focused deep dive of individual risks at each meeting. IJ suggested that committees prioritised risk in their agendas, advocating for a shift that allowed committees to address risks early in their meetings. RD agreed, highlighting the need for better integration of risk assessments into committee agendas and confirming that his approach would be strengthened moving forward. The Committee **NOTED** the Committee Risk & Assurance Report for Assurance.
ARAC 1209/16	**Internal Audit Progress Report including 2024/25 Internal Audit Work Plan** Stephen Chaney (SC), Head of Internal Audit reported on the ongoing internal audit plan for 2024-25, with no major concerns raised. The Committee was asked to approve the merger of the Analytics and Information Use (AIU), and the IMTP Service Delivery Plans audits due to significant overlap, which the Committee approved. The Committee **NOTED** the Internal Audit Progress Report for Assurance.

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ARAC 1209/17	**To Receive Internal Audit Reports** Stephen Chaney (SC) - Head of Internal Audit, presented the Committee with findings from the audits outlined below. **Saving Programmes – Reasonable Assurance** The review focused on the management and delivery of saving initiatives to address the ongoing deficit rather than assessing the overall financial position. Two recommendations were raised: one involved defining RAG (Red, Amber, Green) ratings for clarity, while the other suggested exploring ways to maximise savings where targets had not been achieved. The review highlighted that continuous improvement efforts were expected to yield further savings, with no immediate material concerns identified in other areas. Overall, significant work had been done to retrieve the financial balance despite the existing deficit. **Waiting List Management – Reasonable Assurance** The review highlighted key factors affecting service delivery, particularly the high demand in trauma and orthopaedics, where waiting lists were extensive. It assessed ongoing patient validation and prioritisation, noting the challenges in managing patient flow due to the size of the waiting lists. Despite these difficulties, initiatives to reduce waiting times were in progress. Neil Patrick (NP), Independent Member, inquired whether the Health Board was analysing patient presentations against waiting lists to determine the impact of rising demand versus successes in reducing wait times. It was noted that while significant resources were dedicated to managing waiting lists, demand often exceeded capacity. Efforts to balance financial constraints with performance and safety were ongoing, alongside a commitment to improve communication with patients about wait times and explore options for consultant flexibility. Overall, while steps were being taken to address these challenges, high demand remained a significant obstacle to optimal outcomes. **Regional Radiotherapy Satellite Centre – Reasonable Assurance** Murray Guard (MG), Senior Auditor, Internal Audit presented the report, noting that this was the second audit of the project, and that the review was focused on the management arrangements for the development of the Regional Radiotherapy Satellite Centre at Nevill Hall Hospital (NHH). The Committee was informed that the review determined that the project board's governance and scrutiny needed to be improved, and that potential risks associated with the adequacy of remaining contingency funds should be evaluated. It was also

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	observed that several of the recommendations made had already been implemented. Furthermore, seven of the nine audit recommendations that had been previously issued had been implemented, with one being replaced by a new recommendation. The Committee **NOTED** the internal audit reports for Assurance.
ARAC 1209/18	**External Audit Progress Report 2024/25** Sara Utley (SA), Audit Wales, presented the Committee with an overview of the 2024/25 External Audit progress report noting that the Charitable Funds Audit was scheduled for November with the intention of completing mid-December. The Committee **NOTED** the External Audit Progress Report 2024/25 for Assurance.
	Items for Information
ARAC 1209/19	**Chairs of Audit Committees Operating Arrangements** The Committee **NOTED** the arrangements for Information.
ARAC 1209/20	**National KPI Template for Capital Projects** The Chair enquired about the template's origin and requested confirmation of its source. **ACTION: Head of Corporate Risk and Assurance**

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ARAC 1209/21	**Response from Welsh Government to the Audit Wales Community Pharmacy Data Matching Report** The Committee asked for an assurance note to confirm that the actions detailed in the report had been implemented. **ACTION: Head of Corporate Risk and Assurance**
	Other Matters
ARAC 1209/22	**Items to be Brought to the Attention of the Board and Other Committees** • No items raised
ARAC 1209/23	**Any Other Urgent Business** • Nothing reported.
ARAC 1209/24	**Date of the next meeting** • Tuesday 12 November 2024

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2024	**ARAC 0907/1.5.1** Job Planning Assurance Note	An update on the progress of Consultant Job Plans is to be received. The report should include the number of plans recorded in the system, demonstrate progress against the target, and outline any challenges. Where there are areas of low compliance, the report should also detail the interventions implemented to address these issues.	Medical Director / Director of Workforce and OD	**12 November 2024**	**Completed.** Item on the agenda for November 2024.
July 2024	**ARAC 0907/2.2** Audit Recommendation Tracker	In future reports, include an appendix for any recommendations that exceed two previous deadline extensions. This appendix should provide detailed explanations for why the recommendation has not yet been implemented	Head of Corporate Risk and Assurance	**02 September 2024**	**Completed.** Implemented from November 2024 reporting.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
September 2024	**ARAC 1209/08** Use of Single Tender Action (STA)	Share the proforma for the Acorn Project with Neil Patrick, Independent Member.	Director of Finance and Procurement	**30 September 2024**	**Completed.** Proforma shared.
September 2024	**ARAC 1209/10** Mid-year Report on the delivery of the Clinical Audit Plan	Create and share a document with the Medical Director's Office outlining the reporting schedules and focus of reports for the Audit Risk and Assurance and Patient Quality, Safety and Outcomes Committee.	Head of Corporate Risk and Assurance	**12 October 2024**	**In Progress** **03.10.24 – Document being drafted.**
September 2024	**ARAC 1209/13** Implementation of the Governance Priorities set out within the IMTP 2022-25	The Committee to receive an update on the Health Board's decision and progress regarding a suitable electronic risk management system.	Head of Corporate Risk and Assurance	**January 2025**	**Not Yet Due**

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
September 2024	**ARAC 1209/20** National KPI Template for Capital Projects	Confirm with the Capital Planning Team the template's origin and update the Chair of the Committee.	Head of Corporate Risk and Assurance	**30 September 2024**	**Completed.** Origin sourced and Chair updated.
September 2024	**ARAC 1209/21** Response to the Audit Wales Community Pharmacy Data Matching Report	Request an Assurance Note be drafted and shared with the Committee for assurance that the actions detailed in the report have been implemented within the Health Board.	Head of Corporate Risk and Assurance	**12 November 2024**	**Completed.** Item on the agenda for November 2024.

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

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

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

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

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit Risk and Assurance Committee (the Committee) with a comprehensive overview of the current status of all identified internal and external audit recommendations as of 30 September 2024.

The report also updates the Committee on the progress made since the last reporting period, highlighting recommendations with revised deadlines, those that remain outstanding, and those where management action plans have been fully implemented.

Cefndir / Background

As of the end of the last reporting period on 31 August 2024, the following was noted:

- **24** recommendations were completed.
- **30** recommendations had their timeframes revised.
- **3** internal and external recommendations remained overdue.

From 01 September to 30 September 2024:

- An additional **39** recommendations became overdue.
- **42** updates were requested for overdue recommendations within this period.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking

The master tracker has been updated to include all Internal and External Audit Recommendations up to the last Committee meeting on 12 September 2024. This tracker includes a total of **124** recommendations across **39** audits, though only those overdue by 30 September 2024 are detailed in this report.

As stated, a total of **42** recommendations required an update on progress. Table 1 provides the Committee with a breakdown of the **42** recommendations by the Lead Director.

Table 1

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Director of Strategy, Planning & Partnerships	Director of Workforce	Total
Total recommendations requiring an update	**6**	**2**	**10**	**7**	**12**	**4**	**1**	**42**

The position reported in Table 2 reflects the position following updates received from Lead Directors against their overdue recommendations. The Committee is asked to approve **22** revised deadlines and **17** completed recommendations.

Table 2

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Director of Strategy, Planning & Partnerships	Director of Workforce	TOTAL
Revised Deadline	**4**	**1**	**8**	**1**	**8**	**0**	**0**	**22**
Completed	**2**	**1**	**2**	**6**	**1**	**4**	**1**	**17**
Residual Overdue against Deadline	**0**	**0**	**0**	**0**	**3**	**0**	**0**	**3**
Reconciliation with requested updates	**4**	**1**	**8**	**1**	**11**	**0**	**0**	**25**

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

- **Table 3:** Details the **22** revised deadlines. (See Appendix A for revised implementation dates)
- **Table 4:** Lists the **3** residual overdue recommendations. (See Appendix B for details)

- **Table 5:** Highlights the **17** completed recommendations. (See Appendix C for details)

Table 3

REVISED DEADLINES		
Audit Year and Title	**Assurance Rating**	**Number by Priority Rating**
2020 IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	2
2021 IT System Controls (WRIS)	Reasonable	1
2021 Facilities - Care After Death	Reasonable	1
2022 IT Strategy	Reasonable	3
2022 Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	1
2022 Discharge Planning	Limited	1 | 2
2022 Dementia Services	Reasonable	3
2023 Clinical Coding; Final Internal Audit Report	Reasonable	1
2023 Integrated Performance Dashboard Data Quality	Substantial	1
2023 IT Infrastructure	Reasonable	1
2023 Decarbonisation	Limited	1
2023 Waiting List Management Final Internal Audit Report	Reasonable	1
2023 Structured Assessment 2023	Not Rated	1
2023 Putting Things Right: Final Advisory Review	Reasonable	1 | 1
	TOTAL	**22**

Table 4

Audit Year and Title	**Assurance Rating**	**Number of Overdue Recommendations by Priority Rating** (No revised deadline)
2022 Discharge Planning	Limited	**2**

2022 Dementia Services	Reasonable	**1**
	TOTAL	**3**

Table 5

COMPLETED RECOMMENDATIONS		
Audit Year and Title	**Assurance Rating**	**Number by Priority Rating**
2021 Facilities - Care After Death	Reasonable	**1**
2021 NIS Directive (Cyber Security)	Reasonable	1
2022 Structured Assessment	Not Rated	**1**
2022 It Strategy	Reasonable	**1**
2022 Dementia Services	Reasonable	**1**
2023 Estates Condition Jan 2024	Limited	**2**
2023 Asset Management	Reasonable	**1**
2023 ABUHB Financial Controls - Regional Partnership Board	Limited	**3** **1**
2023 Theatre Stocks	Reasonable	**1**
2023 Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	**2**
2023 Review of Workforce Planning Arrangements	Not Rated	**1**
2023 Primary Care Follow Up	Not Rated	1
	TOTAL	**17**

At the last Committee meeting, it was agreed that the report would include more detailed information on any recommendation requesting a revised deadline beyond the agreed threshold of two extensions. In this reporting period, 3 recommendations have exceeded that threshold, further detail can be found in the briefing report attached in (**Appendix D**).

This approach has been taken to ensure accountability and transparency in the audit process. By requiring more detailed reporting and justifications for multiple deadline

extensions, the Committee can better understand the challenges or obstacles preventing timely implementation of recommendations. It will also help to:

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

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **APPROVE** the revised timescales for the **22** Recommendations;
- **NOTE** the status of the **3** overdue audit recommendations;
- **NOTE** the completion of **17** audit recommendations; and,
- **NOTE** the ongoing efforts to ensure timely completion of recommendations.

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

Strategic Equality Objectives 2020-24	

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

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

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

Appendix A: 22 Revised Deadlines

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	30/11/2024		Overdue	Overdue	6		October 2024: Meeting taking place with chair of the clinical council to review terms of reference and agree reporting arrangements, this will take place at the end of October. August 2024: Agreed that the clinical council will report into the wider Health Board's clincial advisory group so terms of reference now being reviewed to note this change. June 2024: Sign-off of the terms of reference has been delayed to the end of June to ensure consideration of clinical engagement and the role of the clinical council in the governance structure. March 2024: The Information Governance, Health Records and Cyber Security governance groups are now meeting and the first Information Governance Sub-Committee is being held on the 26/03/2024. The Digital, Data & Technology Sub-Committee terms of reference are completed and will be taken to the Executive Committee on the 11th April pending agenda setting.				30/09/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R5	R5 R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	30/11/2024		Overdue	Overdue	5		October 2024: All Divisional meetings are in place bar Medicine. Meeting agreed, Awaiting confirmation of date of 1st meetingl August 2024: agreed format for Divisional Meetings with Mental Health, Families & Therapies and Medicine. Anticipate meetings will be in place by end of Q2 Mar 24 - Divisonal engagement meeting dates for meetings are being established for Families & Therapies and Unscheduled care division and will be in place in April 24 subject to Divisional staff availability. A communications an engagement plan that covers all the activities of the Health Board will be developed in Q1 2024/25. An annual operational plan has been developed to provide a detail account of the delivery plan for 2024/25 to sit alongside the IMTP Digital Enabler section. Divisional meetings are in place for Clinical & Support Services, Scheduled care, Primary & Community care & Urgent Care. New Digital Service Requests are in place to ensure all new requests are reviewed by the Senior Leadership team on a fortnightly basis. The digital enabler component of the IMTP has been completed A Microsoft Team Planner board is in place to track progress and outcome of requests to Projects or production. Internal Directorate communications are in place using Teams channels including a communications, learning & development and job vacancy segments				30/09/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R2	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMB for an integrated electronic process cannot be delivered. The Health Board should carry out an analysis to fully identify its needs for a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	31/12/2024		Overdue	Overdue	2		Oct 24- We will be meeting with Philips/Soliton who will be the new PACS/RIS provider, clinical apps team in order to scope out the requirments of the RISP project and it's integration with CWS. Within this we will be looking to integrate the current CWS request form to make this electronic within our new RIS. If this isn't feasable then we will look to integrate the WCP requesting solution in CWS so there is an electronic requesting solution that integrates with our RIS at go live of our new PACS/RIS. The current go live is November 2025. January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and is with clincial apps and is being trialled in Primary Care on the 11/09/2023. There are discussion amonst informatics about integrating the WCP requesting within CWS and we have done early scoping exercises with a bussiness analysist revewing this currently. May 23: The UAT has been passed and is with clincial apps and Mr Rice to look at.	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			30/09/2024
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Care After Death Manager	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	31/03/2023	30/04/2025		Overdue	Overdue	2		October 2024: CAD team database was on Qlik for intiial period but was removed due to data quality issies and planned recommencement end of Nov 24 beginning Dec 24. TCLE 2025 UAT underway for CAD and Mortuary , no requirment currently for a bespoke database for CAD, Current CAD database will transfer to TCLE upon completion January 2024: Partially completed. This risk has been resolved/removed by some minor changes to the current CAD database and development work that will make the body store details available in Qlik. Awaiting final verification of Qlik data. Estimated date of completion 31/03/24 November 2023 - new software was not procured due to cost implications. Work undertaken to cleanse databse and ensure that relevant fields are completed to enablel reports to be produced through Qlik. Work on reporting is currently underway.	IT Infrastructure Team resouce capacity may delay the implementation.	November 2023 - Meeting with IT and support has been put in place for basic maintence of database with reports being run through Qlik Mar 23 Ongoiong liaision with Associate Director of Informatics Strategy & Planning	Q4 of 2022/23	30/09/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	30/11/2024		Overdue	Overdue	2		October 2024: CNIO JD reviewed and shared with Digital Director and Assistant Director of Nursing for consideration. March '24 - no confimation of resourcing to support clinical engagement. Position not changed. CNIO position to be reviewed with Digital / Nursing directors with the retirement of current CNIO in July '25 Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Exeuctive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relauch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				30/09/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	30/11/2024		Overdue	Overdue	2		October 2024: Clinial engagament model still not approved. Council being reformed Dec '24. Workshop being undertaken with clinical leads in early November to discuss arrangements going forward. March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed. HAR group review has identified a number of skateholders who would like to join the council Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			30/09/2024

Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	31/12/2024		Overdue	Overdue	1		October 2024: ToR updated, will now report to Clinical Advisory Forum. Meeting 5th December with refreshed membership March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				30/09/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024	31/01/2025		Overdue	Overdue	1		October 2024: Assistant Medical Director to pilot 'perfect week', ongoing engagement with medical staff re completion of discharge notifications, identify areas to focus on for improvement by site/ward, link with ops team to re measurement/patient flow, streamlining of mandatory field to reduce time completing, CWS technical changes due early next year				30/09/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024	30/11/2024		Overdue	Overdue	1		October 2024: October: SBAR training across all wards with champions identified, monitoring of compliance ahead of implementation of new SBAR, video produced for staff to support training, aim to roll out end of November, delay of roll out due to system pressure, meaningful engagement with ward staff June: SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document . The SBAR was reviewed May 2024 and new version will be rolled out August 2024				30/09/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024	30/11/2024		Overdue	Overdue	2		October 2024: The pace of the roll out of the new HB digital sysytem, CWS2, has increased significantly and will be completed November 2024. This will facilitate the capturing of both simple and complex discharges and will integrate with Qlik to provide live data capture. June 2024: the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days', the Health Board has focused on implemeting these principles and the new electronic management tool will enable collaltion of data to demonstrate the impact. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded however the electronic data system is currently being rolled out .				30/09/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	31/12/2024		Overdue	Overdue	3		October 2024: There have been meetings with all parties in the HC and have agreement in principle that they will all sign a lease. The holding point at the moment is the level of Service charge each contactor will be expected to pay going forward, once these negotiations are complete I would expect the leases to be signed promptly. June 2024"Solicitors are working on Stakeholder queries. The dentist has requested a meeting to discuss the revenue costs. This is due to be set up this week. Further discussions have taken place within Project and agredd that this will be escalated to the Divisional Director and Clinical Director of Primary Care in order for them to discuss with the proctice. It is anticipated that this will be finalised by end of September 2024." March 2024: Tredegar Medical Practice (TMP) have recently has become an Independent Practice. Legal & Risk are in connection with TMP solicitors to sign off the Lease. Glan-Y-Afon (GYA), have changed solicitors, Legal & Risk are corresponding with GYA solicitors. GYA had queries which have been responded to. Jan 2024: Still being progressed by Shared Services Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	None	N/A	Aug 2023: Agreed leases	30/09/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	R2	Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	31/03/2025		Overdue	Overdue	2		October 2024: There is a national, NHS Biographical Tools task and Finish group who are reviewing the use of the various tools and the development of an App to support. March 2024: The challenge of raising awareness of the benefits of this biographical tool is part of an ongoing programme of improvements through the Meaningful Activities and engagement training delivered monthly from the patient Experience and Involvement team. The national Improvement Cymru team are facilitating an All Wales Biographical tool discussion and implementation group which will help support this message of this tool. Dates unconfirmed as being led by Improvement Cymru. Review September 2024 Nov 2023: Review of the outcomes from the National Audit of Dementia there is a recommendation for a relaunch of information to raise awareness of the diagnostic Code for Dementia on Clinical Workstation (136). The information will be added to the Internal Pulse web pages and shared through ABUHB e mail communication network.			June 2024: Patient stories continue to be collected and shared at relevant meetings. The PALS 6 monthly evaluation report contains a number of case studies for onward sharing and learning. Listening and learning from feedback is reported through QPSOC.	30/09/2024

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager linking in with Patient Flow Leads	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023	31/03/2025		Overdue	Overdue	2		October 2024: An invite is extended to the Patient Flow team to attend the Dementia Hospital Charter workstream. There is a wider 6 Goal review taking place where members of the dementia, Patient Experience and Involvement team are invited to be part of. This workstream is focused on improving discharge planning, appropriate ward placements and transfers of care. March 2024: Invitations have been sent to the Patient Flow Team to join the hospital dementia group. Still awaiting representation to be confirmed. Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Language team.			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Language team who we collaborate with closely.	30/09/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	31/03/2025		Overdue	Overdue	2		October 2024: Unfortunately a vacancy within the Welsh language team has meant that representation at the Dementia Strategic Group has not been possible. However resources which are being shared are being made available in Engish and Welsh. Language preference is recorded at the bedside using the patient bedside board. March 2024: Colleague from the Welsh language team are members of the Dementia Hospital steering Group. Language preference and choice have been included on the patient bedside boards introduced to the COTE and medicine wards. The patient Experience and involvement Team are participating in the Cultural Competency accreditation programme to ensure all activities supported through the team consider cultural awareness and accessibility. Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.				30/09/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R1	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	31/12/2024		Overdue	Overdue	2		October 2024: October 2024: A comprehensive review of the complaints process has been undertaken. PALS service launced in November 2023 which has had a positive impact by facilitating early engagment with patients and families, addressing concerns and reducing escalation of complaints. The PTR policy has been updated to streamline process, provide clarity and improve efficiency. Acknowldegment team and communications standards launched. The QPS and complaints team are focusing on improving the quality of complaint responses, ensuring compassionate meaningful and timely investigations are undertaken. The Health Board is committed to reaching 75% compliance within WAG targets. March 2024: The OCP has now concluded on 9th February 2024. Centrailising all PTR teams to ensure PTR regulations are adhered to. Trajectory has been devised for all divisons the Health Board has comitted to be within the 75% Welsh Government target by September 2024.				30/09/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Chief Operating Officer	High	R6	Actions to address the circumstances that have led to individual complaints and those that have been identifed to address complaint themes through boarder learning pathways should be captired in actions plans. The delivery of the plans should be monitored by appropriate oversight groups.	Review all QPS resourses being undertaken via an OCP which will include learning.	31/12/2023	31/12/2024		Overdue	Overdue	2		October 2024: October 2024: In May 2024 ABCI improvement team joined the central QPS teams. Quality Coach programme launched in September 2024. QI strategy in development. Patient Quality + Safety Learning and Improvement forum has been established. ABUHB Listenting and Learning Framework and Learning respository launched. Listenting and Learning divisional assurance agendas developed. Safe Care Partnership co-design to set All Wales platform and national direction October 24. March 2024: The organisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divsional leads to be trained by ABCI team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Listenting and learning operational group commenced March 2024. Listenting and learning framework under development. Will be completed End of May 2024. QI coaches training September 2024.				30/09/2024
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Chief Information Officer	High	R4.1	we reccommend that the Health Board devise a plan to address the longstanding underperformance in the monthly coding of episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	The Executive Committee approved the restructing of the Clinical Coding department in August 2023, the agreed restructure when comlete wil deliver on the monthly coding of episodes target.	30/06/2024	31/01/2025	09/07/2024	Overdue	Overdue	1		October 2024: Recruitment is ongoing but is proving problematic due to previously stated issues of posts in Enggland being a higher band for the same work. June 2024 Recruitment to implement the new Clinical Coding structure is on going and estimated to complete by end of September. When the structure is completed, iccremental improvements towards the monthly target will commence. Jan 2024: The Executive Committee approved the restructuring of the Clinical Coding Department in August 2023, the agreed restructure when complete will deliver on the monthly coding of episodes target.All posts have been approved by the vacancy scrutiny panel, they have been advertised on NHS Jobs and shortlisting / interview processes are completed. Some of the posts are being readvertised due to a lack of suitability of candidates.				30/09/2024
Internal	2023.07	Intergrated Performance Dashboard Data Quality	Substantial	Director of Digital	Director of Digital	Low	R1	We recommend that the Health Board develops a procedure document covering the steps to compile the Integrated Performance Report dashboard for Executive Management Team, committees and the Public Board Meeting.	With the development of the new electronic Integrated Performance Dashboard now being complete, a standard operating procedure for updating the dashboard to reflect reported performance will be developed.	30/09/2024	31/01/2025		Overdue		0		October 2024: The procedure is now in place and the dashboard is able to be updated by multiple teams in the department. Usage of the dashboard is being assessed following the move of the Performance funstion from Information to Planning.	A meeting was held in which the Director of Facilities provided reassurance and assurance on the effectiveness of the division's reporting mechanisms for escalating capital and estates-related risks. The governance structure for reporting these risks are reviewed at the relevant risk meeting to confirm that risks are being managed at the appropriate level. If needed, escalation to the corporate level will be initiated by the Director of Facilities, in line with the Risk Management Framework.			30/09/2024

External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	Medium	R1	The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could public unconfirmed committee meeting minutes shortly after the meeting	The Health Board remains fully committrf to operating with openness and transparency. Greater transparency of the Boards committee buisness will be implemented, building on existing practicies.	30/04/2024	31/03/2025		Overdue	Overdue	2		October 2024: A Project of work is udnerway, working with the Digital Directorate, to assess solutions for live streaming across all committees to ensure effectiveness. June 2024 - This action is included with the Improving Board Business Action plan which is with the Director of Corporate Governance. The focus of activity has however been upon ensuring consistency of processes of board business through the development and agreement of a documented end to end process. Discussions at Director level continue regarding the move to live streaming meetings but a date has not been agreed.				30/09/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be defined.	ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services	31/07/2024	31/12/2024		Overdue		1		October 2024: The resources library continues to expand and is reviewed and updatred regularly. Gap analysis is still to be undertaken July 2024 - The Resources area of the DDaT Sharepoint site contains approved and published policies and procedures that span the directorate. All of the document requirements for Service Desk Insitute Audit are here plus many others. A review with Head of ICT and team managers will be undertaken to identify and fill any gaps.				30/09/2024
Internal	2023.25	Decarbonisation	Limited	Director of Finance and Procurement	Director of Finance/Decarbonisation SRO	Medium	2.1	The specific risk that the Health Board is unlikely to reach the Welsh Government targets of 16% emissions reduction by 2025 and 34% reduction by 2030 needs to be clearly raised.	Agreed - this is already under consideration and a risk analysis is in construction for the Board.	30/09/2024	30/10/2024		Overdue		1		October 2024: Risk analysis being finalised end of October		07/24 - Risk 8791 closed as duplicate. Risk 7092 reviewed and updated and governance reviewed. Monthly directorate risk meetings in place to manage ongoing monitoring of risk. Joint risk review between directorate and DDaT established via formal monthly meetings.	Action Log to be updated regularly	30/09/2024
Internal	2023.34	Waiting List Management Final Internal Audit Report.	Reasonable	Chief Operating Officer	Head of Health Records/Referral & Booking Centres.	High	1.1a	Management should review the process of managing waiting lists. A targeted approach to continual validation of patients ensuring they are on the correct pathways and are not duplicates should be undertaken.	The Planned Care Academy purpose is to ensure that education and training of staff becomes embedded into ways of working, to develop and support staff as well as improving the effectiveness and compliance with national requirements relating to management of patients on their pathways. The development of tools, bespoke training packages, policies and standard operating procedures has now been completed. Initial training will provide basic RTT knowledge targeted at new starters and staff whose dealings with patient pathways are minimal. This cohort must still understand the concept of the 26 week pathway and the consequences of failing to record information correctly and in real time. Advanced RTT training is aimed at staff who require a full understanding of the 26 Week Rules. A comprehensive range of WPAS modules have been developed mirroring the patient pathway and designed to be role based i.e. tailored training. The training will include DNA's, how to rebook, the rules around Non-Admitted, Admitted and Incompletes, how to validate a PTL and what to look for within the data of a PTL to help manage pathways. Staff will learn how to record patient pathways correctly using the appropriate National RTT Status codes on WPAS. Refresher training will be provided to existing staff and competency assessed.	30/09/2024	31/11/2024		Overdue				October 2024: OCP process beginning in DDaT, part of which is the creation of the WPAS team who are required to deliver the training. This process has now commenced. New revised training materials, user guides are complete together with scenario based training to test competency and understanding. An app is in the final stage of development to allow users to book onto training sessions and this will also include refresher training for existing staff. A soft launch is planned for mid November.				30/09/2024

Appendix B: 3 Overdue Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	30/09/2024	09/07/2024	Overdue	Overdue	1		October 2024: Discharge champions identified and teaching sessions underway. WNCR has been rolled out across the HB the discharge checklist features within this. June 2024: The Welsh Nursing care records are rolled out to all areas and the discharge documentation is audited to ensure compliance. Further work is ongoingthrough the Intrograted Discharge board and focus groups to ensure that the checklist and discharge documentation is embedded meaningful and robust. This includes discharge champions in inpatient areas and a learning focus with the safer discharge group				30/09/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Planning Director / Head of Performance	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	01/10/2023	30/09/2024	09/07/2024	Overdue	Overdue	2		October 2024: The HB currently has the ability to monitor re-admsion rates, categorised as failed discharges, this can be broken down by site, speciality, ward, time and day of the week. June 2024: An initial meeting has been held and a scoping document is being prepared to develop a business case for a new data capture system to enable greater depth of analysis on discharge data and infromation March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review				30/09/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set formal deadlines for reporting. Auditors' comment on management response We agree with the current approach in the absence of mandatory deadlines. Therefore, whilst formal deadlines may not be the most suitable approach, we believe that the Health Board should continue to focus on the key principles of the Standards and the implementation of these. However, as this will be closely integrated with performance metrics and current monitoring arrangements, we recommend that exceptions are regularly escalated / reported following the commencement of workstream monitoring by the Dementia Programme Manager	01/07/2024			Overdue		0		October 2024: There isnt a standard data set required for the All Wales Dementia Standards of care. Each workstream within each Health Board is expected to update on improvments in care around the standards, which are ongoing. This is a standing agenda item on the Strategic Dementia Group and reported through the annual dementia report.	This is not an action which can be considered complete as the improvements in care are ongoing. But is complete in that there is a structure in place to monitor and record progress. Each workstream supports the All Wales Dementia Standards of Care, currently working on the agreed 20 standards. Each of the workstreams have a priority of objectives and a working action plan which supports the work. These action plans are reported into and to the Welsh Goverment, NHS Executives and the Gwent Regional Dementia Strategic Group as well as the Quality Patient Safety structure.			30/09/2024

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022			Completed/ Closed	Completed/ Closed			October 2024: Cyber Assuarance Group ToR drafted and inaugral meeting held. Thre has been a reconfiguration of governance groups which is still being implemented before this assurance group's reporting structure is finalised June 2024; "11/06/24 Work to establish SIAOs and IAOs continues within the GAGS. Once individuals are in place they will be fully involved in the next CRU NIS Audit program. March 2024: As part of the NIS CAF, CRU have supplied Cyber with a "Findings Update" Excel documentation, which allows Cyber to provide monthly updates against the outcome recommendations for the Principle(s). Currently, Cyber's responsibility is to gather updates for CRU from Remedial Action Owners until CSAG (Cyber Security Assurance Group) meetings are held; however, CRU require monthly updates and CSAG will be on a quarterly basis. We are reviewing the project management arrangements to ensure the reporting requirements can be met. January 2024: In our assessment with the Cyber Resilience Unit in January we are discussing the documentation requirements and how we can ensure this audit recommendation can be satisfied going forward. Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessemnt scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023				30/09/2024
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Care After Death Manager	Low	R4	R4 The Care after Death Team should: • develop call cascade lists to identify staff contact details in advance; • identify additional scenarios that may arise and detail action plans to overcome them; • test a range of continuity events regularly (at least once a year); and • identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.	The CaD Team accept this recommendation in full.	29/03/2023	30/09/2024	08/02/2024	Completed/ Closed	Completed/ Closed	1		October 2024: Local escaltion plan for capacity has been developed. January 2024: Partially completed. BCP has been developed and fridge and freezer plans in place to manage winter pressure. Additional capacity has been implemented. Cascade lists still to be added to BCP by 31/01/24 November 2023 -fridge/freezer capactiy is still available on the database and space can be identified in the event of unavailability. Work underway at RGH to install 56 further fridge/freezers (est completed December 2023). Decased patient storage business contuity plan is currently being updated to identify/reflect new or additional scenarios. Update August 2023 - fridge/freezer capactiy available on the database and space can be identified in the event of unavailabtily. Mar 23 Being developed by CAD Manager. 24/03/2023 CAD Team have been sited within CSS Division since November 2022. Due to temporarily return to E&F in April; Facilities Manager to work with team to completion during Q1 of 2023/24.	28/07/23 Environment Act (Wales) increased recycling regulations to be enforced from Apr 24 (non-inpatient premises) and Oct 25 (inpatient premises). Requirements may change in the lead up to implementation of the Act		Developed a live capacity spreadsheet. Fridges and freezers have been installed and all working . Daily liasion/huddle wth GUH mortuary regarding transfers to RGH site.	30/09/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Director of Digital/Chief Technology Officer	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023	30/09/2024	16/04/2024	Completed/ Closed	Completed/ Closed	1		October 2024: There is no further actions identified in relation to skills development across the directorate. PADR rates are in the low 90% which addresses training needs, there are lunch and learns in place, a skills development licence and a formal application process aligned to objectives. Apprenticerships being investigated in 25/26 and a number of staff are being supported through degree programmes. March 2024: Application Process will close April 24 . We will receive applications for review and the standard interview process will start for an appointment September 24 "Jan-24: For Digital Specialist Procurement we have identified utilising Network 75, this combines a work placement and part time study as a route to a degree , the ethos of this scheme is for the directorate to grow their own talent for the future. •Analysis of current skills matched to Job Role has been largely completed and gap analysis is being undertaken. •Pre-requisite certification at Prince II foundation and ITIL v4 foundation desirable against all job roles. •Training Agreement has been implemented and is in use within the directorate but this needs consistency across all departments. •Budget restrictions have caused the removal of ring fenced training budget however many staff are taking advantage of non cost training (PLA etc) and being provided protected time for CPD. •Development of Learning & Develop Hub is making excellent progress •Need to agree on a skills management platform to implement -			There is no further actions identified in relation to skills development across the directorate. PADR rates are in the low 90% which addresses training needs, there are lunch and learns in place, a skills development licence and a formal application process aligned to objectives. Apprenticerships being investigated in 25/26 and a number of staff are being supported through degree programmes.	30/09/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for OAMH / Informatics Programme Manager - WCCIS	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	31/07/2024	16/04/2024	Completed/ Closed	Completed/ Closed	1		October 2024: This was an issue within the Older Adult Mental Health Division which was being managed as part of their divisional reviews. March 2024: No further action via WCCIS. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.	Older Adult Mental Health teams have reviewed this action and made changes to their recording and review. This is monitored through their own strategic Older Adult reporting structure and Memory Assessment services.	30/09/2024
Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Divisioal Director of Estates and Facilities	High	R2.1	Appropriate surveys should be undertaken following dialogue with NWSSP: SES.	Agreed – the Divisional Director has, since the fieldwork for this audit, been involve in two national level conversations with NWSSP about the future of facet surveys and how they should be done. There is no formal funding for regular surveys and these discussions are ongoing relating to most effective and cost effective solutions with WG and NWSSP across NHS Wales and will dictate the final implementation of this action	31/08/2024			Completed/ Closed	Completed/ Closed	0		Discussions remain ongoing with SSP on this matter and HBs are not commissioning additional surveys pending these discussions.	Subject to All Wales approach.		SES are leading and ABUHB are not doing any facet surveys until further guidence is provided and therefore the recommendation is beyond the control of the Health Board as it is subject to an All wales approach.	30/09/2024
Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Director of Corporate Governance	High	R6	The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	At its meeting in January 2024, the Board approved its Revised Risk Management Framework which set out the revised hierarchy for risk management within the organisation, alongside an agreed Risk Appetite Statement. In-line with this Framework, the Head of Risk and Assurance will work with the Divisional Director of Estates & Facilities to review the risk management arrangements in place, ensureing appropriate escalation reporting from service to Board level.	31/01/2024			Completed/ Closed	Completed/ Closed	1		June 2024 - The Head of Risk Assurance has scheduled a discussion with the Divisional Director of Facilities to look at how estate risks are monitored and escalated to determine if any estate risks require escalation. There is a commitment to bringing all risks into one report. March 2024 - The Head of Corporate Risk and Assurance will work with Estates to ensure that their divisional risk register is robust and up to date, underpinned by operational risk reporting, and that it feeds the hierarchy process to CRR and SRR (in accordance with the framework). Furthermore, the Finance & Performance Committee is responsible for seeking assurance on estates compliance matters, which has been included in the committee workplan 2024/25 to ensure sufficient assurance is built in. -			A meeting was held in which the Director of Facilities provided reassurance and assurance on the effectiveness of the division's reporting mechanisms for escalating capital and estates-related risks. The governance structure for reporting these risks are reviewed at the relevant risk meeting to confirm that risks are being managed at the appropriate level. If needed, escalation to the corporate level will be initiated by the Director of Facilities, in line with the Risk Management Framework.	30/09/2024

Internal	2023.10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance	High	R3.1	We recommend that the Health Board examine each exception individually and take appropriate action to rectifythe matter when the reason for the anomaly is determined.All items that were not found in the register during a physical asset test should be accounted for. Asset owners that did not submit a disposal form at the time of the disposal should be required to provide documentation to evidence the disposal method and to corroborate what took place.	Agree. These issues will be resolved in readiness for the end of year accounts and disposal forms requested for those assets that cannot be located.	31/03/2024	30/09/2024	09/07/2024	Completed/ Closed	Completed/ Closed	1			Four of the seven asset issues have been resolved with the assets either located or processed as a disposal. Of the remaining three assets one is due to be disposed in June. The remaining two assets (total NBV £4k) are thought to be still within the Health Board but have not yet been located in GUH as they move with patients around the hospital. The Capital Finance team will work with EBME to locate these assets over the next few months and if not found will action a disposal.			Review and form work now completed for disposals	30/09/2024
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	Head of Board Business	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023	30/09/2024	09/07/2024	Completed/ Closed	Completed/ Closed	3		June 2024. In preparation for the new financial year revised fwps for committees have been developed with dialogue occurring with relative Executive Directors. This has been supplemented with greater planning in the development and timing of Chairs notes to guide the Chair during the meeting. To supplement this a performance tracker for meetings has been established which identifies those meetings which overrun. During Qtr. 4 1 meeting overrun. This was the Patient Safety, Quality Outcomes Committee with improvements in other committees noted. Work continues to address those circumstances where meetings overrun and this includes discussions with Executive Leads and Chairs. March 2024 -A review of Board Business processes and products has been undertaken and the outcome of this work is included in an Improving Board Business action plan and report that will be submitted to a future Board meeting. In terms of practical application there is greater focus taken at agenda setting meetings to ensure that sufficient time is allocated to support the meeting agenda. November 2023: The HOBB is undertaking a review of all board processes and procedures to secure greater consistency of approach and to ensure that all regulatory and statutory requirements are addressed though an action plan to improve board buisness. This will include the timeliness of meetings and scope of papers for consideration.			Forward work plans established and embedded. Agenda setting meetings used to consider breadth of agendas to ensure meetings are effective.	30/09/2024
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R6	The People Plan update reports provide a reasonable coverage of the actions and meetings that have taken place since the last update. However, there needs to be greater assurance provided on the impact of delivery of the People Plan (i.e., the extent that it is making a difference). The Health Board should clearly structure its People Plan updates to better describe the impact that delivery is having.	The People Plan deliverables are subject to scrutiny through People and Culture Committee with updates provided to the Board. The People Plan deliverable benefits and outcomes are also supported by a monthly reported Workforce dashboard. We will look at different ways of time series measures over time to demonstrate outcomes and benefits where appropriate.	31/04/2024	30/09/2024		Completed/ Closed	Completed/ Closed	1		October 2024: new dashbaord in place with tiem series measures as per audit recommendations August 2024: A revised dashboard has been developed which includes different measurements that demonstrate progress against targets/objectives and impact on delivery. Formal ratification is in progress with a view to launching in August 2024.			Revised dashboard to deonstrate impact of People Plan v. core workforce KPIs in place	30/09/2024
External	2023.06EA	Primary Care Follow Up	Not Rated	Director of Finance and Procurement	Director of Finance	N/A	R1	A) Calculate a baseline position for its current investment and resource use in primary and community care. b) Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	The baseline position for investment and resource in Primary and Community Care has been calculated and this has remained consistent across financial years.Work is ongoing to right size the offer in the community in order to divert demand away from acute.	30/09/2024			Completed/ Closed	Completed/ Closed	0						30/09/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospitals & Partnerships	Medium	2.3.2	We recommend that the Health Board ensures that clarity is provided over the steps to be taken with any internal financial checks and the evidence retention required, to ensure Section 6.1 of the Accounts Payable Financial Control Procedure is adhered to.	2.3.2 On receipt of appropriate documentation such as award letters or RPB approved reports, the RPB Finance team are currently responsible for raising requisitions on behalf of the RPB, ensuring that the appropriate governance routes and procedures have been adhered to. The ledger on the system is set up so that the correct financial code is driven by the appropriate funding stream, which is included in the award letters that are issued. However, as noted in section 1.2, to ensure there is a clear differentiation with roles and responsibilities to support the segregation of duties, the process of raising requisitions will be allocated to the PMO Team going forward, rather than PMO Finance.	31/07/2024	30/09/2024		Completed/ Closed	Completed/ Closed	1		October 2024: To ensure there is adherance to Section 6.1 of the Accounts Payale Financial Control Procedures, the purchase order requisitions are now being raised by requistioners approved by the budget holder. They will ensure that the correct financial code in inserted within the requisition. August 2024: This is currently in progress ensuring the relevant team members have the correct access and training in place. Once this process is operating as expected the standard operationg procedures will be updated accordingly.			This process has been agreed and the standard operating procedures have now been updated. A Procurement training session with the PMO took place on the 19th August 2024.	30/09/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Assistant Finance Director for Out of Hospitals & Partnerships	Medium	2.3.3	We recommend that the Health Board ensures that clarity is provided over the steps to be taken with any internal financial checks and the evidence retention required, to ensure Section 6.1 of the Accounts Payable Financial Control Procedure is adhered to.	2.3.3 A list of appropriate documentation, such are award letters, approved reports, minutes and decision logs, will also be included in the standard operating procedure to ensure orders are raised with the correct evidence and approvals.	31/07/2024	30/09/2024		Completed/ Closed	Completed/ Closed	1		October 2024: Purchase requisitions are raised after the indicative award letters are provided. The payment tracker has been enhanced to capture all details of each requisition, including the approvals. Additionally, the tracker contains a decision log regarding assurance for claims. The standard operatong procedures have now been updated. A matrix of evidence of expenditure for Capital has now been produced. This is currently nearing completion. Purchase requisitions are raised after the indicative award letters are provided. The payment tracker has been enhanced to capture all details of each requisition, including the approvals. Additionally, the tracker contains a decision log regarding assurance for claims. Once this process is operating as expected the standard operationg procedures will be updated accordingly.			Internal processes have been reviewed and now reflect the approved documentation list. It has been agreed that the Regional Partnership Team will produce a log of all agreed actions. The Memorandum Of Understanding will need to be taken to the Regional Partnership Board to ensure that the partnership are aware of the expected documentation required to support this process. In the interim, this information has been included in the award terms and conditions.	30/09/2024

Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Procurement Business Manager	High	4.1	We recommend that the Health Board ensures that the outstanding single tender action is promptly reported to the Audit, Risk and Assurance Committee for their oversight, in compliance with the SFI requirements.	Procurement will ensure that the STAs referenced are included in the Q1 report for 2024/25 for the Audit, Risk and Assurance Committe	31/08/2024	30/09/2024		Completed/ Closed	Completed/ Closed			August 2024: Due to be noted at the next Audit Committee on the 12th September 2024			The process as been reviewed by procurement and additional checks have been put in place to ensure all STAs are appropriately recorded for further actions.	30/09/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Assistant Finance Director for Out of Hospitals & Partnerships.	Medium	5.1	We recommend that the Health Board provides clarity to all parties, to ensure purchase invoices are sent to the central Accounts Payable address. If this is not considered appropriate, then the purchase order detail should be amended, and any such deviation from the Accounts Payable FCP be documented and approved.	Having considered the recommendation and the complexities of the partnership arrangement, it has been agreed that it is not appropriate for invoices to be sent directly to the central Accounts Payable address. This will increase the risk of payments being made in error. Arrangements will be made for the purchase order details to be amended, and the deviation from the Accounts Payable FCP to be documented and approved.	31/07/2024	30/09/2024		Completed/ Closed	Completed/ Closed	1		October 2024: Having looked into the options, changing the address on the purchase order may create further risk and confusion for non-RPB related orders . Therefore, it has been agreed that the request for invoices to be adressed to the PMO finance address will be included in the body of the requistition as an appropriate alternative. Section 6.7.1 Address on PO of the Accounts Payable FCP has been reviewed and updated to reflect this as an exception. This will be presented to the ABUHB Executive Committee on the 17th October for review, followed by the Audit Risk & Assurance Committee on the 12th November 24. Once approved it will then be published on Sharepoint.			Action has now been completed and the FCP has been updated. The updated FCP is going to the Executive Committee (17th October) and by the Audit Risk & Assurance Committee (12th November)	30/09/2024
Internal	2023.31	Theatre Stocks	Reasonable	Chief Operating Officer	Business Support and Omnicell System Manager/Service Manager PACCT	High	3.1	We recommend that workflows are redesigned to enable the stripping out of legitimate discrepanices from reported QOH differences ('Discrepancies') and that the remainder are individually investigated further to determine their cause.	Investigation of discrapancies is time consuming and complex. We detail the null transactions made by staff via reporting, this is shared with the Senior Theatre Team to improve clinical team practices. There are limitations in further development due to the time required to investigate this to the level of detail required, particularly against competing demands and expanding workload. However, we are currently reviewing the level of stock control resource and assessing the risk further. Following the review we will be in the position to reassess and if required prioritise workstream/resource demand.	30/09/2024	01/09/2024		Completed/ Closed	Completed/ Closed	1		October 2024: The Business Support Manager For the Theatres Supply Chain has created two new reports to reduce noncompliance, one to look at the null transactions, people entering cabinets and not registering what they take and also a Usage Case study report for staff leaving doors open and not logging out.. These are sent out to theatre teams monthly to action with staff, and both of these are having a positive impact (see appendix) . August 2024: The investigation into discrepancies is ongoing, and the findings or report will be shared with the staff and the Senior Theatre Team to enhance clinical team practices. Despite the challenges posed by the detailed level of investigation required and the competing demands on time amidst an expanding workload, we are assessing the risk further and reviewing the level of stock control resource. Post-review, we will be in a better position to reassess and, if necessary, prioritise workstream or resource demand. The target date of September 30, 2024, remains unchanged.		07/24 - Risk 8791 closed as duplicate. Risk 7092 reviewed and updated and governance reviewed. Monthly directorate risk meetings in place to manage ongoing monitoring of risk. Joint risk review between directorate and DDaT established via formal monthly meetings.	The team investigate discrepancies where there is an impact on service delivery, and will continue to monitor this through Divisional SMT. We propose to close the action.	30/09/2024
Internal	2023.35	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Project Director	Medium	3.1	The UHB should ensure appropriate signed authorisation for every invoice submitted in accordance with the UHB's Standing Orders Reservation and Delegation.	Agreed - Authorisations are always carried out in line with the scheme of delegation. Further authorisation measures have now been put in place to ensure a physical signature is provided on Authorisation Forms prior to the invoice payment. This will also be rolled out to all Capital Projects.	31/08/2024			Completed/ Closed	Completed/ Closed						Closed - we ensure that all authorisations are signed in line of the scheme of delegation also ensuring compliance with the NEC Contract	30/09/2024
Internal	2023.35	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Head of Capital Finance	Medium	6.3	The Project Board should be appraised of any discrepancies, inefficiencies, or risks associated with the project's cash flow. This highlighting of key project financial metrics to the Project Board would allow for an informed understanding of the financial health of the project and any potential issues that need to be addressed and ensure appropriate challenge and scrutiny.	Agreed - Project Cash Flow to be discussed at Project Board, ensuring that any potential risks are highlighted	30/09/2024			Completed/ Closed	Completed/ Closed						Closed- project cashflow is discussed at Project Team and Project Board highlighting any potential risks, followed by discussion if appropriate	30/09/2024

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Executive Lead	Leanne Lewis, Chief Operating Officer
Reporting to:	Audit, Risk & Assurance (ARA) Committee

Summary

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

This assurance note provides the committee with more detailed information on the progress of the implementation of **1** recommendation from **1** audit reports that have exceeded the agreed threshold and are held by the Chief Operating Officer.

1. **Tredegar Health & Wellbeing Centre Final Internal Audit Report**

Recommendation 4:	Management should obtain signed lease agreements with relevant parties at the earliest opportunity		
Management Response:	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.		
Number of Extensions requested * *including the current request*	3	**Most recent requested extension date**	30/12/2024

Update

Ty Dant Dentist- Has agreed in principle to sign the lease. The agreement required changes to the lease documentation. The lease is currently with Shared Services for the changes and will be returned to the contactor for consideration promptly.

Pharmacy – Negotiations ongoing**,** the majority of issues amended. Awaiting final service charges costs to present to the contractor.

Tredegar Practice – The Practice has requested the lease be placed in a limited company. Seeking legal confirmation through Shared Services that this can be carried out with no Risk to the HB.

Glan Yr Afon Practice – The HB with shared Services and the Practice are currently completing a room utilisation. Once complete lease will be amended as required and presented to the Practice for agreement.
Summary Planned completion date for all is late December. The issues around the Lease delays are complex and require external agencies to the HB to complete the drafting of the lease or give expert advice. This may due to the Christmas break push the completion date to Mid-January.

Executive Lead	Paul Solloway, Director of Digital
Reporting to:	Audit, Risk & Assurance (ARA) Committee

Summary

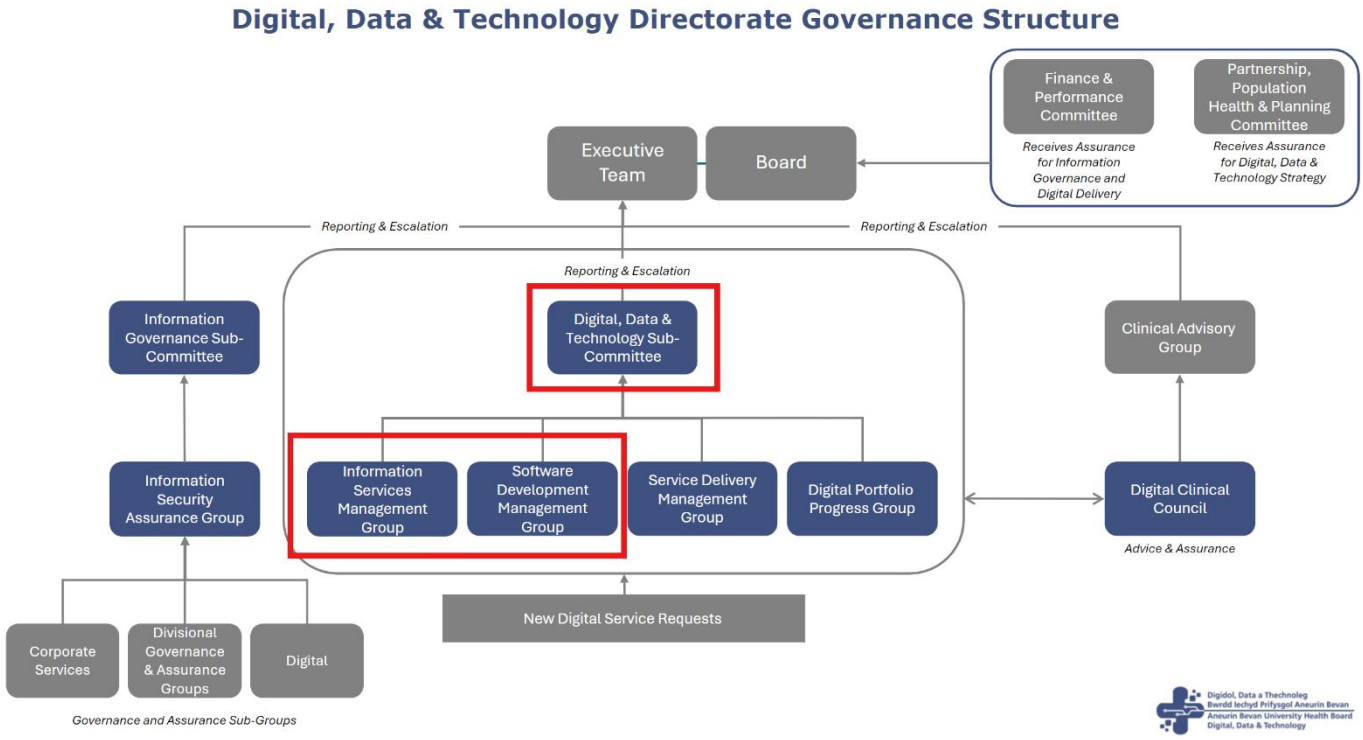
At the last Committee meeting, it was requested that an assurance report would be produced on any recommendation requesting a revised deadline beyond the agreed threshold of two extensions.

This assurance note provides the committee with more detailed information on the progress of the implementation of **3** recommendations from **2** audit reports that have exceeded the agreed threshold and are held by the Director of Digital.

2. Audit Report Title: **IM&T Control & Risk Assessment 2020/21 – Advisory**

Recommendation 1:	The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.		
Management Response:	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 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 are scheduled to be presented to Exec TeamQ1, and Board in Q2;		
Number of Extensions requested * *including the current request*	6	**Most recent requested extension date**	30/11/2024
Update			

The governance structure for Digital, Data & Technology has been agreed as below.



All the groups are now in place, or first meetings are planned apart from the Information Services Management Group and Software Development Management Group where their terms of reference are being developed.

Reporting is now in place to Finance & Performance Committee and once the remaining two groups are in place the Digital, Data & Technology Sub-Committee will be formed.

Recommendation 5:	The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.
Management Response:	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify

	risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.		
Number of Extensions requested * *including the current request*	5	**Most recent requested extension date**	30/11/2024
Update See above as this recommendation will be addressed by the governance structure being implemented.			

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Single Quotation and Tender Actions –30th August 2024 to 18th October 2024**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Alex Curley – Head of Procurement**

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

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

Appendix 1 provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 30th August 2024 to 18th October 2024.

Cefndir / Background

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

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

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

The Audit, Risk and Assurance Committee should note the detail of the attached table (Appendix 1) and should monitor the number and value of business that are being submitted for a Single Tender or Single Quotation approval. The overarching guidelines on spending of public money are that it should be carried out in a fair, transparent, and open manner, ensuring that competition is sought wherever possible. Therefore, the number of single action requests should be kept to a minimum.

There has been 1 request submitted which has been approved during the period with an annual value of £335,227.13 Ex VAT.

The reason given for the request was continuity of service whilst a full procurement process is let. The procurement / pathology team have encountered delay in the process.

The response from the Head of procurement was that on the basis of compatibility and business continuity along with the cost implications of utilising the NHSSC framework, an STA is an appropriate course of action to allow time to work through a procurement process.

Argymhelliad / Recommendation

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

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

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

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

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

Appendix A - Summary of Single Tender/Quotation											
Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO & DoF Approval Date	Chairs Approval Date (If Applicable)
26/09/2024	Single Tender Action	ABU-STA-57352	IHC and ISH Staining System - Reagent Rental	£335,227.13	Leica Biosystems	Goods & Services	Continuity of service whilst a full procurement process is let. The procurement / Pathology team have tried to procure a contract renewal via a complaint framework, however this process has experienced delays and a direct award on the framework would have incurred a £126k cost pressure to the health board. Direct quotation via an STA is most appropriate course of action due to the system already being embedded into the lab and would incur patient risk and significant delays if retender process was completed now.	Approved - Alex Curley - on the basis of compatibility and business continuity along with the cost implications of utilising the NHSSC framework I am in agreement that an STA is an appropriate course of action to allow us time to work through the issues of any potential switches and to understand feasibility and implications if a change is possible	Approved	30/09/2024	01/10/2024

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

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

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

- Approve the updated financial control policy and procedures.

    - Accounts Payable (Appendix 1)
    - Recovery of Overpayments to Employees (Appendix 2)

- Note the updated All Wales policies and procedures.

    - All Wales No PO No Pay policy (Appendix 3)
    - NWSSP Recovery of Overpayments to Employees (Appendix 4 & 5)

Cefndir / Background

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

The FCPs presented were considered and approved by the Executive Committee at their meeting on the 17th October and are presented to the Audit, Risk and Assurance Committee for approval.

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

Asesiad / Assessment

1.Financial Control Procedures (FCP)

Although not due for a routine review, the FCPs presented have been reviewed and updated as a result of two All Wales Procedures going live - the All Wales No Purchase Order (PO) No Pay policy and the NHS Wales Shared Services Partnership (NWSSP) Recovery of Overpayments to Employees procedure.

The Accounts Payable FCP is being updated to take into account the update to the All Wales No PO No Pay policy and also reflect a change of process with regard to Regional Partnership Board invoices, following an Internal Audit recommendation.

The Recovery of Overpayments to Employees FCP is being updated following the development of the NWSSP procedure. The NWSSP procedure has been developed and agreed by NWSSP and all Wales organisations so there is consistency across Wales on the Payroll Services process.

As a consequence of the above, there is an update to two Health Board procedures. The procedures are:

- Accounts Payable (Appendix 1)
- Recovery of Overpayments to Employees (Appendix 2)

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

1. Accounts Payable

Owner: Director of Finance, Procurement and Value
Review Date: February 2026

It is the Health Board's responsibility to ensure that adequate controls are in place when paying invoices.

The procedure sets out a control framework to ensure that payments to suppliers are made correctly and on a timely basis.

In order to adhere to the Public Sector Payment Policy (PSPP), payments should be made within 30 days or a shorter period if contractual terms require.

The document has been circulated for comment as follows:

- Head of Financial Services & Accounting
- NWSSP – Head of Accounts Payable and eEnablement
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
6.7.1	**Regional Partnership Board (RPB)** – added to list of exceptions of departments who receive invoices directly
6.7.1	**Regional Partnership Board (RPB)** – explanatory paragraph added, the RPB BPA team will receive and review the invoices prior to sending through to AP for processing
6.7.2.2	**All Wales No PO No Pay Policy** – link added (Appendix 3)
Appendix 1	**All Wales No PO No Pay Policy Exceptions** – list updated

2. Recovery of Overpayments to Employees

Owner: Director of Finance, Procurement and Value
Review Date: August 2025

The procedure 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 (NHS Shared Services), Corporate Finance, line managers, staff and the Counter Fraud department who are all involved in the process.

The scope of the procedure relates to all staff within the Aneurin Bevan University Health Board, covering both manual and electronic systems.

The document has been circulated for comment as follows:

- Head of Financial Services & Accounting
- NWSSP – Payroll Services
- Head of Counter Fraud
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
1	**All Wales Shared Services Recovery of Overpayments** procedure – link added (Appendix 4)
6.3	Change of **payment type** – from 'Minor' and 'Significant' to 'Automatic' and 'Standard'
7.1.1	**Automatic Overpayment** – definition added
7.1.2	**Standard Overpayment** – definition added
7.3.1	**Automatic Overpayments** – process for recovery added
7.3.2	**Standard Overpayments** – process for recovery added
7.3.2.1	**Staff who remain in post** – section added to clarify process
7.3.2.2	**Staff who have left the organisation** – section added to clarify process
7.5	**Overpayments Team** email added
7.8	**Counter Fraud Referral** – section updated to reflect that all 3 criteria must be met before referral to Counter Fraud ie individual has not notified Line Manager/Payroll; overpayment occurred for over 3 months; the value is estimated to be more than £5,000
Appendices 1 to 5	Updated to reflect the **All Wales Shared Services Overpayments** process

Summary Position on Financial Control Procedures

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

2. All Wales No PO No Pay Policy

As noted above, there has recently been an update to the All Wales No PO No Pay policy including an update to the All-Wales list of exceptions to the policy. The policy has been reviewed by the All-Wales P2P Governance Group and ratified by the Directors of Finance group.

The policy allows for local deviation to the All-Wales list of exceptions, and as such the Health Board has limited the number of exceptions and apply the No PO No Pay rule for more payment types than other organisations. The list of exceptions allowable can be found in Appendix 5.

The issue of a PO is a key control and exceptions are largely where there is already a control process and therefore control is not compromised.

As part of the update to the policy, it was agreed that it would be communicated externally to all Suppliers. The letter of communication was issued to Suppliers by NWSSP at the start of September.

It was also agreed that the policy would be issued internally to all users, including requisitioners and budget holders. The letter of communication has been issued internally by the Director of Finance.

3. Technical Accounting Issues

Technical updates

There has been one technical accounting update issued by Welsh Government since the last committee meeting in September 2024.

Update note 3 covered the following areas.

- NHS Wales Indices 2024-25 to 2028-29. Updated indices have been provided by the district valuer, which are to be sued by organisations for future forecasting.
- Asset Transfer Templates. Welsh Government provided updated S1 and S2 templates for organisations to use in relation to 2024/25 asset transfers. The templates have been updated to include:
    - Confirmation of transfer type; and
    - Value For Money review & inclusion of information for IFRS 16 lease transfer.

4. Public Sector Payment Policy (PSPP)

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

Category	Invoices	In Mth %	YTD %
NHS	Value	99.4	97.0
	Number	93.6	91.2
Non NHS	Value	95.3	95.8
	Number	97.6	97.5

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

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

5. Payments in Excess of £100K

There were no exceptional issues to report.

6. Standing Financial Instructions

There is no further update on the standing financial instructions.
Argymhelliad / Recommendation The Audit, Risk and Assurance Committee is requested to note the report and approve the updated procedures: • Accounts Payable (Appendix 1) • Recovery of Overpayments to Employees (Appendix 2)

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

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

	P2P – Procure to Pay NWSSP – NHS Wales Shared Services Partnership
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

Accounts Payable Financial Control Procedure

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

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

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0238

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Introduction

This policy covers the payment and approval of invoices for goods and services supplied to Aneurin Bevan Health Board. Invoice payments are processed on behalf of the Health Board by NHS Wales Shared Services Partnership (NWSSP) – Accounts Payable Department in Companies House, Cardiff.

1 Statement

The procedure sets out the requirements of the Health Board to ensure there are adequate controls over the payment of invoices to ensure that invoices are paid correctly, properly authorised and on a timely basis within Welsh Governments Public Sector Payment Policy 30 day target and in compliance with Standing Financial Instructions (SFIs).

2 Aims

The purpose of this document is to clearly set out the responsibilities of NWSSP and Health Board staff to ensure that payments to suppliers are made correctly and on a timely basis.

3 Objectives

The objective of this procedure is to set out a control framework to ensure that payments to suppliers are made correctly and on a timely basis. That payments are made within 30 days of the receipt of an invoice in order to comply with the Public Sector Payment Policy or within a shorter period if contractual terms require this.

4 Scope

The document relates to staff as follows:

- All staff and managers that process requisitions for goods and services across the organisation.
- All staff and managers that receive goods and services across the organisation.

- Staff within the Corporate Finance department that maintain the Authorised Signatory List of approved budget holders for the organisation and provide the banking and cash flow management function for the organisation.

- Staff within Accounts payable, NWSSP that process invoice payments.

- Staff within the Procurement function within NWSSP who provide the stores, order and contract management functions for the organisation.

5 Roles and Responsibilities

5.1 NWSSP Accounts Payable Staff

Are responsible for:

- Recording invoices on the Oracle system and promptly processing payments to suppliers in line with the requirements of this policy

- Notifying the Corporate Finance Department of the causes of delays to the payments process

- Accrue for unpaid invoices at month end in line with agreed timetable

- Operate the Construction Industry Scheme in line with this policy

- Ensuring queried invoices (on hold) are resolved on a timely basis and that numbers on hold are minimised at all times

- To immediately notify Corporate Finance of any concerns of where financial controls may be compromised or Counter Fraud in relation to suspected fraud

5.2 Corporate Finance

The Corporate Finance Staff are responsible for:

- Maintaining the Authorised Signatory List (ASL) of approvers

- Providing the banking and treasury management function in support of the Accounts payable function
- Reconciling the General Ledger and Accounts Payable modules of the Oracle system

- Being the lead point of contact within the Health Board for Accounts Payable queries

5.3 Budget Holders

Budget Holders are responsible for:

- Approving requisitions for good and services
- Ensuring that goods/services are promptly receipted on the Oracle system for those goods and services delivered or provided directly to the department from the supplier

5.4 Procurement Department

The Procurement Department are responsible for:

- Sourcing the supplier of goods and services
- Creating orders to suppliers from approved requisitions
- Resolving price and catalogue queries in relation to invoices marked as 'on hold'

5.5 Receipt & Distribution Centre Staff

Receipt & Distribution Centre staff are responsible for:

- Confirming receipt of goods delivered to the Receipt & Distribution Centre promptly on the Oracle system.

6 Accounts Payable

The standard process for the payment of invoices is as follows:

Steps	Individual Involved
1. Requisition Raised on the Oracle system	Requisitioner
2. Requisition Authorised on Oracle system	Budget Holder

3. If catalogue items, order created automatically and issued to supplier	(Automatic via Oracle workflow)
4. For Non-Catalogue items prices and suppliers checked and Purchase Order (PO) created on Oracle system	Procurement Team
5. PO sent to Supplier	Procurement Team
6. Supplier delivers goods and/or services	Supplier
7. Goods and Services booked into (receipted)the Oracle system to confirm that goods/services have been received	Requisitioner/Other designated HB staff in Receipt and Distribution centres
8. Invoice Received	Accounts Payable
9. Invoice matched to PO on system	Accounts Payable
10. Invoice Paid	System/Accounts Payable

All requisitions for goods and services must be made through the Oracle system but for a number of specific exceptions which are set out in Section 6.3 Order Creation.

The Accounts Payable Department will not pay any invoice without a matching purchase order that has been 'receipted' indicating the goods and services have been received but for the exceptions shown in Appendix 1.

6.1 Requisitions

Only requisitioners approved by budget holders within their responsibility areas will be set up as requisitioners within the Oracle system. A list of approved budget holders who are able to approve requisitions is maintained in an Authorised Signatory List (ASL) by the Corporate Finance Department and is reflected in the Oracle system.

It is the responsibility of the requisitioner of goods and services to ensure that the correct financial code is inserted within the requisition.

6.2 Requisition Approval

Only a budget holder, or the next budget holder above in the approval hierarchy is able to approve a requisition for goods and services, this is in line with the Health Board's Authorised Signatory List (ASL).

6.3 Order Creation

The Procurement Department receives requisitions via Oracle. All items ordered are checked against the Oracle catalogue, if not available from the catalogue, requisitions are processed in accordance with the Standard Financial Instructions (SFIs). If the requested item is in the Oracle Catalogue, but not selected, the requisition line is returned asking for a new requisition to be raised selecting the appropriate item from the catalogue.

The following departments source goods and services directly with the assistance of the Procurement Department to ensure that the Standing Financial Instructions (SFIs) are followed:

- IT Department for IT equipment
- Works & Estates

The Pharmacy Department have their own purchasing system to order pharmaceutical items, additional items for the Pharmacy Department are ordered via Oracle.

6.3.1 Pharmacy Department Interface Process

The Pharmacy Department maintains their own computer system for orders and stock control. Invoices received for goods and services that have been entered onto the Pharmacy system are subsequently entered into the Oracle system, using an interface file from the Pharmacy system. The Accounts Payable department are responsible for transferring the files into the Oracle system.

The process for all pharmacy invoices is as follows:

- Invoices are matched against orders within the Pharmacy Department and a sequentially numbered file is generated by the Pharmacy system
- The supporting documentation is submitted to the Accounts Payable Department
- The numbered file is transferred via the pharmacy system which generates a separate file which can then be uploaded in the Oracle system.

- Once the file has been generated the Accounts Payable officer will create a report identifying the batch header to be able to view and validate each payment.
- The Accounts Payable Officer must then verify that the details submitted by the Pharmacy Department match the payments being made. Any discrepancies that can be corrected including those identified on the interface table are corrected and the payment is made.

The batch is then filed with the relevant invoices within the Accounts Payable Department. There is a separate Oracle user guide that identifies the process for transferring the pharmacy interface file into the Oracle system.

6.4 New Suppliers and Supplier Amendments

All supplier creation and amendment, including changes to supplier bank account details in Oracle is managed by the Supplier Maintenance Team, NWSSP, Alder House, St Asaph. Oracle system access to supplier maintenance functions of the system is therefore restricted to this group of staff.

All requests for new suppliers and changes to existing suppliers is managed through an electronic form, which is completed by Procurement, and accompanied by headed note paper from the supplier. Once completed the form is submitted to the Supplier Maintenance Team who will process.

6.5 Supplier Delivers Goods or Services

All goods must be delivered to a designated Receipt & Distribution Stores within the Health Board for onward delivery by stores staff to the relevant department. Goods received into the R&D stores must be receipted in Oracle against the PO by staff in these Stores.

The address of the R&D stores are as follows:

341097 YYF Receipt & Distribution Stores,
Ysbyty Ystrad Fawr, Ystrad Fawr Way, Caerphilly Road,
Ystrad Mynach, Hengoed, CF82 7EP

320061 RGH Receipt & Distribution Stores,
Royal Gwent Hospital, Cardiff Road,
Newport. NP20 2UB

326362 STC Receipt & Distribution Stores,
St. Cadocs Hospital, Caerleon,

Newport. NP18 3XQ

326363 Nevill Hall Hospital Receipt & Distribution Stores,
Main Stores, Nevill Hall Hospital, Brecon Road,
Abergavenny. NP7 7EG

324551 GUH Receipt & Distribution Stores,
Grange University Hospital, Llanfrechfa,
Cwmbran. NP44 8YN

There are exceptions, where some departments within the Health Board are set up for direct delivery e.g. Catering, Pathology. If a department has requested to be set up for direct deliveries it is their responsibility to ensure that the goods are receipted on the Oracle system.

All departments have responsibility to ensure that orders have been receipted for goods that have been delivered and should ensure that the delivery notes are filed appropriately to support any queries arising.

All departments have responsibility to regularly check requisitions for non-delivery of goods, notifying Procurement where appropriate.

All departments have responsibility to ensure that orders for services (as opposed to physical goods) e.g. maintenance and repairs, are receipted in Oracle.

6.6 Receipting Goods

Once goods or services have been received in the locations shown above the Oracle system must be updated immediately to indicate that the goods or services have been received. See also the previous section.

6.7 Invoices

6.7.1 Invoice Received

The invoicing address is shown on all orders as:

NWSSP_PSU_P2P@wales.nhs.uk
342049 ACCOUNTS PAYABLE OCR ABHB
PO BOX 114
PONTYPOOL
NP4 4DJ

All invoices should be sent to the following postal/ email address:

Aneurin Bevan University Health Board
P.O. Box 114
PONTYPOOL
NP4 4DJ

NWSSP_PSU_P2P@wales.nhs.uk

Accounts Payable Staff will

- Ensure invoices are date stamped on the day of receipt
- All invoices are recorded on the Oracle system as soon as received with both the invoice date and date the invoice was received

There are exceptions to this, where invoices are sent directly to the department responsible for processing the invoice. The departments that will receive invoices directly are:

- Pharmacy
- Continuing Healthcare (CHC)
- Commissioning
- Nurse Bank/ Nurse Agency
- Regional Partnership Board (RPB)*

*The RPB Business Partner Accounting team will receive and review all invoices related to RPB before sending through to the Accounts Payable team for processing.

6.7.2 Invoice paid

6.7.2.1 Public Sector Payment Policy (PSPP)

NWSSP Procure to Pay staff must ensure that all invoices are paid within 30 days of the invoice date, or date of receipt of the invoice, whichever is the later date. The Health Board must be notified if any managers or departments are causing delay in the process which prevents this target being achieved.

Where possible invoices should be paid within 10 days of receipt of invoice or the invoice date in line with Welsh Government recommendations, although this is not a mandatory target.

If contractual terms require payment to be less than 30 days, invoices must be processed and paid accordingly.

6.7.2.2 No Purchase Order Number No Pay policy (No PO No Pay)

No invoice can be paid without an accompanying purchase order (PO). Any invoices received without a PO number must be referred to the budget holder requesting that a requisition and an approved PO is raised in order to enable payment of the invoice.

The Health Board is part of the All Wales No PO No Pay Policy, which has been agreed by the NHS Wales Finance Academy P2P group. The policy dictates that no invoice should be paid without an accompanying PO. If an invoice is received by the organisation without quoting a PO, Accounts Payable will record the invoice on the system before notifying the Supplier that the invoice will remain unpaid until a PO is raised, and requesting they contact the requisitioner to provide a PO. The detail of the policy can be found in the All Wales No PO No Pay Policy.

A number of exceptions to the policy have been agreed. The list of exceptions for Aneurin Bevan can be found in Appendix 1 below.

All suppliers are notified of the requirement that an order number must be obtained in advance of the supply of goods or services. Therefore, where invoices are received, that do not quote an order number, the Accounts Payable Department will mark the invoice as disputed and exclude it from the calculation of PSPP non-compliance whilst the invoice is sent to the user department to confirm the supply of goods or services.

Payment of Exception Invoices
Where invoices are processed from the exception list identified in Appendix 1, without the requirement for a purchase order, the Accounts Payable Department are responsible for verifying, prior to entering the invoice on Oracle, that the person signing the invoice is an authorised Health Board signatory and has the required level of authorisation.

6.7.2.3 Paper Invoices

i. All invoices must be date stamped by Accounts Payable staff as they are received.

ii. Accounts Payable staff must record all invoices on the Oracle system as soon as they are received.

iii. Accounts Payable staff will match the invoice to an Oracle order and ensure that both price and quantities reflect the ordered values. If successfully matched the invoice is marked for payment.

iv. Any invoices not successfully matched to order (within the tolerances set out in 6.7.2.7 below) must be placed 'on hold' and cleared within 28 days by the Accounts Payable Department liaising with Procurement or user department to resolve the query.

6.7.2.4 Electronic Invoices

All invoices received from companies using the electronic payment exchanges must be cleared from the electronic invoice interface on a daily basis by Accounts Payable staff.

The system will match the invoice to an Oracle order and ensure that both price and quantities reflect the ordered values. If successfully matched the invoice is marked for payment. Unmatched invoices must be reviewed and cleared on a daily basis.

6.7.2.5 OCR Scanning Invoices

Invoices from suppliers that are scanned into the Oracle system using the OCR software functionality must be cleared on a daily basis from the interface by Accounts Payable staff.

Accounts Payable staff will match the invoice to an Oracle order and ensure that both price and quantities reflect the ordered values. If successfully matched the invoice is marked for payment. Unmatched invoices must be reviewed and cleared and are entered on Oracle with the description field populated with NSO (Not Sent Out) and a brief description as to why the invoice has not been processed e.g. invalid Purchase order number, no purchase order number quoted. These invoices are then transferred to the query team to resolve the issue and to progress to payment stage.

In line with All Wales No PO No Pay policy, any invoice which is received without a valid Purchase Order is placed on a No PO No Pay hold. All invoices marked with a No PO No Pay hold are collated, and on a weekly basis a detailed list of all invoices with this hold is sent to the Corporate Finance team for review and action.

6.7.2.6 Interface File Payments

The Health Board utilises the Interface File process within Oracle to enable departments which process a large volume of invoices on a regular basis to transfer the invoice information to Accounts Payable.

In addition to the Pharmacy Department (as detailed in 6.3.1), the following departments currently utilise this process:

- Continuing Healthcare (CHC)
- Commissioning
- Nurse Bank/ Nurse Agency
- Litigation

It is the responsibility of the department sending the Interface File to AP to ensure that full authorisation has been provided for each and every invoice which has been recorded on the Interface File.

There is a separate Oracle user guide that identifies the process of transferring the interface file into the Oracle system.

Where a department wishes to create a new Interface File process, the department must liaise with Corporate Finance to ensure that the correct Governance arrangements are in place to ensure that the process adheres to the ASL prior to implementation.

6.7.2.7 System Payment Tolerances

<u>All-Wales Agreed General Tolerances</u>

The following tolerances have been agreed across NHS Wales and should be applied to invoices when clearing for payment and be embedded in the Oracle system:

Price difference	10%
Maximum Ship	£5 (this is the total tolerance which will override the price tolerance)
Carriage Difference	£15

Procurement will regularly validate carriage charges to ensure compliance with contractual terms.

<u>Local Meat Deliveries Quantity Tolerance</u>

Fresh butchery products inevitably differ in weight on delivery from the amount ordered. Therefore a 50% receipted quantity tolerance is applied to

these products to allow catering staff to receipt actual quantities delivered, that vary to order, without the invoice going on hold.

6.7.3 Credit Notes

Credit notes should be processed on the Oracle system using the same procedure as an invoice ensuring that the credit note terms are changed to immediate to ensure that the credit note is taken at the same time as paying the invoice. The description entered against the credit note must refer to the original invoice number.

6.7.4 Supplier Discounts

The Health Board has engaged in a Priority Supplier Programme with Oxygen Finance, which is a single solution for NHS Wales, providing early payment discounts for the Health Board based on the speed at which invoices are paid.

Oxygen Finance, on behalf of NHS Wales, engage with suppliers proposing that contract terms are agreed to allow for a Supplier Discount if invoices are paid within 10 working days of the invoice date. The % discount will vary per supplier and be dependent on the date the invoice was paid.

Invoices from Suppliers who have engaged in the Priority Supplier Programme will be processed by Accounts Payable and departments in the same way as other invoices. Invoices will be prioritised for payment by AP once they are validated for payment, by ensuring the payment terms are set to "Immediate".

On a daily basis, Oxygen Finance will receive a list of unpaid invoices which are validated for payment for Suppliers who are on the Priority Supplier Programme. They will then calculate the discounts, referred to as "credits", that are due on each invoice.

The list of invoices and associated credits is then issued to AP for them to process on the payment run.

On a monthly basis Oxygen Finance will issue the Health Board with a report, reconciling the total credits taken during the month, and an invoice with their fee for providing the service.

6.7.5 Copy Invoices

Accounts Payable staff must carry out appropriate checks to ensure that the original invoice has not been paid when requests are received to pay copy invoices. The copy invoice is to be clearly marked 'COPY' and the checker must sign the front of the invoice as formal evidence of the check being carried out.

6.7.6 Batch Headers

Manual invoices should be entered onto Oracle in batches of no less than 30 invoices. Batch Headers must comply with NWSSP procedures and follow the following format – ABUHB (number)–Initials of the inputter. The number is generated from a spreadsheet maintained by the Accounts Payable Department.

6.7.7 Invoices on Hold

Invoices are placed on hold for a variety of reasons e.g. price queries, quantity queries, distribution holds, No Purchase order quoted etc. Accounts Payable staff are responsible for reviewing the hold report on a weekly basis to clear the queried invoice. Discrepancies relating to price, quantity, nil value, goods not booked in etc. should be sent to the Procurement department for investigation and if the dispute is supplier generated, flagged as disputed on the system. Credit notes should be obtained for any overcharges.

A list of invoices received where the Purchase order has not been quoted is sent to the HB by Accounts Payable on a weekly basis for the HB to liaise with the requisitioner to ascertain the PO number and to reiterate the No Po No Pay Policy to the requisitioner. Accounts Payable are also required to send a list of invoices to suppliers on a weekly basis asking them to ascertain a PO from the HB requisition. This process does not apply to those suppliers/goods/services that have been deemed to be an exception.

6.7.8 Payment Process

6.7.8.1 Payment Systems

All invoice payments must be processed within the Oracle System, Accounts Payable Module.

6.7.8.2 Payment Methods

The following payment methods are used, all of which must be recorded as payment transactions within the Oracle AP module:

BACS Payments.
This is the default method of payment for the bulk of invoice payments to suppliers.

Payable Orders
These are payments made via the Government Banking Service using Royal Bank of Scotland. This method is used only when the supplier is unable to accept payments via BACS and should be used only as an exception.

Faster Payments
This system is normally used for urgent payroll payments but there may be an occasional need to process an urgent payment by electronic transfer to a supplier using the RBS Bankline facility.

6.7.8.3 Payment Controls

BACS Payments.

(a) A Payment listing (preliminary register) detailing all payments due is to be produced by the Accounts Payable Manager or Supervisor, from the Oracle Accounts Payable module.

(b) A reasonableness check is to be carried out by Accounts Payable to verify that the payments are correct.

(c) All payments exceeding £25K are checked by an AP manager for approval prior to payment.

(d) The Accounts Payable Manager will liaise with the Assistant Head of Financial Services or in their absence the Treasury Manager or Head of Financial Services & Accounting to ensure that the necessary cash is available. The payment run must be amended if the Assistant Head of Financial Services advises that there are cash constraints or issues with an invoice exceeding £25k.

(e) The Accounts Payable Manager will check and sign the preliminary register to approve the payment run.

(f) Once satisfied the planned Payment Run is correct, the run is to be confirmed. The Final register is generated, printed, signed and dated by the Accounts Payable Manager/ Supervisor.

(g) The BACS payment is then made, and a call is logged with the Oracle Central Team to acquire a service request number.

(h) The service request number is entered on the BACS transmission and confirmation form which is then faxed to Version One Ltd to process.

(i) Where possible remittance notes are emailed to the supplier; if no email account exists the remittances are posted.

AP Payable Orders

(a) The process is the same as the BACS process steps (a) to (f) above with the following addition.

(b) The payment listing is sent to the Treasury Department, who are notified of the number of payments to be made.

(c) The Payable orders are printed by the Treasury Officer in the Treasury Department, and the AP Manager notified of the cheque serial numbers.

(d) The Payable orders are issued by the Treasury Department, along with the remittance advice.

Non-AP Payable Orders

a) The process is the same as the BACS process steps (a) to (f) above with the following additions.

b) Payable Order printing (for charitable funds and petty cash) is initiated by the Charitable Funds Manager (for charitable funds payments) and the Treasury Manager (for petty cash payments). Payable Orders and supporting remittances are issued from the Corporate Finance Department.

Faster Payments

In exceptional circumstances, the Health Board will determine that an invoice requires immediate payment. In which case, AP will contact the Treasury Manager, requesting that the invoice is paid via Faster Payment through the Health Board's bank.

(a) Any payments processed through this method will need to be approved in advance by the Head of Financial Services and Accounting or Assistant Head of Financial Services.

(b) The invoice must be cleared for payment on the Oracle system following the normal process by Accounts payable staff.

(c) The payment request and supporting invoice and paperwork must be sent to the Head of Financial Services and Accounting.

(d) The Head of Financial Services and Accounting authorises AP staff to note the cancellation of the invoice on Oracle and for the Treasury Manager to process the payment via the RBS online banking facility.

(e) The Treasury Manager will request the Business Systems team to close the associated Purchase Order, to ensure that no future invoice is matched to the PO and cleared for payment.

(f) The payment transaction is accounted by a journal transaction by the Treasury Manager.

Timetable

Payment runs will be produced in line with agreed timetable with the Corporate Finance Department. Where changes to the agreed timetable are required, they must be agreed in advance with the Assistant Head of Financial Services and Accounts Payable department.

6.8 Overdue Accounts

The Accounts Payable Department will notify the Health Board as soon as it is aware of a supplier account becoming overdue because invoices are not being cleared promptly or where there is a risk that a supplier place the health board 'on stop'.

6.9 Supplier Statements

The AP staff will reconcile supplier statements to the Oracle system on a regular basis to ensure that all invoices are properly recorded.

6.10 Value Added Tax

VAT will be reclaimed on Contracted out Services, in accordance with relevant guidance issued by HMRC.

VAT will only be paid on receipt of a valid VAT invoice.

Where invoices are input electronically onto the AP system, via OCR, the application of VAT will be automatic, and will be based on the VAT treatment applied by the requisitioner when raising the requisition. The responsibility for the correct application of the VAT legislation will therefore be held by the requisitioner, supported by NWSSP – Procurement Services and the Financial Services Manager – VAT, who will provide advice and guidance.

Where invoices are input into the AP system manually, the Accounts Payable Manager will be responsible for the correct application of VAT legislation to the payments process. Any queries should initially be directed to the Financial Services Manager – VAT in the Corporate Finance Department.

VAT compliance will be reviewed by the Health Board's VAT Advisors on a regular basis.

7 Financial Control Weaknesses or Suspected Fraud

The Accounts Payable Manager will notify the Assistant Director of Finance (Financial Systems & Services) immediately of any concerns arising in relation to any breaches of, or apparent weaknesses in financial controls or governance. In addition, the Counter Fraud Department must be notified immediately of any concerns about fraud or suspected fraud.

8 Month End Procedures

Month end accruals are completed on the first working day of every month. An Unaccounted Transactions report is run at month end sorted by value, items over £500 highlighted in order to be accrued by the relevant team member. At year-end AP should make every effort to reserve as much as possible below £500.

Journals are to be completed by 10:30am with notification of completion to the following email address FinanceBusinessSystem.abb@wales.nhs.uk in order for all journals to be posted to the ledger.

At the end of every month the Accounts Payable Team Leader will close the current Accounts Payable accounting period and open up the next

accounting period, in line with the Aneurin Bevan Health Board's Financial Reporting timetable, and the AP sub-ledger close process timetable.

Goods Received Not Invoiced (GRNI) accruals will be reviewed on a monthly basis by the Corporate Finance Department. Any orders over 6 months old will be reviewed by the appropriate officer and where necessary closed.

The Accounts Payable Team Leader will run a Trial Balance report at month end closedown, showing the total value of invoices on the AP module of Oracle.

The Corporate Finance function will reconcile the AP Trial balance to the General Ledger and resolve any differences.

9 Construction Industry Scheme

The Accounts Payable Team Leader, in conjunction with the Works & Estates Department and Supplier Maintenance, should identify all suppliers who come within the scope of the HMRC Construction Industry Scheme.

The Accounts Payable Team Leader should ensure that the status of all suppliers identified under the Construction Industry Scheme (CIS) have been verified on-line with HMRC to confirm whether they have Net or Gross payment status.
The CIS information should be added by Supplier Maintenance into the Oracle system, with the Supplier identified with Net or Gross payment status. Any subsequent invoices entered onto Oracle for payment to the CIS supplier must be reviewed and the type of work undertaken identified as either inside or outside the scope in accordance with the classifications issued by HMRC.

The Accounts Payable Team Leader should:

Where a subcontractor is classified as 'Net', make a deduction from all payments for labour of an amount on account of the subcontractor's tax and NI contribution liability in accordance with the published Inland Revenue rate. Tax deduction will be coded to a specified code in the Oracle system.

Where the subcontractor has a 'Gross' status pay the contractor gross.

In certain circumstances where the HMRC are still reviewing the classification of a contractor the Health Board may be asked to process payments to the supplier at a higher rate of deduction.

If any doubt exists as to the nature of the payment to the supplier, the supplier site should be inactivated to prevent payment until further clarification is received and the issue resolved. This will prevent deductions being made in error or overpayments made.

Following the month end, the Accounts Payable Team Leader:

Produce a report detailing all invoices paid to subcontractors during the tax period, e.g. 6 April to 5 May. To extract this information a Qlikview report should be run on a monthly basis –

https://ctsqlikviewprodap2.cymru.nhs.uk/qlikview/index.htm

Classify the payments to subcontractors as inside or outside the scope of the CIS, as per the latest guidance issued by the Inland Revenue

Complete the monthly CIS return online in accordance with the deadline for submission.

Enter the details onto the CIS Spreadsheet for each supplier and send a letter to each supplier detailing the invoices paid and for those suppliers with a CIS status of 'Net' and 'Gross' identify the deductions made in month.

On a monthly basis, the Accounts Payable Team Leader should reconcile the relevant AP CIS Qlikview report compared to the payments made that relate to the 6th of the month to the 5th of the following month.

The monthly payment to HMRC needs to be actioned via a BACS payment which in accordance with the HMRC deadline needs to be paid by the 15th of each month.

On a monthly basis the accountancy team will undertake an overall reconciliation of the posted entries on the Oracle system in relation to the CIS deductions made to the payments made to HMRC ensuring that any incorrect transactions are adjusted for in the following month.

10 Further Information

Enquiries regarding this procedure should be directed to either the Director of Finance, Procurement and Value or the Assistant Finance Director (Financial Systems & Services)

11 Training

VAT training will be provided to Accounts Payable and Procurement staff on an annual basis.

12 Audit

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

13 Review

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

Appendix 1

Exceptions to the No PO/No Pay Policy

The following areas do not require a valid PO number.

The Exceptions List currently covers:

- Barrister Fees
- Blue Badges
- CHC/ Nursing Home Payments
- Collaborative Fees (GPs)
- Eye Tests
- GP Loads (Drugs)
- HMRC
- Hospital Car Service
- Losses & Compensation including Redress
- Nurse Agency
- Orthotics
- Patient Reimbursements including Patients Travel
- Petty Cash
- Pharmacy (including home deliveries ordered through Pharmacy System)
- Primary Care contracts OOHRs
- Primary Care Low Vision – HESP Forms
- Salary Deductions
- Tax, NI & Superannuation

Aneurin Bevan University Health Board

Recovery of Overpayments to Employees

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.

This policy should be read in conjunction with the **All-Wales Recovery of Overpayments Procedure.**

This All-Wales procedure has been developed by NHS Wales Shared Services Partnership and agreed by All Wales Directors of Finance and Directors of Workforce and Organisational Development.

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 'automatic' or 'standard'.

- 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 to 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. Automatic Overpayment

NWSSP Payroll Services have defined that an Automatic Overpayment will be identified as such, when all of the following applies:

- The overpayment was a result of late notification of changes (i.e. change of hours, termination of employment, sickness, pension or other absence, **and**
- The change or termination of employment should have been actioned less than one month before notification was received by Payroll Services, **and**
- The deduction will not amount to more than a 30% reduction in gross monthly salary.

Where the overpayment meets all of the criteria above, the overpayment will automatically be recovered over a maximum 3-month period.

7.1.2. Standard Overpayment

Where the overpayment is for a larger sum of money and has occurred for a longer period of time, (i.e. it does not meet the criteria for an Automatic Overpayment), then it will be defined as a Standard Overpayment.

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 or absences, 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 or are notified that an overpayment has occurred.

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

7.3.1. Automatic Overpayments Recovery

Where an *automatic overpayment*, as defined in 7.1.1 above, has been made the employees pay will be automatically adjusted in the next pay period to reclaim the amount of the overpayment, over a maximum 3-month period.

Gross monthly pay overpayments of 0-10% will be recovered over 1 month, 10-20% over 2 months and 20-30% over 3 months.

Payroll Services will inform the individual, before pay day of the adjustment setting out the reasons and appropriate calculations. See Adjustment to Salary Letter, Appendix 2.

If the individual terminates their employment before the overpayment is repaid in full via their salary, payroll services will contact the individual with a view to recovering the outstanding amount from the final salary.

If the employee wishes to Appeal the overpayment, and notify Payroll Services prior to adjustments being made, then Payroll Services will proceed with applying the Standard Overpayment process and recovery will be made via invoice.

7.3.2. Standard Overpayments Recovery

Where a *standard overpayment*, as defined in 7.1.2 above, has been made, Payroll Services will issue a notification letter to the employee, Overpayment Letter 1 (Appendix 3), which will outline the reasons for the overpayment and period it relates to.

The employee's line manager will also be issued a letter (Appendix 4) via email, informing them of the overpayment, by Payroll Services.

Once calculated in full, Payroll Services will send the completed Overpayment Letter 2 (Appendix 5), to the individual, their line manager and the Corporate Finance Department.

The Corporate Finance Department will subsequently issue an invoice, with accompanying backing documentation, for the amount due for repayment.

7.3.2.1. Staff who remain in Post within the Organisation

Where an overpayment is discovered and the employee remains in post within the organisation, recovery of the overpayment should be made via salary deduction. Individuals have the option to choose to repay in full or agree to set up a standing order. Full details of the repayment terms can be found in Section 7.4, below.

7.3.2.2. 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, regardless of value will be deemed as *standard overpayments* for the purpose of recovering any outstanding amounts. Full details of the repayment terms can be found in Section 7.4, below.

7.3.3. 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 7.3.3 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.

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 Services Team via email, NWSSP.AllWalesOverpayments@wales.nhs.uk, as detailed in the overpayment letters.

The Payroll Overpayment Team will respond to queries in a timely manner, 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 *Automatic* and *Standard* overpayments as defined in 7.1 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.

An initial high-level assessment by Counter Fraud Services will be requested by Payroll Services, only if all three of the criteria below are met, which indicate there may be evidence to suggest fraud may have occurred:

1. The individual has *not* notified the Organisation/Line Manager/ Payroll Services of the overpayment; **and**
2. The overpayment has occurred for more than 3 months; **and**
3. The overpayment value is estimated at more than £5,000.

If all three criteria are met, Payroll Services will send a notification to the relevant Local Counter Fraud team via the Overpayments dashboard.

The Local Counter Fraud team will subsequently assess if any further investigation is required.

The Local Counter Fraud team will have 5 days to make this assessment and make a decision whether the matter should be rejected and referred on to Corporate Finance to proceed with financial recovery, or to accept the case and commence a formal investigation.

When the case is rejected by the Local Counter Fraud team, Payroll Services will inform Corporate Finance and provide the relevant documentation to enable financial recovery.

It may subsequently be necessary for the Corporate Finance team to liaise with the Local Counter Fraud team to determine the level of investigation and communication that has already taken place.

It is important to note, that 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 6. 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 Process Flow

ABUHB - Overpayment Recov

APPENDIX 2 Adjustment to Salary Letter

English Version

Adjustment to Salary Letter.pdf

Welsh Version

LLythyr Addasiad Cyflog.pdf

APPENDIX 3 Overpayment Letter 1

English Version

Overpayment Letter 1.pdf

Welsh Version

Llythyr Gordaliad 1.pdf

APPENDIX 4 Managers Letter

English Version

Line Manager Letter.pdf

Welsh Version

Llythyr y Rheolwr Llinell.pdf

APPENDIX 5 Overpayment Letter 2

Individual Remains in Employment

English Version

Overpayment Letter 2 - Individual Remai

Welsh Version

Llythyr Gordaliad 2 - UNIGOLYN YN PARI

Individual no longer works for the organisation

English Version

Overpayment Letter 2 - Individual no lor

Welsh Version

Llythyr Gordaliad 2 - UNIGOLYN NAD YW

APPENDIX 6 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

NHS Wales Shared Services Partnership

NHS Wales No PO No Pay (No Purchase Order No Payment) Policy

To be adopted by Each Health Board, Special Health Authority and Trust in NHS Wales

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1 Introduction/Overview

The P2P - the Procure to Pay process – encompasses the end-to-end process from sourcing goods and services through to delivery and receipt of goods and payment to the supplier. A No PO No Pay policy is where invoices arriving in the system without an order number (unless on the approved exception list – see Appendix 1) are placed on hold and a weekly communication is emailed to the supplier who is instructed to seek an order number from the relevant department and manager that was supplied before payment is made. The aim is to drive up compliance with the Standing Financial Instructions as well as the standard order management process.

2 Policy Statement

The implementation of a national policy of 'No Purchase Order No Pay' is to be an essential and fundamental building block from which the efficiency and effectiveness of the P2P process can be developed.

3 Aims/Purpose

To ensure:

- That all goods and services are ordered appropriately and are supported by official Purchase Orders in line with LHB, Trust and Special Health Authority Standing Financial Instructions.
- Efficient processes are put in place so that goods are delivered when required.
- Costs are controlled by:
    - Ensuring all non-pay expenditure incurred by the organisation is valid and appropriately authorised in advance of the goods/services being received.
    - Minimising transactional costs associated with payment for goods.
    - Paying supplier invoices within deadlines set by Welsh Government.
    - Maximising financial incentives for early payment offered by suppliers.
    - Reducing the risk of late payment interest and fees being charged by suppliers.

4 Objectives

This policy seeks to ensure that NHS Wales only pays for goods, services and works which have been properly ordered and authorised in accordance with the NHS Wales Procurement rules and Standing Financial Instructions. It also ensures invoices received by the NWSSP Accounts Payable teams can be processed efficiently to minimise delay in payments to suppliers and contractors. Invoices received by the NWSSP Accounts Payable Team without a valid PO number will severely delay payment to the suppliers. Successful adoption of this policy will lead to the following benefits:

- Better control environment – the correct level of authorisation of purchase orders, in advance of expenditure being incurred.
- Catalogue compliance will be improved leading to less off catalogue purchasing and lead to revenue savings.
- More comprehensive procurement intelligence being captured through the system about what and where goods and services are purchased allowing for better sourcing decisions.
- Costs will be more accurately accrued by the system reducing management accounting and Accounts Payable (AP) team workload.
- Public Sector Payment Policy compliance will improve because processing times reduce.
- Early payment discounts can be maximised.
- Overall processing costs in NWSSP P2P will reduce, releasing resources for NHS Wales.
- Suppliers will be paid on time thus supporting the wider economy.
- Less late payment interest and fees will be charged.
- Supplies of goods / services will not be disrupted or stopped due to late payment of invoices.

5 Scope

This policy is relevant to the following groups of staff within NHS Wales Health Boards, Special Health Authorities, Trusts and NHS Wales Shared Services Partnership:

- ***Requistioners***
  Those staff that process requisitions for goods and services in departments and directorates within NHS Wales.

- ***Approvers/Budget Holders***
  Those staff that approve requisitions for goods and services in departments and directorates within NHS Wales.

- ***Staff that Receive Goods/Services***
  Those staff that indicate within the Oracle or other ordering systems that the goods/services ordered have been received.

- ***Procurement Staff***
  All NWSSP Procurement staff in the Procurement Directorate.

- ***Accounts Payable Staff***
  All NWSSP Accounts Payable staff involved in the invoice payment process.

- ***Finance Departments***
  All staff involved in financial management.

6 Roles and Responsibilities

6.1 All Staff with Responsibility for Ordering

It is the responsibility of all staff, designated under the local scheme of delegation, that order goods and services to ensure that a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.2 Requistioners

All staff that raise requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. If the goods/services being ordered are on the Exception list, then all staff must ensure they are aware of the correct payment authorisation process for those goods/services.

6.3 Requisition Approvers/Budget Holders

All managers and budget holders designated to approve requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied. It is their responsibility to ensure the person raising the order has sufficient information to be able to do so, and knowledge of when the goods / services are received to be able to update the system accordingly. If the goods/services being ordered are on the Exception list, then all managers and budget holders must ensure their staff are

aware of the correct payment authorisation process for those goods/services. These invoices will come in requiring Authorisation and be put on an Awaiting Authorisation hold. Any invoice not classed as an exception and does not quote a valid PO number will be subject to a non-compliance escalation procedure.

6.4 Staff who 'Receipt' Goods and Services

All staff that work in central stores, receipt and distribution points and local departments where goods are delivered, or services are received have responsibility for recording the goods/services as being received. They must ensure that the Purchase Order is marked as 'received' as soon as possible within the Oracle system within 2 working days following delivery of goods or provision of the service.

6.5 Procurement Services Staff

All staff working within NWSSP Procurement Services will engage with Health Board/Trust/SHA accountable Budget Holders to ensure that this policy is adopted and adhered to by all HB/Trust/SHA staff and that local operational procedures for supporting the No PO No Pay Policy are observed at all times. Procurement Services will ensure training and awareness of the Policy with Key HB/Trust/SHA stakeholders.

6.6 Accounts Payable Staff

All staff that process the payment of invoices within NWSSP Accounts payable must ensure that no invoice is paid (unless it is identified as an exception in Appendix 1) if a Purchase Order number is not quoted on the invoice. All invoices received with no Purchase Order number must be recorded within the Oracle system and the supplier notified in accordance with the communications shown in Section 8. The invoice will be placed on a No PO No Pay hold and marked as disputed.

6.7 Finance Staff

The Finance P2P Lead in each Organisation must promote this policy to finance staff, requisitioners, approvers, budget holders & receipters within their Organisations.

Finance staff must ensure there are processes in place to capture data on invoices received but unpaid, that have no Purchase Order, so that expenditure can be accrued if necessary.

7 Operation of the Policy

7.1 How does No PO No Pay Work?

No PO No Pay policy operates by requiring all invoices submitted by suppliers to contain an official PO number. In all but agreed exceptional circumstances the PO number will be:

- Generated from NHS Wales Oracle Ordering system or
- Generated from other local ordering systems e.g. pharmacy; and
- Given to the supplier or contractor BEFORE making any commitment to spend NHS Wales's monies.

There are a number of categories of expenditure that are excluded from the policy which are shown in Appendix 1.

Any invoice received by the Accounts Payable Team that is not on the exception list and does not quote a valid PO number will incur processing and approval delays which could result in severe delays to supplier payment. Exceptions will be reviewed and amended from time to time and users notified of the amendments accordingly.

7.2 What constitutes a Valid PO?

An exercise will be undertaken to remind suppliers of the NHS Wales No PO No Pay Policy and reinforce that they must not, under any circumstances, accept any verbal or written order from NHS staff unless a valid PO number is given or there is an agreed exception as set out in Appendix 1.

Any invoice received that does not quote a valid PO number will be placed on hold until a valid PO number is provided.

7.3 What is a Valid PO number?

Valid PO numbers are generated from NHS Wales ordering systems as follows:-

- Oracle Financial and Procurement System
  - Oracle is the standard financial system used by NHS LHBs/ Trusts/SHAs in Wales.
- Oracle via Basware

    - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- Oracle EBS via GHX
    - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- The Pharmacy system used for generating pharmaceutical orders.

7.4 Submission of invoice

The Purchase Order will confirm which address invoices need to be submitted for payment. Some invoices will be submitted through the electronic exchanges or via the OCR process.

7.5 Public Sector Payment Policy

Provided a supplier has quoted a valid Purchase Order number which has been obtained in advance of supply, NHS Wales commits to paying invoices in line with the Public Sector Payment Policy i.e. within 30 days from the later of the receipt of goods or services or receipt of a valid invoice [not the invoice date].

All NHS Wales organisations are required by Welsh Government to be at least 95% compliant with this policy. Compliance is reported quarterly to Welsh Government, and annually in the Organisation's annual financial accounts.

7.6 Notification to Supplier of No PO on Invoice

If a supplier sends an Invoice without a Purchase Order number quoted and it does not sit within the agreed exception list, Accounts Payable will email the supplier weekly to inform them that their invoice has been placed on hold and that the supplier must contact the Health Organisation and request a Purchase Order number to be given to them. The supplier will be reminded of outstanding invoices awaiting confirmation of a Purchase Order every time the No PO No Pay report is run.

8 Non-Compliance

Non-compliance with this policy results in non-compliance with the Organisation's Standing Financial Instructions. The method of dealing with non-compliance will be for each organisation to determine but may include:

- Retraining of member of staff
- Escalation to senior management
- Escalation to Audit Committee (or equivalent)
- Escalation to Board

- Removal of access rights to the Oracle system

9 Training

Training resources aimed at the key staff affected by this policy have been developed and iProcurement training can be provided upon request from the NWSSP e-Enablement team.

10 Implementation

The No PO No Pay policy was implemented across NHS Wales on the 1st September 2018. In accordance with clause 12 below, the latest formal review of the Policy has been undertaken in June 2024 and the proposed changes/amendments to it will be adopted by all NHS Wales Organisations

11 Audit

The application of this policy will be subject to internal audit review as part of the NWSSP Accounts Payable audits.

12 Review

This policy was implemented in September 2018, reviewed in September 2023 with further amendments in June 2024 and is due for further review in June 2027.

APPENDIX 1

All Wales Exceptions to the No PO No Pay Policy

The following items are exceptions and do not require a valid PO number. This includes a number of areas where local ordering systems are in place with appropriate authorisation control processes that do not require an Oracle PO to be raised.

	ALL WALES EXCEPTIONS
Barrister Fees	Yes
Blue Badges	Yes
Bunkered Fuel & Fuel Cards	Yes
Capital Construction contracts (where approval outside of Oracle)	SBU only
CHC - FNC	Yes
CHC/Nursing Home Payments	Yes
Collaborative Fees (GPs)	Yes
Estates (Grammes/Studio 3 Feed)	BCU & WAST only
Eye Tests	Yes
Fleet vehicles (Chevin Feed)	WAST only
GP Loads (Drugs)	Yes
Grants	Yes
HMRC	Yes
Hospital Car service	Yes
Lease Car repairs	Yes
Local Government/Authorities including Business Rates	Yes
Losses & Compensation including Redress	Yes
NHS Organisations excluding NHS Supply Chain	Yes
Nurse agency	Yes
Orthotics	Yes
Patient reimbursements including patients travelling	Yes
Petty Cash	Yes
Pharmacy (including home deliveries ordered through pharmacy system)	Yes
Primary Care contracts OOHRs	Yes
Primary care Low vision - HESP forms	Yes
Public Finance initiative	Yes
Purchase/Procurement Card	Yes
Telephone Landline - Line Rental, Call Charges & Maintenance	Yes
Telephone - Mobile Phone Charges	Yes
Salary deductions	Yes
Salary Sacrifice Schemes	Yes

Same day couriers	Yes
Tax, NI & Superannuation	Yes
Taxi Patient transport	WAST & NWSSP only
TV & Music Licences	Yes
Utilities (Gas, Electricity, Water and Oil heating)	Yes
Work Permits/Certificate of Sponsorship	Yes

PROCEDURE FOR THE RECOVERY OF OVERPAYMENTS – Salary & Expenses

Procedure Status: FINAL APPROVED
Procedure Issued: September 2024
Implementation Date: October 2024
Review Date: October 2027

Procedure for the Recovery of Overpayments

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1. Introduction

This Procedure has been written to bring a unified approach in how an overpayment should be handled across NHS Wales. This All-Wales procedure will replace any existing local processes to ensure consistency by NHS Wales Shared Services Partnership Payroll Services and NHS Wales Organisations upon the identification of an overpayment.

An overpayment is defined as any monies incorrectly paid to a current or former employee or worker through the payroll system.

2. Procedure Statement

Everyone involved in the application of the procedure will be treated with respect and dignity throughout the process.

It is recognised that overpayments are not usually the fault of the employee or worker, and this procedure seeks to support those who have been overpaid to have the overpayment recovered in a fair and reasonable manner.

Overpayments primarily arise from a "mistake of fact" (where a payment was inconsistent with the facts e.g. due to clerical, computer input or procedural error). NHS Wales Organisations have a legal right to recover any overpayments which have arisen from a mistake of fact.

NHS Wales Organisations must pursue the recovery of all overpayments regardless of fault. NHS overpayments come out of public funds and therefore NHS Wales Organisations have an obligation to recover them although this must be done in a fair and reasonable way.

Consideration will be given to individual needs and financial circumstances.

3. Aims

This procedure aims to standardise the recovery of overpayments to ensure consistency across NHS Wales.

It also aims to ensure all overpayments are recovered efficiently and as quickly as possible without imposing hardship and to ensure that employees, ex-employees, workers and ex-workers are treated fairly and consistently without any needless stress or worry.

4. Equality

NHS Wales aims to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. It is recognised that equality impacts on all aspects of day-to-day operations and all policies and procedures have an Equality Integrated Impact Assessment (EqIIA) undertaken and Welsh Language Impact Assessment undertaken.

We will ensure that we deliver this procedure in line with the requirements of the Welsh Language Standards, specifically:

- Making our service available in Welsh that is equal to the English language service that we provide by:
  - Providing Welsh language correspondence to staff through the medium of Welsh without staff having to request this.
  - Provide any communication about this procedure through the medium of Welsh without staff having to request communications from us through the medium of Welsh.
  - Provide a telephone service through the medium of Welsh that is equivalent and equal to the English language service that we provide.
  - Make available all documents and forms in relation to this procedure and its delivery available through the medium of Welsh without hesitation or delay.
  - Ensure that information about this procedure is available on our intranet pages and webpages are available to NHS Staff.
  - Any social media posts relating to this procedure will be made available through the medium of Welsh at the same time as English medium posts are available.

5. Objectives

The objectives of this procedure are to ensure:

- An equitable process for the recovery of overpayments while allowing the personal financial circumstances of those who have been overpaid to be considered.
- The recovery of the overpayment should be affordable and sustainable.
- The responsibilities of those who may be involved in the process are made clear - Appendix A.
- The potential reasons for overpayments are explained - Appendix B.
- The reduction in the frequency of overpayments through using information found in this procedure to educate and improve.

6. Scope

This procedure will apply to employees, ex-employees, workers and ex-workers of NHS Wales Organisations and covers both manual and electronic systems utilised across NHS Wales.

Where NHS Organisations have rolled out Manager Self-Service (MSS) in the Electronic Staff Record (ESR), the Line Manager should utilise MSS to update employees' assignments. If MSS is not fully rolled out, information should be communicated to Payroll Services using the forms/Staff Movement Advice (SMA) available under Useful Documents through the Organisations page on the link below.

This link also details Payroll Services contact information: Payroll Services (sharepoint.com)

7. Overpayment Recovery Process

Automatic Recovery

There may be circumstances where an overpayment could be automatically recovered from future salary payments.

This will only happen if the following applies:

- The overpayment was a result of late notification of changes i.e. a change of hours, termination of employment, sickness, pension or other absence **and**
- The change or termination of employment should have been actioned less than one month before notification was received by Payroll Services **and**
- The deduction will not amount to more than a 30% reduction in gross monthly pay.

If all these criteria are met, the overpaid salary will automatically be recovered over a maximum 3-month period. Gross monthly pay overpayments of 0-10% will be recovered over 1 month, 10-20% over 2 months and 20-30% over 3 months.

If an automatic deduction is to happen, Payroll Services will inform the individual before pay day by sending an **Adjustment to Salary Letter** (Appendix C). The letter will detail the intended recovery values per month. This is intended to provide an affordable and sustainable recovery option. Tools to help you work out what is affordable can be found at Appendix D.

If the proposed overpayment recovery timescale is not affordable, NWSSP Payroll Services can be contacted via the contact information provided on the letter. If recovery cannot be agreed over the 3-month period, the overpayment will be referred to the All Wales Overpayments Team to progress the standard recovery procedure outlined below.

If the individual terminates their employment before the overpayment is repaid in full, payroll will contact the individual with a view to recovering the outstanding amount from the final salary.

Standard Recovery

Where an overpayment is a larger sum of money and/or has occurred over a longer time period, so the criteria for automatic recovery are not met, the standard recovery process will be as follows.

This is also set out in a flow chart at Appendix E.

1. Payroll Services will send **Overpayment Letter 1** (Appendix F) to the individual who has been overpaid as soon as they are made aware of a potential overpayment.
   The letter will provide notice that a potential overpayment has occurred, detail the reason for the suspected overpayment and the period it relates to (if known). It will reference the follow up letter (**Overpayment Letter 2** – Appendix G) that will be sent with the detailed overpayment calculation once confirmed.
2. Payroll Services will send an email with an attached letter to the individuals Line Manager informing them of the potential overpayment (Appendix H). This may include an MS Forms link to provide details or reasons for why and how the overpayment may have occurred and a video link explaining how to reduce overpayments in future.

3. Once the overpayment has been calculated, Payroll Services will issue **Overpayment Letter 2** to the individual and their Line Manager detailing the overpayment calculation (Appendix G). The Finance Department from their Organisation will be copied into this letter.

(a) Where the individual remains in post within the Organisation:

Overpayment Letter 2 will show the calculation of the overpayment and the full value. The letter will explain that the overpayment will need to be recovered in full and the ways this can be done.

We aim to recover any overpayments over the same time frame as the overpayment occurred e.g. if you were overpaid for 3 months, this should be recovered over 3 months. There is also the option to repay the overpayment as a lump sum or to discuss the arrangement of a more affordable monthly recovery option.

Any requests to recover the overpayment in excess of 12 months will need to be agreed by the Director of Finance and/or Director of Workforce/People for that Organisation or their nominated deputies. Any requests will be reviewed with consideration of how and when the overpayment occurred and the individual's financial circumstances.

There can also be the consideration of alternative options such as undertaking additional hours to pay back the sums owed.

Overpayment recoveries should be made via salary unless you choose to repay in full separately or agree to set up a standing order.

Overpayment Letter 2 will mention that an invoice will be sent shortly, and this will include information on who you can contact to agree the recovery of the overpayment.

The Finance Department for your Organisation will receive a copy of this letter so that the invoice can be sent. They will note that you are a current employee or worker who may have recoveries made via salary deductions.

A copy of the salary deduction request proforma is included in Appendix I to be completed if requested.

Tools to help you work out what is affordable can be found at Appendix D.

(b) Where the individual is no longer working for the Organisation:

Overpayment Letter 2 will show the calculation of the overpayment and the full value. The letter will explain that the overpayment will need to be recovered in full and the ways this can be done.

The letter will mention that an invoice will be sent shortly, and this will include information on who you can contact to agree the recovery of the overpayment.

The Finance Department for your Organisation will receive a copy of this letter so that the invoice can be sent. As the individual is no longer an employee or worker for the Organisation, recovery via salary is not possible so payments can be made by Standing Order, Bank Transfer, Cheque or Debit/Credit Card (where Organisations have this facility).

We aim to recover any overpayments over the same time frame as the overpayment occurred e.g. if you were overpaid for 3 months, this should be recovered over 3 months. There is also the

option to repay the overpayment as a lump sum or to discuss the arrangement of a more affordable monthly recovery option.

Longer recovery periods **may** be possible but will need to be agreed by the Director of Finance and/or Director of Workforce/People for that Organisation or their nominated deputies.

Tools to help you work out what is affordable can be found at Appendix D.

The Finance Department reserves the right to progress debt collection procedures through a debt collection agency once local Organisation procedures and attempts to collect the outstanding debt have been exhausted.

Counter Fraud

There may be occasions where an overpayment needs to be assessed by Counter Fraud Services.

An initial high-level assessment by Counter Fraud Services will be requested only if **all three** of the criteria below are met which indicate there may be evidence to suggest fraud may have occurred:

1. The individual has not notified the Organisation/Line Manager/Payroll Services of the overpayment; **and**
2. The overpayment has occurred for more than 3 months; **and**
3. The overpayment value is estimated at more than £5,000

If all three criteria are met, Payroll Services will send a notification to the relevant Local Counter Fraud team using the review form in Appendix J.

Local Counter Fraud teams will make an initial assessment and advise within 5 working days if an investigation is required, or if the overpayment recovery can continue with the usual recovery procedure. If no response is received from the Local Counter Fraud team within 5 working days, Payroll Services will request final confirmation to continue with recovery of the overpayment in line with this procedure and as shown in Appendix E.

Any overpayments under initial assessment by Local Counter Fraud teams are included under the Counter Fraud section of the overpayments dashboard. Senior Workforce/People and Finance colleagues within Organisations have access to this dashboard to monitor assessments being undertaken.

If Counter Fraud Services identify that further investigation is required, the overpayment recovery will be placed on hold by Payroll Services until further advice is received from the Local Counter Fraud team.

Prior to further investigations commencing, the Local Counter Fraud team will follow local Organisation procedure for informing the Director of Workforce/People and/or Director of Finance of the details of the case to be investigated. This may include obtaining any agreement to further investigation if required locally by Organisations. In the event of any local disagreement on the correct course of action, the Local Counter Fraud team will seek advice from the national NHS Counter Fraud Service Wales.

To ensure any potential criminal investigations are not compromised, it is important that no contact is made with the individual who has been overpaid until the Local Counter Fraud team has confirmed they do not need to investigate the matter further.

8. Dispute Resolution

Where an individual refuses to consent to the recovery of the overpayment and where discussions have been exhausted, the overpayment should be referred to the Director of Workforce/People and/or Director of Finance or their nominated deputies for the Organisation with the aim of reaching an agreement for the recovery of the overpayment, taking into account the individual's personal circumstances.

A meeting should be arranged between the individual who has been overpaid and the Director of Workforce/People and/or Director of Finance or their deputies. The individual has the right to be accompanied by either a Trade Union representative or a workplace colleague.

Members of the Finance team or Payroll Services along with the Line Manager or Budget Holder may also be requested to attend this meeting where it would be helpful. The proposed outcome of the meeting may require approval by the Director of Finance or other authorised budget holder if they are not present at the meeting.

Where an individual feels they have been treated unfairly, they are encouraged to use the Respect and Resolution policy. No further action should be taken on recovery during any dispute resolution process including a complaint under the Respect and Resolution process.

If you have left NHS Wales employment and have been unable to reach an agreement, you may be able to get support through:
Acas | Making working life better for everyone in Britain or
Work - Home (citizensadvice.org.uk)
Or your Trade Union if you are still a member (if you pay through your salary, you can switch to Direct Debit to maintain membership).

It is important to remember that there is a legal right for NHS Organisations to recover any overpayment. NHS Organisations reserve the right to engage a debt collection agency should it be required.

9. Training and Awareness

NHS Organisations should make employees or workers and managers aware of this procedure on commencement. A copy of the procedure should be available on the NHS Organisation's Intranet Site and referenced in any induction and/or new manager training.

Overpayments can be minimised if everyone does their part. Managers can ask for guidance on how to ensure prompt and accurate updates of employment information including new starters, changes, terminations, and employee or worker absence should they require.

Delayed submission of payroll documentation or Manager Self-Service updates can cause significant inconvenience and anxiety for staff and unnecessary additional administration for

NWSSP Payroll Services. It can also lead to complexities for those affected in respect of tax and universal credit issues.

The roles and responsibilities of all parties detailed in this procedure are outlined in Appendix A.

10. Information Governance

Any personal data utilised within the application of this procedure will be processed in accordance with the relevant UK General Data Protection (UK GDPR) and records management strategic frameworks and policies.

APPENDIX A

Key responsibilities in respect of the overpayments process can be summarised as:

NHS Wales Shared Services Partnership Payroll Services will: -

- Pay staff correctly and on time in accordance with employee/worker data held on ESR at the point of payrolls being run.
- Make an itemised payslip available to the employee/worker. This will be an electronic payslip where MyESR (Employee Self Service) is in use.
- Inform relevant staff regarding cut-off dates for submission of Electronic Paperwork for example starters, changes, terminations, and variable pay data Payroll Services (sharepoint.com).
- Correct identified errors.
- Undertake an assessment of overpayments against the criteria to establish if a review by Local Counter Fraud Services is required
- Rectify any identified overpayment in line with this procedure for the recovery of overpayments of salary. This will include writing to the employees/ex-employees/workers/ex-workers, providing them with a detailed explanation of the overpayment.
- Inform the Line Manager that an overpayment has occurred and issue a MS Forms link for them to complete an overpayment report, which will request detail on why the overpayment has occurred and what remedial action has been taken to prevent future reoccurrence.
- Maintain a register of overpayments to share monthly/bi-monthly with nominated representatives from each Organisation. NWSSP will inform the NHS Organisation of overpayments, the reasons for them and if there is a recurrence of the manager not complying with processes and procedures relating to employee/worker data.
- Review the register of overpayments with NHS Organisations in the regular Payroll Customer Relationship Manager meetings
- Liaise with local trade union representatives where appropriate.
- Deduct monies from the employees'/workers salary in line with the agreed recovery period where appropriate.
- Upon termination, deduct any outstanding overpayments, overtaken annual leave, including salary sacrifice arrangements from the final salary where possible.
- Deal with overpayment matters with compassion and understanding, noting that in the vast majority of cases the employee/worker is not at fault
- For a limited time after termination of employment, ensure ex-employees/ex-workers have access to their payslips, P60s and P45s via a Leavers Dashboard.

- Liaise with HMRC and/or NHS Pensions if an overpayment is likely to affect tax or pension.

- Implement this procedure through the medium of Welsh in line with the Welsh Language Standards.

Employee/Ex-employee/Worker/Ex-worker Responsibility:-

Employees/Ex-employees/Workers/Ex-workers must:

- Verify basic pay, contracted hours and other regular payments included in their payslip to ensure they are in line with their contract.

- Where applicable, and possible, verify variable hours are correct on e-roster systems before rosters are finalised.

- Raise any payslip queries with their Line Manager in the first instance. This may be in respect of incorrect contracted salary, hours, regular payments, incorrect receipt of variable hours or receipt of any unexpected monies.

- Seek clarification from Payroll Services if their Line Manager cannot resolve any queries on their payslip.

- Immediately inform Payroll Services if an overpayment is identified so that recovery can begin. Any employee, ex-employee, worker or ex-worker that knowingly or willingly fails to advise Payroll Services of an overpayment may be subject to referral to the Local Counter Fraud team and if necessary the Police.

- Agree terms of recovery and ensure full recovery of any overpayments.

- Be aware of payroll cut-off dates to know when to reasonably expect payment of travel, subsistence claims, shifts on e-roster systems or variable pay elements.

- Submit expense claims and additional hours worked claims for payment within 3 months. Please note that any claims older than 3 months will not be processed for payment unless circumstances prevented the submission of the claim in time.

- Ensure the NHS Organisation is aware of any change of address and contact details to be updated via MyESR (Employee Self Service).

- Access support and advice from trade union representatives where applicable.

Line Managers:

Line Managers must notify Payroll Services of any pay impacting changes as soon as they become aware of them and their responsibilities include:

- To complete the employee change notifications and submit to Payroll Services prior to employees/workers commencing new position/hours/base.

- To complete the employee termination process at the point of the employees/workers resignation.

- For employees/workers accessing NHS Pension - in line with NHS Organisations Retirement Policy a termination form must be completed a minimum of 4 months prior to termination.

- To resolve any initial queries received from employees/workers regarding variable hours paid in month or receipt of unexpected payments, advising them they must report any suspected overpayments to Payroll Services without delay.

- To open and close employee/worker sickness absence on their ESR record at the point of notification.

- To notify Payroll Services of any unpaid leave.

- To submit authorised notification of Maternity/Paternity/Adoption/Career Break. Application forms for payment under these policies must be completed and submitted to Payroll Services prior to the date the employee/worker commences the period of leave.

- To verify an employee's/worker's contract details via Manager Self Service and monthly budgets and advise Payroll Services immediately where an employee's/worker's contractual details are incorrect.

- To ensure the employee/worker rotas (where applicable) are correct in accordance with E-roster systems. Discrepancies should immediately be brought to the attention to Organisational E-Systems Teams.

- To ensure payroll workbooks (where applicable) are completed accurately in accordance with the employees/workers working pattern.

- Support individuals who have received an overpayment.

The Workforce/People Department will: -

- Act as a link between NWSSP Payroll Services, the Line Manager, the Finance team and the employee/worker where required.

- Ensure that managers are aware of their requirements to submit payroll data including employee/worker change notifications, termination notifications and e-rostering data in line with published payroll submission deadlines.

- Ensure that managers are aware of the potential for overpayments and their requirement to see that such instances are kept to a minimum.

- Ensure that managers are aware of the Recovery of Overpayments Procedure through the inclusion on induction and Manager training programmes.

- Review overpayment data on a regular basis to identify key themes and any areas where overpayments are a regular occurrence bringing it to the attention of the respective Managers to escalate.

- In conjunction with Senior Finance staff, review and jointly agree any hardship applications with regard to extended recovery periods.

- Ensure individuals who are subject to the overpayment process are treated fairly and compassionately.

Finance/Accounts Receivable Teams will: -

- Be responsible for issuing invoices to individuals to recover overpayments.

- Agree recovery terms in line with this procedure.

- Progress debt collection procedures where recovery of overpayments is not forthcoming.

Local Counter Fraud Teams will: -

- Undertake an initial assessment of any overpayments referred to them by NWSSP Payroll Services that meet the three referral criteria

- Respond to any referrals within 5 working days and confirm to Payroll Services whether normal recovery proceedings can commence or if further investigation is required.

APPENDIX B

Reasons for Overpayments

It is important that all information relating to appointments, changes and terminations are completed promptly and accurately by the Line Manager. Notifications/Staff Movement Advice (SMA) must be submitted to NWSSP Payroll Services or updated on ESR via Manager Self-Serve (MSS) immediately after they have been agreed.

Please note that:

- Employees or workers will continue to be paid according to the details held in ESR until Payroll Services are instructed to do otherwise (i.e. via change form or termination form)
- For changes to be reflected in the next monthly salary, any changes must be notified to Payroll Services by the last day of the current month (i.e. changes to be reflected in the April salary must be notified to Payroll Services by 31st March).
- monthly salary payments cover the period to the end of the month and not only up to the pay date.
- If an employee or worker self-declares an overpayment of salary, with their agreement in writing, Payroll Services will look to suspend the relevant overpaid element of their pay to prevent any further overpayments occurring while the issue is investigated and relevant documentation is requested.

Prevention of an overpayment occurring is paramount.

NHS Wales Organisations must ensure that managers are adhering to policies and procedures that minimise the potential for overpayments.

The most frequent reasons for overpayments are: -

- Late Termination Notification – A termination form, Staff Movement Advice or update via Manager Self-Serve must be actioned as soon as it is known that an employee or worker is leaving their post, i.e. at the point of resignation, end of contract or on dismissal. Consideration must be given to whether the employee or worker has taken the correct amount of annual leave. If they have taken more leave than they have accrued, they can either work additional hours to repay the time, or they can repay the money. If they are owed annual leave, they may be able take the leave off the notice period or can be paid instead if required.
  It is important that the termination form is submitted to NWSSP Payroll Services as swiftly as possible in case a deduction needs to be made from the final salary payment.
- Late and inaccurate update of employee or worker contractual hours – as soon as the new hours are agreed, the information should be passed on via Manager Self-Serve or an employee change form. This should be prior to the date that the employee or worker begins working the new hours.
- Late and inaccurate update of an employee or worker absence (sickness, maternity, unpaid leave etc) – absences should be reported via ESR Manager Self-Serve or submission of forms to payroll as soon as possible and monitored for the duration.

Managers must ensure that the absence is closed as soon as the individual reports as fit for work.
Payroll Services will (on behalf of NHS Organisations) pay 'average sick pay' based on open sickness absence periods. If the absence is not closed, this may lead to inaccuracies.

- Late or inaccurate reporting of enhancements, overtime, on call, start date, salary, banding etc – the manager or supervisor should submit information, changes or variable pay promptly and with enough time for it to be processed by Payroll Services.
- System errors - while these errors do not happen often, once a system error is discovered, action should be taken as soon as possible in order to minimise incorrect payments. These can include ESR, E-roster and E-Expenses.

Where NHS Organisations have rolled out Manager Self-Service (MSS) in the Electronic Staff Record (ESR), the Line Manager should utilise MSS to update employees' assignments. If MSS is not fully rolled out, information should be communicated to Payroll Services using the forms/Staff Movement Advice (SMA) available under Useful Documents through the Organisations page on the link below.

This link also details Payroll Services contact information: Payroll Services (sharepoint.com)

NWSSP Payroll Services will endeavour to keep errors to a minimum, however human error can occur due to inaccurate calculation or misinterpretation of information.

APPENDIX C – ADJUSTMENT TO SALARY LETTER

NWSSP All Wales Overpayment Team
NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Private and Confidential

Name
Address 1
Address 2
Address 3
Post Code

Our Ref: JEC/Assignment number
Tel: 02921 500100

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear

We are writing to let you know that we have discovered an overpayment of your salary and/or expenses.

The amount overpaid is **£XXX** and occurred due to the late submission of information to NWSSP Payroll Services relating to a change to your pay that should have been made within the last month.

The All-Wales Procedure for the Recovery of Overpayments classes such an overpayment as an 'Adjustment to Salary' and allows the automatic recovery of overpayments of up to 30% of salary, with 0-10% recoverable in one month, 10-20% over two months and 20-30% over three months. Your overpayment was **X%** of your salary so will be recovered over **X** months.

If you would like further details of the overpayment or feel the planned automatic recovery is not affordable, please contact us on 02921 500100 quoting the reference number above. The team is happy to help and support both employees and managers.

If you would like more information on how the recovery of overpayments are handled, please read the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site link Payroll Services (sharepoint.com)

Yours sincerely,

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

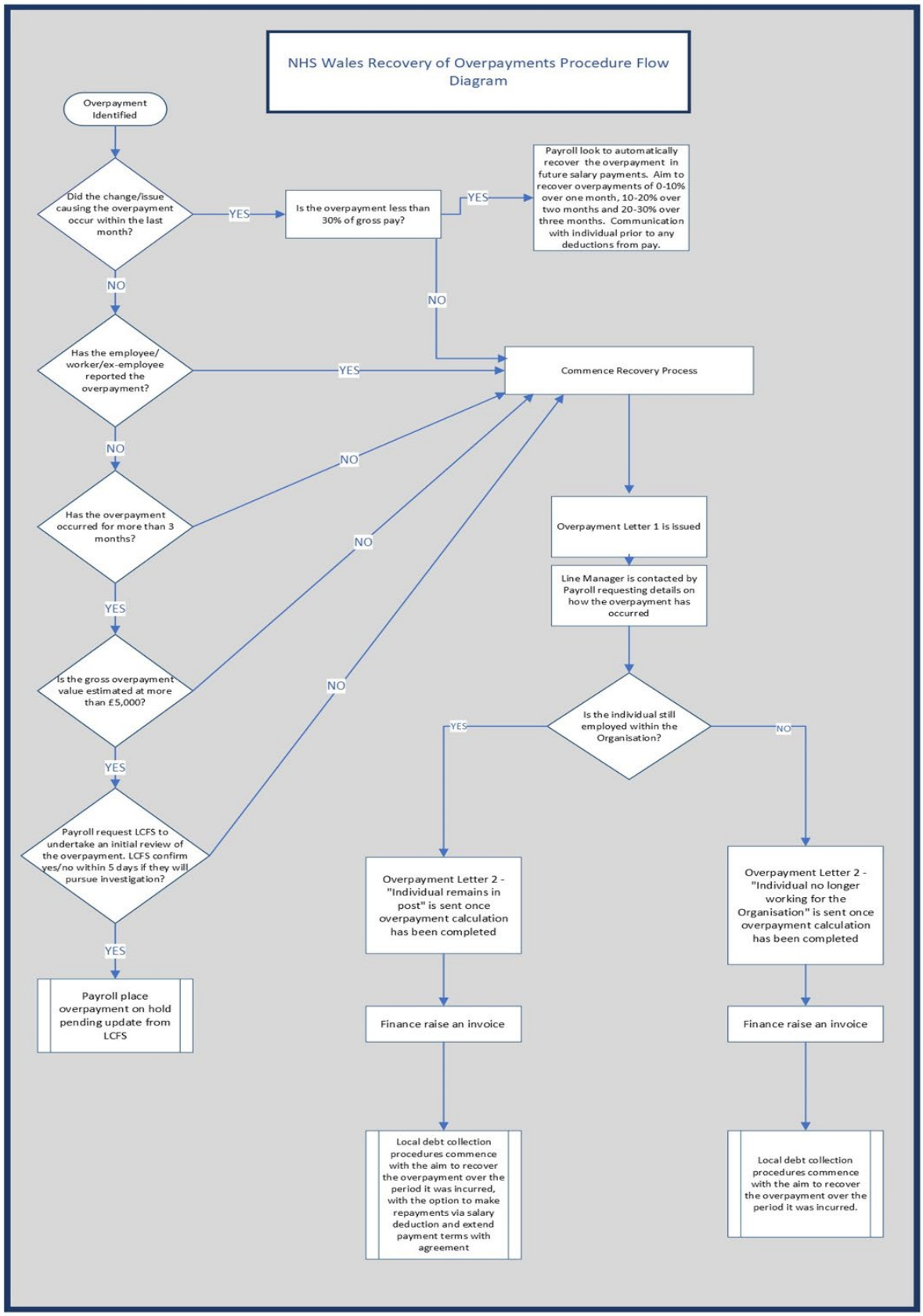
APPENDIX D – INCOME & EXPENDITURE TEMPLATE

Income%20and%20
Expenditure%20Sum

Tools and calculators | MoneyHelper

If you find yourself in financial hardship, there may be help or debt advice available from your Trade Union.
You can also check if you may be eligible for any benefits here:
Tackling Financial Insecurity Together | Turn2us
Debt advice from reputable sources Get free debt advice - GOV.UK (www.gov.uk)

APPENDIX E – OVERPAYMENTS PROCESS DIAGRAM



APPENDIX F – OVERPAYMENT LETTER 1

NWSSP All Wales Overpayment Team
NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Private and Confidential

Name
Address 1
Address 2
Address 3
Post Code

Our Ref: JEC/Assignment number
Tel: 029 21 500055

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Notification of Potential Overpayment of Salary

Dear

We are writing to let you know that we have discovered a potential error that may have resulted in an overpayment of your salary and/or expenses.

The potential error was a result of ******Insert reason here******.

The payroll team are currently looking into this and will be in touch soon to confirm the overpayment, show a detailed calculation of the amount and give details of how this can be recovered.

We have also contacted your manager to advise them of the potential overpayment so they may provide any additional information which could help clarify the overpayment calculation.

You do not need to do anything at this time, but should you want to contact the **Overpayments team you can reach them on 02921 500055 quoting the reference number above [JEC/Assignment].** The team is happy to help and support both employees and managers.

Please be aware, until the calculations are complete NWSSP Payroll Services will not be able to provide you with any overpayment figures, therefore, please allow time for these to be completed before contacting us.

If you would like more information on how the recovery of overpayments are handled, please read the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site link Payroll Services (sharepoint.com). You can access support and advice from Trade Union representatives where applicable.

Yours sincerely,

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Private and Confidential

APPENDIX G - OVERPAYMENT LETTER 2

Individual remains in post

Our Ref: JEC/Assignment
Department: NWSSP Payroll Services for All Wales Overpayments
Tel: 029 21 500055

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear

Following on from our previous letter dated ** [insert date] ** we can now give more details of your overpayment. Please accept our sincere apologies for this overpayment and any upset or inconvenience it may cause you.

The overpayment is calculated as follows: -

Period of Overpayment:	
Reason for Overpayment:	

Gross Overpayment:		**£**
Less		
	Pension:	£
	PAYE:	£
	National Insurance Contributions:	£
	Student Loan:	£
Net Overpayment Due:		**£**

An invoice will be sent to you directly from your previous organisation's Finance Department so they can begin to recover this overpayment.

Contact details of the Finance Department will be shown on the invoice should you have any queries on how to make payment. As you are no longer employed by your previous Organisation the options to repay will be either by bank transfer, standing order, cheque or debit/credit card if the facility is available within the Organisation.

You can arrange an affordable monthly recovery option or choose to repay the amount in full in one payment. Ideally, the recovery of the overpayment should occur over the same time period in which the overpayment occurred. Should you wish to discuss a different recovery time frame please contact the Finance Department.

If you have any queries in relation to the calculation of the overpayment please do not hesitate to contact the NWSSP All Wales Overpayments Team by emailing NWSSP.AllWalesOverpayments@wales.nhs.uk, or contact them on **02921 500055 quoting the reference number above [JEC/assignment number]**. The team are happy to help and support both employees and managers.

We do understand that overpayments are regrettable and may cause anxiety, so we aim to answer all queries swiftly to minimise any upset or distress.

NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Individual no longer working for the Organisation

Private and Confidential

Our Ref: JEC/Assignment
Department: NWSSP Payroll Services for All Wales Overpayments
Tel: 029 21 500055

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear

Following on from our previous letter dated ** [insert date] ** we can now give more details of your overpayment.

Please accept our sincere apologies for this overpayment and any upset or inconvenience it may cause you.

The overpayment is calculated as follows: -

Period of Overpayment:	
Reason for Overpayment:	

Gross Overpayment:	**£**
Less	
Pension:	£
PAYE:	£
National Insurance Contributions:	£
Student Loan:	£
Net Overpayment Due:	**£**

An invoice will be sent to you directly from your organisation's Finance Department so they can begin to recover this overpayment. Contact details for the Finance Department will be shown on the invoice should you have any queries. As you are still employed by your Organisation recovery of the overpayment is possible through monthly salary deductions.

You can arrange an affordable monthly recovery option or choose to repay the amount in full in one payment. Ideally, the recovery of the overpayment should occur over the same time period in which the overpayment occurred. Should you wish to discuss a different recovery time frame please contact the Finance Department.

If you have any queries in relation to the calculation of the overpayment please do not hesitate to contact the NWSSP All Wales Overpayments Team by emailing NWSSP.AllWalesOverpayments@wales.nhs.uk, or contact them on **02921 500055 quoting the reference number above [JEC/assignment number]**. The team are happy to help and support both employees and managers.

We do understand that overpayments are regrettable and may cause anxiety, so we aim to answer all queries swiftly to minimise any upset or distress.

Recovery of overpayments will be made in line with the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site: Payroll Services (sharepoint.com). The Procedure also includes a budgeting tool to help you work out what you can afford to pay at Appendix H. You can also access support and advice from Trade Union representatives where applicable.

Yours sincerely

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Recovery of overpayments will be made in line with the All-Wales Procedure for the Recovery of Overpayments, a copy of which can be provided if requested.

The Procedure also includes a budgeting tool to help you work out what you can afford to pay at Appendix H. You can also access support and advice from Trade Union representatives where applicable.

Yours sincerely

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

NWSSP Payroll Services for All Wales Overpayments
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

APPENDIX H – LINE MANAGER LETTER

Private and Confidential

Our Ref: JEC/Assignment Number
Department: NWSSP Payroll Services for All Wales Overpayments
Tel: 029 21 500055

Email: NWSSP.AllWalesOverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear Manager

We are writing to let you know that a potential overpayment of salary has occurred for a member of staff that you line manage.

Details of the potential overpayment of salary are noted below:

Employee Name:
Assignment Number:
Period of Overpayment:
Reason for Overpayment:

Next Steps…

Once the overpayment has been verified and processed in ESR, both you and the employee will receive a further letter which will confirm the overpayment and show a detailed calculation of the amount. It may take up to 14 days from the date of this letter.

The employee will then be issued with an invoice from your Organisation's Finance Team with instructions on how recovery of the overpayment can be made.

As the manager of the individual who has been overpaid, please could you discuss the overpayment with them and ensure they understand the need to repay the overpaid funds and that all overpayments are recoverable regardless of fault.

The employee will need to be made aware that if they do not repay the overpayment, the Organisation has the right to engage a debt collection agency or take legal action in order to recover the debt.

Please be supportive of your employee and draw their attention to the tools at Appendix D of the Procedure mentioned below if they need help to work out what is affordable.

For full details of how the overpayment will be treated, please refer to the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services SharePoint site: Payroll Services (sharepoint.com)

You will also be sent an Overpayment notification form to complete electronically. The information gathered will support your Organisation to monitor overpayments, understand how they occurred and what measures have been put in place to avoid future overpayments.

If there are any questions about the overpayment, please contact the **Overpayments Team on 02921 500055 quoting the reference number above [JEC/assignment].** The team are there to help and support employees and managers.

Yours sincerely

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

APPENDIX I – SALARY OVERPAYMENT DEDUCTION

Deduction direct from Salary Payment – Authorisation Form

Name:	
Assignment Number:	
Health Board/Trust/SHA:	
Department:	

I authorise NHS Wales Shared Services Partnership Payroll Services to deduct the sum of £ _____ direct from my Salary each month.

I understand that this will be deducted as a Net payment and that this deduction will continue until the overpayment £ _____ has been repaid in full.

I give my full consent for this deduction.

If my employment comes to an end, I agree that I will contact the Finance department to discuss options to either recover the outstanding balance of the overpayment from my final pay or agree how payment of the outstanding balance will be made.

Signed _____

Print Name _____ Date: _____

Once completed, please email to [Organisations to insert their accounts receivable teams email].
Finance Teams to note recovery of the overpayment is being made in instalments via salary deduction and then forward this deduction authorisation form to NWSSP.AllWalesOverpayments@wales.nhs.uk for Payroll services to action

APPENDIX J – COUNTER FRAUD INITIAL ASSESSMENT - INFORMATION REQUIRED

Individuals Name		
Pay Group / Pay Number		
NHS Organisation		
Job Title		
Pay Grade /Hours **Full/Time Part time**	Grade	Hours
Workplace / Location		
Value of Overpayment Please attach O/P Breakdown	**Gross**	**Net**
Period of Overpayment	**Date From**	**Date to**
Reason for overpayment		
Dept / Manager contact name and details		
Payroll Services Contact details		
Salary Overpayment contact details		
Please confirm what checks have been made to verify whether the individual has contacted Payroll Services		**Checks made by:** **Date:**
FURTHER DETAILS OF INDIVIDUAL:		
Address		
Date of Birth		
NI Number		
Bank A/C details		
Form Completed by:	**Date:**	
Please add any further details which may assist the Local Counter Fraud Team with their review: **Please do not contact individuals without consulting your Local Counter Fraud Service team.** **Please report any further contact to or from the individual to the Local Counter Fraud team immediately.**		

Briefing on No PO No Pay Exceptions

The following list of exceptions to the All Wales No PO No Pay policy have been agreed nationally.

However the policy allows for local deviation from this list of exceptions, if the organisation has agreed processes in place that mean Purchase Orders are used for those categories listed.

Appendix 1

	ALL WALES EXCEPTIONS	ABUHB EXCEPTION	REASON FOR EXCEPTION/ DEVIATION
Barrister Fees	Yes	Yes	Legal & Risk Scheme of Delegation ASL applied
Blue Badges	Yes	Yes	-
Bunkered Fuel & Fuel Cards	Yes	**No**	**Purchase Orders Raised**
Capital Construction contracts (where approval outside of Oracle)	SBU only	**No**	**Purchase Orders Raised**
CHC - FNC	Yes	**No**	**Purchase Orders Raised**
CHC/Nursing Home Payments	Yes	Yes	CHC Scheme of Delegation ASL applied
Collaborative Fees (GPs)	Yes	Yes	Reconciliation & Approval by Primary Care Services & Corp Finance Debit Note. Paid by BACS
Estates (Grammes/Studio 3 Feed)	BCU & WAST only	No	**Purchase Orders Raised**
Eye Tests	Yes	Yes	-
Fleet vehicles (Chevin Feed)	WAST only	**No**	**Purchase Orders Raised**
GP Loads (Drugs)	Yes	Yes	Reconciliation & Approval by Primary Care Services & Corp Finance Debit Note. Paid by BACS
Grants	Yes	**No**	**Purchase Orders Raised**
HMRC	Yes	Yes	Reconciliation & Approval by Payroll Services & Corp Finance Debit Note. Paid by BACS
Hospital Car service	Yes	Yes	Internal Recharge
Lease Car repairs	Yes	**No**	**Purchase Orders Raised**
Local Government/Authorities including Business Rates	Yes	**No**	**Purchase Orders Raised**
Losses & Compensation including Redress	Yes	Yes	Legal & Risk Scheme of Delegation ASL applied
NHS Organisations excluding NHS Supply Chain	Yes	**No**	**Purchase Orders Raised**
Nurse agency	Yes	Yes	All timesheets/ shifts approved through Health Roster

	ALL WALES EXCEPTIONS	ABUHB EXCEPTION	REASON FOR EXCEPTION/ DEVIATION
Orthotics	Yes	Yes	Reconciliation & Approved by Corp. Finance. Paid by Cheque
Patient reimbursements including patients travelling	Yes	Yes	Reconciliation & Approved by Corp. Finance. Paid by Cheque
Petty Cash	Yes	Yes	Reconciliation & Approved by Corp. Finance. Paid by Cheque
Pharmacy (including home deliveries ordered through pharmacy system)	Yes	Yes	Orders Place through Pharmacy System
Primary Care contracts OOHRs	Yes	Yes	Reconciliation & Approval by Primary Care Services & Corp Finance Debit Note. Paid by BACS
Primary care Low vision - HESP forms	Yes	Yes	Reconciliation & Approval by Primary Care Services & Corp Finance Debit Note. Paid by BACS
Public Finance initiative	Yes	**No**	**Purchase Orders Raised**
Purchase/Procurement Card	Yes	**No**	**Purchase Orders Raised**
Telephone Landline - Line Rental, Call Charges & Maintenance	Yes	**No**	**Purchase Orders Raised**
Telephone - Mobile Phone Charges	Yes	**No**	**Purchase Orders Raised**
Salary deductions	Yes	Yes	Approval through Employee
Salary Sacrifice Schemes	Yes	**No**	**Purchase Orders Raised**
Same day couriers	Yes	**No**	**Purchase Orders Raised**
Tax, NI & Superannuation	Yes	Yes	Reconciliation & Approval by Payroll Services & Corp Finance Debit Note. Paid by BACS
Taxi Patient transport	WAST & NWSSP only	**No**	**Purchase Orders Raised**
TV & Music Licences	Yes	**No**	**Purchase Orders Raised**
Utilities (Gas, Electricity, Water and Oil heating)	Yes	**No**	**Purchase Orders Raised**
Work Permits/Certificate of Sponsorship	Yes	**No**	**Purchase Orders Raised**

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING	
DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 November 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Update on Losses and Special payments – 1st April 2024 – 30th September 2024**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: REPORTING OFFICER:	**Mark Ross, Assistant Director of Finance (Financial Systems & Services)**

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit, Finance & Risk Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2024 and 30th September 2024.

Cefndir / Background

Losses and Special payments are reported in the financial position monthly and reported to the Audit, Finance & Risk Committee in line with the Committee's terms of reference.

The main content of the report is in the Losses and Special Payments table and sets out the recorded "loss" for the year to date alongside where this category of expense is considered and scrutinised within the Health Board.

The report also provides details of the provision held by the Health Board in relation to all outstanding Medical Negligence and Personal injury claims which are currently under review by NWSSP Legal & Risk Services.

Asesiad / Assessment

The losses and special payments recorded during the period 1st April 2024 to 30th September 2024 totalled £13.6m of which £12.5m is recoverable from the Welsh Risk Pool (WRP), this means the actual loss to the Health Board is £1.1m. The vast majority of this relates to clinical negligence and personal injury payments.

The losses & special payments for which the Health Board is accountable for including movements in provision are recorded as expenditure throughout the year and are reflected in the reported and forecast position of the Health Board.

The summary position for the period to 30 September is shown in the table below.

1 Financial Analysis of Losses

LOSSES AND SPECIAL PAYMENTS
01.04.24-30.09.24

	No. of Cases	Amount of Loss or Payment			Type of loss/ payment	Where reported/reviewed	Notes
		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000			
LOSSES:							
Bad Debts	0	0	0	0	Various	Authorised by Division and notified/approved by Audit Risk and Assurance Committee	
SPECIAL PAYMENTS:							
Loss of personal effects	8	3	0	3	Minor Losses	Losses form completed - Authorised by Division and Putting Things Right team	Lost dentures, glasses etc.
Clinical negligence with advice	177	742	12,363	13,105	Clinical Negligence	Clinical negligence and personal injury - payment verified and lessons learnt addressed by the litigation committee for claims over £25K. Feedback into the quality and patient safety committee re Lessons Learnt. Reimbursement of payment made not processed by WRP until satisfied that lessons learnt have been clearly documented and implemented. Annual Report to Quality & Patient Safety Committee by the Litigation Department. Includes case type, numbers, financial information, and historic comparisons.	Completed cases
Personal injury with advice (includes Permanent Injury Benefit)	89	273	50	323	Personal Injury	As above	Completed cases

Other clinical negligence and personal injury	15	10	127	137	Clinical Negligence and Personal Injury - claims under £25K	Redress committee for payments under £25K. Lessons learnt fed back to division	Completed cases
Other	23	19	0	19	Various	Ombudsman cases - confirmed by putting things right team, other losses reports completed as appropriate	
TOTAL LOSSES AND SPECIAL PAYMENTS	**312**	**1,047**	**12,541**	**13,588**			
Of which, cases of £300,000 or more:							
Clinical negligence with advice	11	30	19,483	19,513			
Personal Injury with advice	1	21	350	371			

2 Clinical Negligence and Personal Injury Provisions

In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet. This is based on the estimated potential liability as advised by NWSSP Legal & Risk Services of the possible future cost for all known cases. It has decreased by £22.9m since 31st March 2024 to an overall provision of £190.4m of which it is expected that £185.2m is recoverable from WRP leaving theoretical potential future losses to the Health Board of £5.2m – largely unchanged from the year end.

The table below shows the analysis of the estimated liability for losses as at 30th September 2024 compared to the position reported at 31st March 2024.

Losses & Special Payments Provisions	**31-Mar-24**		**30-Sep-24**	
	No. of Cases	**£m**	**No. of Cases**	**£m**
Clinical Negligence	255	209.8	258	187
Personal Injury	59	0.2	66	0.1
Permanent Injury Benefit	22	3.0	21	3.0
Redress	33	0.3	33	0.3
Sub Total	**369**	**213.3**	**378**	**190.4**
Less WRP Recoverable: Clinical Negligence	-134	-207.8	-149	-184.9
Less WRP Recoverable: Personal Injury	-2	-0.1	0	0
Less WRP Recoverable: Redress	-32	-0.2	-32	-0.3
Net Liability	**201**	**5.2**	**197**	**5.2**

The percentage of recovery for Personal Injury cases is much lower than Medical Negligence cases as most Personal Injury cases are under £25K. Up to the end of

September none of the Personal Injury cases out of the 66 cases are over £25K whereas 149 of the 258 Medical Negligence cases are over £25K.
Argymhelliad / Recommendation The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	WRP – Welsh Risk Pool NWSSP – NHS Wales Shared Services Partnership
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Title: Assurance Note on the Implementation of the Actions from the Audit Wales Community Pharmacy Data Matching Report	
Executive Lead	Leanne Watkins
Reporting to:	Audit, Risk & Assurance (ARA) Committee

Summary

In May 2024, Audit Wales published a report outlining their findings from a Community Pharmacy Data Matching pilot[1]. This was a three-year pilot involving almost 30% of pharmacies in Wales, which was undertaken in Swansea Bay and Cwm Taf Morgannwg University Health Boards. The focus of this work was on areas of known risk associated with expensive items, specials and higher cost items. The report found no evidence of systemic fraud or error, although posed the following three questions to the Chief Pharmaceutical Officer of Welsh Government.

- Are you satisfied with the current approaches in each health board, and across NHS Wales, to identify and investigate outliers in relation to high cost and risk of fraud for dispensing contractor activity?
- Are key lessons and best practice around these matters being shared between health boards? For example, are the health boards sharing examples of where fraud has been identified to make them aware of risks?
- Is there scope for the NHS in Wales to put extra cost-effective controls in place around the variable costs of Specials?

Welsh Government have responded to Audit Wales' findings (see Appendix 1). The key recommendation from this response was to develop an interactive expensive items dashboard. This will allow health boards to identify prescriptions prescribed and dispensed which may need additional scrutiny. A subsequent letter has been issued to Directors of Pharmacy, to seek assurance that health boards put in place arrangements to utilise this dashboard, to minimise avoidable expenditure and risk of fraud from prescribing and dispensing expensive items. Health boards have been asked to provide this assurance by 29 November 2024.

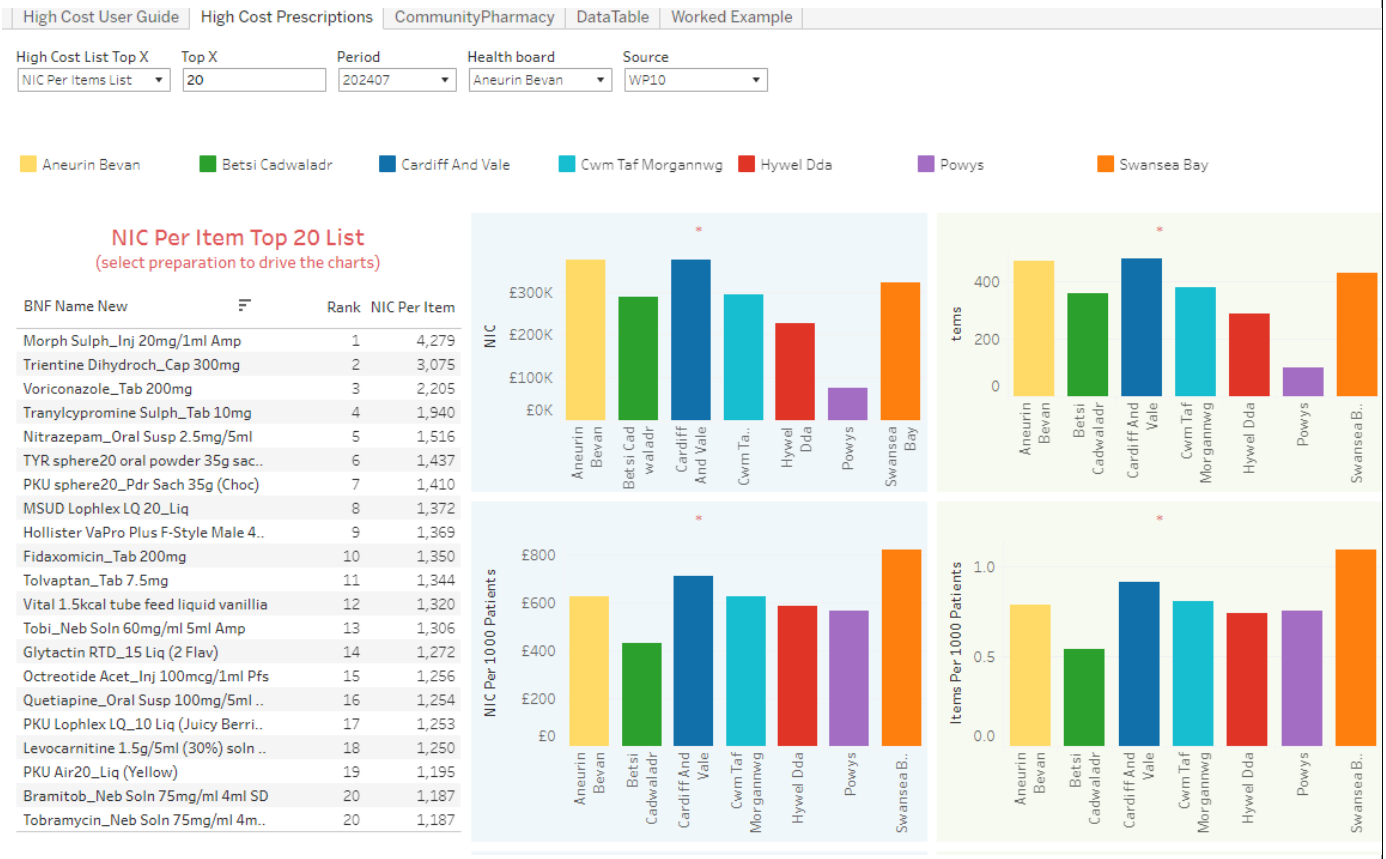
Assessment

Whilst the Medicines Management team routinely monitor prescribing trends for high-cost prescriptions and specials, the new dashboard provides an opportunity to have a single consolidated approach to this activity and allows items to be viewed by community pharmacy contractor.

A meeting has been held to review the dashboard and it has agreed that this will be incorporated into standard monthly monitoring processes. This will be supported by

the development of a standard operating procedure. It is intended to log all prescriptions queried together with the outcome and action taken by prescribers. Future review of the prescription data will therefore be used to determine if appropriate action has taken place. Where significant concerns are identified these be discussed with the counter fraud service as appropriate.

An example of the dashboard for the top 20 is shown below for July 2024.



Examples of prescriptions that will be reviewed will include

- Special formulations that may be available at an alternative strength or formulation which are a lower cost.

- High-cost items that should not be prescribed by primary care, due to the specialist nature of the medicine. E.g. trientine, voriconazole, and tolvaptan.

Any unusual patterns identified will then be cross referenced to the community pharmacy contractor to determine whether any further monitoring or action is required.

The Audit, Risk & Assurance Committee are therefore asked to note the development of the expensive items' dashboard and the incorporation of this into the routine monitoring of the prescribing and dispensing of expensive items. This will provide ongoing assurance in relation to the recommendation made by Welsh Government in response to the Audit Wales report.

Appendix 1

MA_EM_5960_24 Annex 3.pdf

[1] [1] Community Pharmacy Data Matching Pilot | Audit Wales

Prif Swyddog Fferyllol
Chief Pharmaceutical Officer

Llywodraeth Cymru
Welsh Government

Adrian Crompton
Auditor General for Wales
Audit Wales
1 Capital Quarter
Cardiff
CF10 4BZ

By email

19 July 2024

Dear Adrian,

Community Pharmacy Data Matching Pilot

Thank you for your letter of 23 May and the accompanying report describing the findings and recommendations of Audit Wales' community pharmacy data matching pilot. Given the scale of public expenditure on medicines and pharmaceutical services, tackling fraud and error is of considerable importance and I am grateful to you and your colleagues for taking the time to investigate risk in the community pharmacy sector so thoroughly.

I am particularly pleased this extensive pilot involving almost 30% of pharmacies in Wales over a three-year period, found no evidence of systemic fraud or error. I consider these findings are likely to be representative given the large sample size, the mix of pharmacies and prescriptions dispensed in the sample, and the duration of the field work. The report therefore provides welcome assurance in this area of high spend and scrutiny.

We are not making specific recommendations, you ask three questions NHS Wales, should ask itself, given the findings of our pilot.

Are you satisfied with the current approaches in each health board, and across NHS Wales, to identify and investigate outliers in relation to high cost and risk of fraud for dispensing contractor activity?

As I have set out above the report provides a great deal of reassurance that auditors were unable to find any evidence of systemic fraud or error within the community pharmacy

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

Parc Cathays • Cathays Park
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Gwefan • website:
www.llyw.cymru
www.gov.wales

sector. Of course, we cannot be complacent given there may be some types of fraudulent activity which were not investigated by the pilot or fraud may be occurring in health boards other than those included in the sample.

There are examples of significant fraudulent practice having occurred in the community pharmacy sector such as those described in the report. It is reassuring that these historic cases were identified by health boards working closely with NHS Counter Fraud Services, through checks and balances which pre-date the pilot.

The pilot identified risks in three main areas: pricing errors, expensive items and specials.

On pricing errors, between 6 million and 7 million prescriptions in Wales are processed for payment by the NHS Wales Shared Services Partnership every month. Prescription payment accuracy is consistently high with an error rate of only around 1 per 1000 prescriptions processed. Where processing errors occur, they are as likely to result in underpayments to pharmacies as they are in overpayment by the NHS. Audit Wales' work only considered overpayments and it is therefore likely that further investigation of errors would cancel out any potential savings for the NHS over time. The level of pricing accuracy is agreed between the NHS and Community Pharmacy Wales on behalf of pharmacy contractors we do not therefore propose to take any further actions to address under and overpayments. It will however remain possible to make corrections in respect of individual errors on an ad hoc basis.

Turning to expensive items, I agree additional checks by health boards are likely to improve how risks are managed in this area. Whilst I am aware health boards may undertake some checks on expensive prescriptions already, such checks generally focus on the prescriber of the medicine rather than the pharmacy which dispensed it. I agree with your assessment that health boards would have greater assurance if additional checks on pharmacies dispensing large numbers of expensive prescriptions were undertaken. We will therefore take three actions to improve the work health boards undertake in this area.

Firstly, we have commissioned the Wales Analytical Prescribing Support Unit (WAPSU) to develop an interactive expensive items dashboard which can be accessed by health boards and used to identify expensive prescriptions issued by general practitioners and hospital outpatient departments in their area. The dashboard allows health board users to access aggregated and individual prescription data including the individual prescription images retained by the NHS Wales Shared Services Partnership.

Secondly, we will work with the NHS Wales Shared Services Partnership to develop a monthly report detailing expensive items dispensed by pharmacies in each health board area and make this report routinely available to health boards.

Finally, we will write to health boards providing information about both the interactive dashboard and the community pharmacy expensive items report, asking them to confirm what arrangements they will put in place to ensure the new tools are used to minimise the risk of fraud or error occurring within the health board.

Are key lessons and best practice around these matters being shared between health boards? For example, are the health boards sharing examples of where fraud has been identified to make them aware of risks?

I agree there are likely to be significant benefits arising from sharing lessons learned and best practice between health boards. We will therefore write to the Head of NHS Counter Fraud Services in Wales and the Directors of Pharmacy of each health board asking what arrangements might be put in place to facilitate such information sharing.

Is there scope for the NHS in Wales to put extra cost-effective controls in place around the variable costs of specials?

Specials are often considerably more expensive than licenced medicines, due to the bespoke nature of the product and include costs of sourcing raw materials, manufacturing, quality control, or importing products and distribution.

The nature of specials make them much more liable to price fluctuations arising from changes to the prices of raw materials or from an urgent need for a special to be manufactured where a surcharge may be payable for faster delivery.

Action has been taken over a number of years to reduce the cost of specials to the NHS. In 2011, standard reimbursement prices were introduced for the most commonly prescribed manufactured specials (for example liquids, creams and ointments made to an individual formula). Between 2018 when Audit Wales began its fieldwork, and 2023 the total annual spend on these medicines fell by more than 50% (from £1.01 to £0.48m per year) as a result of the changes.

More recently in March 2022, further changes were made to reduce the cost of unlicensed, imported medicines by incentivising pharmacy contractors to source these medicines at the cheapest price possible, reducing variation and excessive prices that do not reflect the cost of manufacturing the special. In the first year following these further changes costs fell by 5% (from £0.65m to £0.62m).

The reimbursement costs of specials have been subject to scrutiny for a number of years including as part of a Department of Health and Social Care consultation in 2019. Various approaches including requiring pharmacy contractors to obtain quotes from several manufacturers, seeking central approval to place orders, and a national specials' procurement service, have all been proposed and discounted as being unlikely to result in significant cost savings.

Given the changes made since Audit Wales' fieldwork, the previous consultation and analysis of options, and the significant reduction in cost in recent years, I do not consider the same potential exists to make the savings estimated by Audit Wales in future years. However, there continues to be potential for health boards to review individual prescriptions for high cost specials which could be replaced with a lower cost standard licensed preparation. The interactive expensive items dashboard developed by WAPSU will support health boards to identify additional opportunities to query the prescribing of expensive unlicensed specials.

I trust this information demonstrates the steps we are taking to ensure fraud is identified and wherever possible prevented in the community pharmacy sector in Wales. The additional actions we will take as a direct result of the data matching pilot will serve to strengthen health boards' approach further and I am grateful to you and your colleagues for your interest and assistance in this important area.

I am copying this letter to the Chairs of Senedd Cymru's Public Accounts and Public Administration Committee, Health and Social Care Committee, and Finance Committee, for information.

Yours sincerely

Andrew Evans FRPharmS
Prif Swyddog Fferyllol/Chief Pharmaceutical Officer
Llywodraeth Cymru/Welsh Government

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Consultant Job Planning - Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert, Executive Medical Director; Sarah Simmonds, Executive Director of Workforce & Organisational Development
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kathryn Bourne, Strategic Lead Medical & Dental Workforce

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

Er Sicrwydd/For Assurance

This paper provides the Audit Risk and Assurance Committee with an update on achievement of actions to address the 2020 Audit recommendations on Consultant Job Planning. It identifies current compliance with annual job planning and the actions taken to improve this.

This report is designed to provide **assurance** that work is progressing.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit, Risk and Assurance Committee (ARA) has previously been apprised of the revised approach to Job Planning, developed to address historic poor compliance with job planning and the low quality of job plans set out in the 2020 audit action plan. The main actions include:

- Implementation of a new Health Board Job Planning Procedure.
- Procurement and roll out of an electronic Job Planning System.

An update on the action plan to address the 2020 audit recommendations is provided in **Appendix 1.**

Achievement of a number of these actions is dependent on the full roll out and realisation of the benefits of the new E-Job Planning System. The perceived benefits of E-Systems is provided within the paper.

Job Planning Compliance

As of 30 September 2024, consultant job planning compliance is 24% across the Health Board. In addition to those consultants with an in-date job plan there are 35 (6.8%) within the system simply awaiting final sign off and 347 (65%) job plans in progress within the system. A further update on compliance up to 31 October 2024 will be provided to the ARA Committee on 12 November 2024.

Cefndir / Background

Aneurin Bevan University Health Board use of job planning and benefits realisation from the Consultant Contract were the subject of an internal Audit (follow up) undertaken in late 2019 (reported 2020).

Progress in relation to addressing the 2020 audit recommendation has been the subject of previous reports to the Audit, Risk and Assurance Committee; People and Culture Committee and the Remuneration and Terms of Service Committee.

These papers:-

- Outlined the work that had been undertaken prior to the 2020 Covid 19 pandemic.
- Acknowledged the impact of the pandemic on progress.
- Identified a revised approach to job planning.
- Provided updates on the approved action plan to address the audit recommendations which included the procurement of an Electronic Job Planning System.

Asesiad / Assessment

Electronic Job Planning System

The implementation of an e-Job Planning System supports delivery of the 2020 audit recommendations and associated action plan.

Following a competitive procurement exercise the contract for an electronic Job Planning System was awarded to L2P in September 2023. This system has been configured to the Amendment to the Consultant Contract (Wales (2003)) and the Health Board's Job Planning Procedure.

The perceived benefits of an electronic Job Planning System include:-

- Access to a central repository for job plans.
- Improved detailed and accurate information and reports.
- Consistent calculation of on call sessions across the Health Board.
- The system is built based on the Health Board's Job Planning procedure.

- Automatic reminders and alerts.
- Once familiar will save time.
- Increased compliance and support better demand capacity planning.
- Integrates with the electronic rostering system.

Implementation and Rollout

Implementation of the e-Job Planning System commenced on 22 January 2024. This "go live" date was amended due to Industrial Action by Junior Doctors, and this has also contributed to a delay in the overall anticipated timeline for completion of the roll out. This has consequently also impacted on job planning compliance.

Issues impacting on implementation and means of addressing:-

- More time than originally anticipated has been required by both the Medical E-system team and the directorate teams to work through specialty specific requirements and ensure that these are accommodated within the system whilst still adhering to the agreed Job Planning procedure. For example, on-call templates vary, such that L2P and the E-Systems team have needed to work with the directorates to build these into the system, as this enables more efficient inputting and more accurate sessional calculations going forward.

- Particularly complex job plans exist in directorates such as Paediatrics and these are being worked through with specialist advice.

- Historically paper job plans provided less detail than required by the new system. This detail once captured ensures granularity of reporting; supports the implementation of the e-rostering system and assists demand capacity planning. The E-Systems team continues to work with the directorates to assist them in inputting this detail into the system. The identification of admin staff within some directorates has assisted in obtaining the required information.

- The support from the central team is being prioritised to those areas first on the rostering implementation plan to reduce delays from a rostering implementation perspective.

Job Planning Compliance

The implementation of the e-Job Planning System proved more complex than initially anticipated and this has impacted on the improvement in compliance. In addition to the actions described above to support the implementation of the system considerable support has been provided to improve compliance and assist in achieving the 85% compliance target by the end of 2024. These are highlighted below.

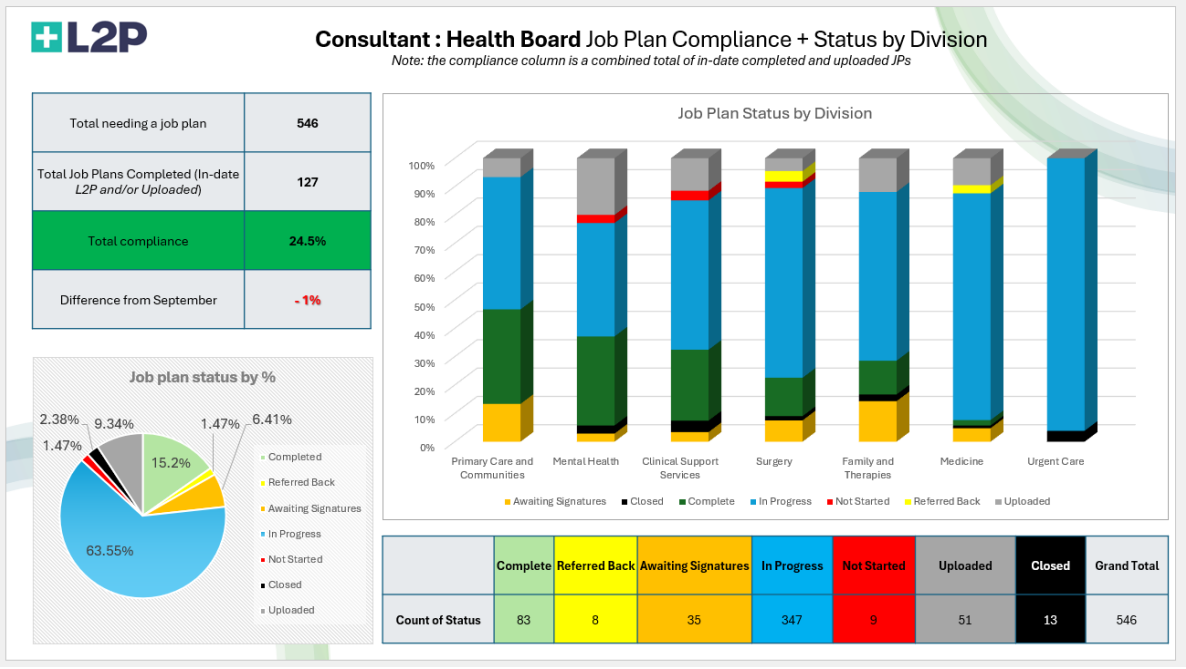
- Divisional Directors have worked with the E-system team to identify a forward trajectory and action plan by area for achieving 85% compliance within the division.

- Compliance reports continue to be sent to the divisional teams on a monthly basis. These reports have been revised and are more robust as they are now provided from the L2P system. From November 2024 these reports will also

provide the detail of the stage in the process for each individual consultant, this will enable Clinical Directors to target action.

- The E-Systems team has supported Divisional Directors and Clinical Directors to increase compliance by assisting with uploading the job plans onto the new E-system.
- The compliance data is discussed at Divisional Assurance Meetings.
- Support for Team Job Planning sessions has been offered.
- Bespoke training and support on the L2P system for the Divisions has been and continues to be provided.
- The E-Systems Programme Board has now been incorporated into the existing Medical Leadership meeting with the Medical Director, Director of Operations, and the Divisional Directors. This allows focused discussion with senior Medical Leaders.
- The E-Systems team have two weekly meetings with the Deputy Medical Director and Strategic Lead for Medical work force to work through issues as they arise and to feed those that are not easily resolved to the Medical Leaders for discussion or to the job planning consistency group as appropriate.
- Following discussion with Medical Leaders, senior workforce staff are holding Senior Divisional bespoke sessions to work through the local challenges to ensure that those Job Plans awaiting signature, with queries or in progress are expedited. If these can be progressed, then that would take Consultant Job Planning compliance to 95%. However, it should be noted that the "In Progress" job plans are in various stages of completion and a large proportion are unlikely to be completed and signed off quickly, thus reaching the target of 85% compliance across the Health Board by the end of 2024 is highly unlikely.

Divisional compliance as of 30 September 2024 is:



Summary of the current compliance for consultants is as follows:

- Completed (paper Job Plan uploaded and complete) – 24.54%
- In progress (at various stages of development) – 63.55%
- Awaiting signatures – 6.41%
- Closed (i.e. non complaint with reasons e.g. maternity leave) – 2.38%
- Not commenced – 1.65%
- Referred back to Division – 1.47%

Summary of Divisional position and projected compliance by end of 2024

Division	**Current Compliance %**	**Work to improve**	**Significant issues impacting on improvement**	**Projected compliance % by end of 2024 -based on work in place to improve**
Mental Health & LD	31.43%	• Working with e-system team to iron out any problems. • 2.86 % of Jobs plans only require sign off, this will be addressed by end of October 2024. • 40% of Job Plans are at various stages of completion within the systems.	None evidenced.	50%
Medicine	1.9%	• 4.76% of Jobs plans only require sign off this will be addressed by end of October 2024. • E-Systems team supporting the inputting of paper job plans into the system. • Complex job plans being worked through with the E-system team.	Service pressure and time for clinical staff to participate in job planning, particularly notable in Acute Medicine & Respiratory. Some Consulnst cover two specialities e.g. COTE & Acute Medicine necessitating a joint job plan, this adds to the complexity.	20%

Urgent Care	0%	• 25% of paper job plans have been provided to the E-system team to input into the system, however the details of the additional SPA activity is required prior to completion and sign off.	None evidenced	25%
Primary Care	33.33%	• Good progress is being made and are on target to achieve 85% by the end of 2024	None evidenced	75%
Family & Therapies	11.9%	• All Obstetrics and Gynaecology job plans are completed in the system and require signatures by all named parties however there is some contention with two of these which is being worked through by the directorate. • Due to the complex nature of their seasonal job plans this has delayed inputting, the E-Systems team are working with the directorate to input the job plans for them.	Complexity of the Paediatric job plans.	25%
Clinical Support Services	25%	• Good progress is being made in Radiology and Pathology and are on target to achieve 85% by the end of 2024	Some complexities in respect of anaesthetic job plans have been raised these are being worked through and will delay progress. Some of these issues related to the need to	50%

			change practice in line with the Health Board's Job Planning Procedure.	
Surgery	17%	• The DD has asked DMs to prioritise job planning and is hopeful that compliance will greatly improve by the end of 2024	None evidenced.	25%
Total compliance	24.00%			
Total projected compliance	38.57%			

Job Planning Procedure and associated policies/guidance

The Audit, Risk and Assurance Committee were informed at the November 2023 meeting that the Health Board's Job Planning Procedure and associated documents and appendices were launched on 18th August 2023. The paper highlighting this also provided information on the supporting documents, training, webpage and FAQs.

Engagement

In order to develop the procedure, considerable engagement with the LNC and Medical Leaders was undertaken. Engagement with the BMA/LNC has been positive and helpful. Although there were some aspects which the BMA/LNC were still seeking clarification on the Heath Board launched the new procedure and associated documents on 18 August 2023 as it did not believe these areas were significant enough to delay implementation. Engagement with the LNC to work through these issues has continued. Any agreed amendments are being incorporated into the review of the procedure scheduled hopefully this will be published in November 2024. Following this the procedure will be reviewed three yearly in line with other Health Board policies and procedures.

Summary

Achievement of 85% compliance by the end of 2024 for consultant continues to be challenging due to the circumstances described above. Based on best efforts and in the context of service pressures as we enter the winter period maximum compliance is likely to be around 38%. However, the time spent currently in working through these issues will ensure that the job planning process and completion within the L2P system is both robust, efficient, and there is consistency in job plans as required with the application of the Health Board's Job planning procedure. Once fully implemented the anticipation is that future rounds of job planning will be easier thus improving both compliance and quality job plans in subsequent years.

Argymhelliad / Recommendation

The Audit Risk and Assurance Committee is asked to note the progress made.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources 7.1 Workforce Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	ARA - Audit, Risk and Assurance Committee BMA – British Medical Association COTE – Care of the Elderley ED – Emergency Department FAQs - Frequently Asked Questions LNC – Local Negotiating Committee SPA - Supporting Professional Activity
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable

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

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2024

The plan for job planning aims to: -

- Support the effective delivery of annual job planning.
- Improve compliance.
- Ensure job planning is aligned to service delivery and outcomes.
- Ensure consistency of application of Term and Conditions.
- Meet internal audit requirements.

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
REF IA/19	**1. JOB PLANNING PROCEDURES & POLICIES**					
R1 R2 R3 R4	1.1	Development of a detailed Health Board Procedure for job planning which will provide consistent interpretation of the T&Cs and align with all Wales guide "effective job planning for Medical and Dental Staff"	First Draft June 2021	Medical Director	Stephen Edwards/Kathryn Bourne	The new procedure and associated policies and guidance were launched on 8th August 2023. This is currently being reviewed as agreed one year post implementation.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2024

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	2. SUPPORTING PROCESSES & SYSTEMS					
R1	2.1	Review existing processes and systems to align with the new Health Board procedure e.g., escalation process, payment of commitment awards	Review – January 2023	Medical Director/Director of Workforce & OD	Stephen Edwards/Kathryn Bourne	Existing processes including Escalation and Commitment awards were reviewed and aligned to the new procedure. As part of the 2024 pay deal Commitment awards are no longer in place in Wales as the pay scale has been revised, hence reference to CAs has been removed in the current review of the procedure. Letters and correspondence in relation to escalation have been automated in the L2P E-Job planning system. Should further processes require review these will be addressed as identified.
R1	2.2	Develop processes and systems to support implementation of the new Procedure	Review – January 2023	Medical Director/Director of Workforce & OD	Stephen Edwards/Kathryn Bourne	A Job Planning consistency group has been established chaired by the Deputy Medical Director this meets 6 weekly specifically to advise on and agree consistent approach to SPA.

16.10.2

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2024

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	3. REPORTING & MONITORING OF THE JOB PLANNING PROCESS					
R1	3.1	Agree with Divisional and Clinical Directors an over-arching plan to identify the job planning cycle within each Directorate/Division	June 2021	Director(s) of Operations/Deputy Medical Director	Divisional management teams	The Medical Director has previously written to Divisional Directors emphasising the need for CDs to undertake job plan review meetings. He has also asked that a named member of the divisional management team is given responsibility for supporting CDs in doing this and that the Deputy Medical Director is made aware of who is identified. The Health Board's Job Planning procedure makes explicit the role of the CD in agreeing a proposal for how the job planning process will be applied in the specialty and also identifies the stages of the planning process. The specifications within the procedure supersede the action within this plan. Divisional Directors have worked with the e-system team to identify a forward trajectory and action plan by area for achieving 85% compliance within the division.
R1	3.2	Monitoring of the plan and job planning compliance via the Divisional management teams and assurance meetings	Monthly and on going	Director(s) of Operations	Divisional management teams	Agreed by Executive team on 1st June 2021 that monitoring of the plan and job planning compliance would be undertaken at the Divisional management teams and assurance meetings.
R1	3.3	Exception reporting to the Executive team on delivery of the plan and compliance	As required	Director(s) of Operations	Divisional management teams	Agreed by Executive team on 1st June 2021 that they will receive exception reports on delivery of job planning and compliance as necessary from the Directors of Operation.

16.10.2

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated October 2024

R1	3.4	Maintenance of the ABUHB's job planning compliance database and issuing of monthly compliance reports to management teams, WFBPs, DOO, MD & WOD, .	Monthly	Director of Workforce	E-Job Planning Project Manager	The compliance reports are now available from the L2p system. These reports continue to be circulated monthly to the divisional teams. Enhanced reporting form the system means that details of any delay in sign off is also highlighted.

16.10.24

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
REF IA/19	**4.E-SYSTEMS**					
R2 R4 R5	4.1	Identify system requirement to • improve link between job planning and the rota, • improve compliance and transparency around job planning • support delivery of contracted session across the year • improve link between rostering and locum bank for locum shift cover, • Improve the link between Locum shift cover and the need to go to agency (third party systems) • Improve and streamline the end to process for workforce planning and management across all functions • maximise reporting and performance	Review March 2023	Medical Director/Director of Workforce & OD/ Director(s) of Operations	Julie Chappelle/ Stephen Edwards	An e -Job planning system has been procured with an e-rostering and e- Bank system. Although these systems stand alone interoperability between the systems was a requirement of the tender process. This ensures the three eSystems work together to provide an effective single solution to Medical workforce planning and management. The Bank system is fully implemented, whilst implementation of rostering is dependent on all job plans being up to date within the L2P job planning system.
R2 R4 R5	4.2	Procurement and implementation of appropriate system(s)	Review March 2023	Director of Workforce/ Director(s) of Operations	Ann Bentley (Programme Manager)	See above - System has been procured and implementation continues

16.10.2

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	5. TRAINING/ SUPPORT & RESOURCES					
R3 R4	5.1	Review the E-training package to align with new Health Board procedure	Review – January 2023	Medical Director/Director of Workforce & OD	Stephen Edwards/Kathryn Bourne	A new E-distance Learning Pack was developed to align with the Job Planning procedure. The electronic link to this was sent in the launch letter from the Medical Director and all Consultants asked to use an SPA session to undertake the training and submit any questions to the ABBjob planning email address for response.
R3 R4	5.2	Review training requirements and means of upskilling staff to undertake job planning	January 2023	Medical Director/Director of Workforce & OD	Workforce Business Partners and DDs	In addition to the new e-learning package the Deputy Medical Director and Strategic Lead for Medical workforce have conducted Q&A session which have been advertised for all involved in Job planning via the intranet. A series of FAQs available on the intranet has been updated as further questions are received. Support and advice is available as required. Where there are specific speciality issues the Workforce Business partners are working through these with the support and advice of the Deputy Medical Director and Strategic Lead for Medical workforce as required. Job planning continues to form part of the Senior Clinician CPD programme.

16.10.2

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	LOCAL LEAD	STATUS AND MILESTONES
	5. TRAINING/ SUPPORT & RESOURCES					
R4	5.3	Work with divisional teams to identify support required to enable Medical managers to fulfil their job roles in respect of delivery of annual job planning aligned to service requirements	June 2021	Medical Director/Director of Workforce & OD	Workforce Business Partners and DDs	See 5.1 & 5.2 Job planning clinics and webinars have previously been offered. Training on the L2P system continues to be available. The Medical Director has previously written to Divisional Directors asking that a named member of the divisional management team is given responsibility for supporting CDs in doing this and that the Deputy Medical Director is made aware of who is identified. The implementation team provides support and advice on the L2P system to the operational divisions.
R1	5.4	Review time required to undertake effective job planning annually and ensure this is provided for with Clinical Director and Directorate Managers job roles/plans and objectives.	July 2021	Director(s) of Operations/Medical Director	Divisional Directors /General Managers	A survey of CDs has been undertaken (N=27). They fed back unanimously that time and training for their roles is insufficient for them to discharge their duties. A review of time job planned for the CD role is being discussed by DOO and MD. The triumvirate development program started in September 2022. The launch of the new procedure and associated resources, support and training was designed to help resolve the lack of knowledge previously identified.

16.10.2

16.10.24

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	**Audit Risk and Assurance Committee**
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Policy: Consultant Private Practice**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert, Executive Medical Director Sarah Simmonds, Director of Workforce and OD
SWYDDOG ADRODD: **REPORTING OFFICER:**	Richard Howells, Executive Business Manager, Office of the Medical Director Kathryn Bourne, Strategic Lead Medical & Dental Workforce

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

ADRODDIAD SCAA / SBAR REPORT

Sefyllfa / Situation

This is a new policy; approved by the Executive Committee on 3rd October 2024.

Cefndir / Background & Context

The Health Board required a policy to ensure that appropriate guidance is in place to inform consultants of their contractual obligations and organisational expectations in relation to the undertaking of private practice.

Asesiad / Assessment

This policy will set out the expectations of consultants undertaking private practice along with the principles they should adhere to. The policy will also provide an explanation on how their private practice should work alongside their NHS commitment and contractual obligations, together with guidance on appraisal requirements and their schedule of work. Instruction on the requirement to complete an annual disclosure of interest is also covered.

The organisation also understands the right of patients to transfer from private sector care back to the NHS. This policy provides governance on the procedure to be followed to ensure that principles of the transfer are adhered to.

The policy ensures that there is clarity around the use of NHS facilities, resources and staff in relation to private practice. This will ultimately benefit the patient population of ABUHB by ensuring equity across waiting lists for NHS patients and ensuring that NHS resources and staff are not used for private practice purposes reducing the burden on NHS employees e.g. medical secretaries.

The relevant staff organisations and groups (BMA and LNC) have been included in the consultation process, as have the senior medical management team. This has provided assurance about the practicalities of implementing and managing the policy in an operational setting.

Argymhelliad / Recommendation

The Audit Risk and Assurance Committee is asked to receive the policy, for assurance that the Health Board is providing appropriate guidance and rules for staff.

Amcanion: (rhaid cwblhau) / Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6. Individual care 7. Staff and Resources
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and priorities areas where evidence shows take up of services is lower or outcomes are worse Improve the wellbeing and engagement of our staff Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) / Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb / Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio / Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	**Long Term –** Improving the experience of trainees, which in turn results in overall improvement of patient care and staff experience, will aid in achieving the long-term Healthier Wales ambition.
	Integration – Delivery of improvements, outlined in the plan, will ensure system resilience and improved patient safety; in collaboration with partner organisations including HEIW.
	Involvement – Patient experience, staff experience and feedback from external stakeholders (including HEIW and the Royal College of Physicians) has been taken into consideration when developing improvement actions.
	Collaboration – The delivery and ongoing work outlined has required collaboration across the organisation and with external stakeholders (especially HEIW).
	Prevention – Implementation of the improvement plan provides a heightened response when unwell patients self-present at our hospital sites, which has been previously been acknowledged as an area of concern. The improvement plan also provides assurance that concerns around the care of deteriorating inpatients are progressed.

Aneurin Bevan University Health Board

Medical Staff Private Practice Policy

This policy provides medical staff with guidance on organisational expectations in relation to the undertaking of private practice.

Whilst this Policy is primarily directed at Consultants undertaking private patient activity, it equally applies to any other medical staff employed by the Health Board who privately charge for their services whilst using NHS facilities, equipment or staff, or who may undertake such activities during NHS time, including private patients travelling from outside of the UK.

For the avoidance of doubt, the term "Consultant" includes any other category of medical staff undertaking private patient activity.

Status/Sensitivity: Draft Confidential
Approved by:
Owner:
Issue date: 24th September 2024
Review by date: dd/month/+ 3 years
Ref Number: ABUHB/Category/Number

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18. Review.....12

1. Introduction

1.1. The contractual right of consultants to undertake private practice is set out in the Amendment to the *National Consultant Contract in Wales (2003))* (chapter 9), paragraphs 40-43 of the *NHS Hospital Medical and Dental Terms and Conditions of Service 2002* and sections 62, 65 and 66 of the *National Health Service Act 1977* (as amended). NHS Employers also provides advice to consultants on undertaking private practice.

1.2. This policy does not affect a consultant's right to undertake private practice in accordance with the *National Consultant Contract in Wales (2003)*.

1.3. The policy also recognises the right of patients to seek care in the Private Sector and to transfer their care back to the NHS at any point.

2. Purpose

2.1. The policy seeks to ensure that guidance is in place to assist consultants in understanding organisational expectations in relation to the undertaking of private practice.

2.2. It is imperative that no individual is paid twice for the same period of time, regardless of by whom or how they are paid. Consultants undertaking private work in NHS contracted time or who contravene the requirements of this policy may be in breach of contract and liable to employment or civil proceedings. SPA activity may not be shifted to undertake Private Work.

3. Objectives

3.1. This policy sets out organisational expectations of consultants undertaking private practice and describes principles to which they should adhere. It explains the organisation's interpretation of rules for how Consultants private practice should work alongside their NHS commitment to avoid conflicts of interest. Guidance will also be provided with respect to appraisal requirements, scheduling of work and the process for completion of an annual disclosure of interest.

3.2. The organisation understands the right of patients to transfer from private sector care, back to the NHS. This policy will provide guidance on the governance arrangements to be followed to ensure adherence to the transfer principles.

3.3. The policy will ensure that there is clarity around the use of NHS facilities, resource and staff in relation to private practice.

4. Scope

4.1. Whilst this policy is primarily directed at consultants undertaking private patient activity, it equally applies to any other medical staff employed by the Health Board who may privately charge for their services. The term "Consultant" as applied in this policy includes any other category of medical staff undertaking private patient activity.

4.2. This policy applies to all planned private patient treatment undertaken by medical staff employed by the Health Board.

5. Consultants Responsibilities

5.1. All consultants undertaking private practice have a responsibility to adhere to the principles set out within this policy.

5.2. Consultants must be aware that failure to abide by this policy and any related policies or processes may result in a referral to Counter Fraud and/or the GMC and/or investigation under the terms of "Upholding Professional Standards in Wales".

6. Clinical Responsibilities

6.1. Consultants treating a patient in the private sector and providing ongoing treatment for the particular condition being treated, maintain clinical responsibility for the patient regarding that condition until the consultant discharges the patient form Private care.

7. Managers Responsibilities

7.1. Managers must be satisfied that the consultant is fulfilling their NHS commitments and that their private practice is not affecting their ability to fulfil these commitments.

7.2. Managers will discuss private practice as part of the job planning process to ensure that private work is not routinely planned during NHS sessions.

8. NHS requirements when conducting private practice

8.1. When conducting private practice a consultant must:

(i) Demonstrate that their private practice does not affect their ability to fulfil their contracted NHS commitments.

(ii) Show that there is **no** conflict of interest between their NHS work and private work and that the private commitments will not adversely affect NHS work, nor in any way hinder or

conflict with the needs of their NHS patients or their contractual obligation to their employer.

(iii) Ensure that the needs of patients in the NHS/NHS services will not be prejudiced by the provision of services to private patients.

(iv) As stated in the Amendment to the National Consultant Contract (Wales (2003) paragraph 9.11) "if NHS sessions are disrupted the Consultant should rearrange the private sessions. Agreed NHS commitments will take precedence over private work".

(v) Inform the Medical Director as soon as possible of any issues arising from their private practice which might significantly affect their ability to fulfil their NHS commitments (e.g. an inability to deliver contracted sessions agreed in their job plan, or their on call and out of hours work).

In addition:

(vi) Consultants must not plan to undertake private patient consultations on ABUHB premises as the Health Board does not currently have the resources to facilitate this.

(vii) Consultants must not plan admission to any of the ABUHB hospitals on a private basis, such that their private care or treatment is provided during contracted NHS duties.

(viii) NHS staff or resources may not be used for patients whose care is on a private pathway, unless this is a pathway commissioned by the NHS with a private provider. This includes the use of NHS secretaries and administrative staff to manage private practice activities during their paid NHS Secretarial time e.g. typing private letters or booking private patients during their NHS contracted time.

(ix) If a patient is seen in private practice and wishes to revert to NHS care this must be facilitated by the consultant. It is suggested that the consultant provide a referral letter to the relevant NHS referral coordinator. Alternatively, they may request the GP to make an NHS referral in the usual way. The patient will join the NHS waiting list at a point appropriate to their clinical urgency as judged by the results of investigations carried out in the private sector. A referral from the private sector cannot be used as a way of circumventing the NHS waiting list unless the patient requires expedited care because of the acuity of their condition.

9. Declaration about Private Practice

9.1. The Health Board's Policy for Standards of Business Conduct[1] requires "any member of staff employed by the Health Board to declare any other employment/self-employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes private practice". Consultants must complete the annual Declaration of Interest form, and lodge this with the Director of Corporate Governance[2]. Where Consultants are unsure of whether they should complete the Declaration Form it is advised that they do as evidence of their acting with probity.

9.2. Details on how to complete and submit a declaration of interest can be found in the Aneurin Bevan University Health Board Policy for Standards of Business Conduct, which can be accessed via the staff intranet.[3]

10. Appraisal

10.1. Under the appraisal guidelines agreed in 2001, NHS consultants must be appraised on all aspects of their medical practice. In line with the requirements of revalidation, consultants must submit evidence from private practice to their appraiser, as part of the whole practice appraisal process.

10.2. Consultants must comply with any specific requirements from their Responsible Officer (RO) with respect to information that is required to permit the RO to make a judgment about a clinician's private practice for the purposes of revalidation. The range of information that must be brought to the NHS appraisal is governed by the same GMC rules as the information that must be collated for appraisal of a doctors NHS practice (this includes audit of private practice, reflection on complaints arising in the Private Sector and appropriate CPD if the Private Practice scope of practice differs from clinicians NHS scope of practice).

Agreement will be required between clinicians undertaking private practice and their NHS appraiser on the information requirements for appraisal of Private Work that must be presented over the 5-year revalidation cycle. The consultant will be expected to replicate the quality and quantity of information which they provide for their NHS practice from their Private Practice. Where the consultant undertakes work for a recognised private provider, completion of a satisfactory appraisal in the Private Sector may be brought as evidence to the NHS Appraisal.

[1] Details on submission of Declarations of Interest Form link Declarations of Interest and Staff Conduct).
[2] Link to Declaration of Interest Form

11. Schedule of Work and Job Planning

11.1. A consultant must ensure that:

(i) That there are clear arrangements to avoid the risk of private commitments disrupting NHS commitments, for instance by causing NHS activities to begin late, run short, or to be cancelled.

(ii) Planned delivery of Private Practice or travel to Private Practice premises must not take place during rostered DCC or SPA time. Exceptions will apply where a patient in a private facility under the care of the consultant requires immediate emergency attendance and no other consultant is available.

(iii) The Divisional Director must be informed as soon as practicably possible about each occasion when this has taken place or may take place.

(iv) Job planned NHS commitments must take precedence over private work.

(v) The job planning process will be used to agree when NHS sessions are scheduled between the employer and the doctor undertaking private practice.

(vi) The needs of patients in the NHS will not be prejudiced by the provision of services to private patients. Scheduled SPA and DCC sessions must not be moved to undertake Private work, unless with by prior written agreement.

(vii) As described in the Amendment to the National Consultant Contract (Wales (2003) paragraph 2.12, "SPA sessions, mutually agreed at the job planning review, may be scheduled across the week such that up to one session of contractual commitment may take place outside working hours leaving a similar period free in which there is no contractual commitment during normal working hours". This previously agreed free period may accommodate private practice.

(viii) When there is a mutually agreed change to the job plan, the Health Board is required to allow a period for consultants to rearrange existing private sessions. This will usually be 3 months' notice, unless the consultant is reasonably able to re-arrange duties sooner and agrees with the shorter notice.

(ix) If job planned NHS sessions are being regularly disrupted the Consultant must re-arrange private sessions or request that a change to their NHS job plan is considered.

(x) Due to the nature of on-call work in many specialities and in the interest of patient safety, the Health Board does not routinely permit consultants to undertake private practice when

on call for the Health Board. However, the amendment to the National Consultant Contract (Wales (2003) states that "A consultant with a low likelihood of recall may undertake appropriate private practice when on-call for the NHS, with the prior agreement of their NHS employer that this will not affect their availability for NHS commitments".

If a consultant believes that the nature of their NHS on call commitments may permit a regular commitment to private practice then, prior agreement with the Divisional Director or Medical Directors Office must be sought ahead of any commitment to private practice being made.

A diary exercise will be requested demonstrate the low likelihood of recall prior to reaching agreement.

In the event that the consultant chooses not or is unable (due to this being a new post) to participate in a diary exercise the Divisional Director will use professional judgment in deciding whether to permit a consultant to undertake private work whilst on call.

(xi) The Health Board does not permit consultants to undertake private practice in time or days that they are **contracted** to the Health Board when the consultant is absent from work for reasons other than annual leave e.g. when on sickness absence, for training paid by the Health Board.

In the interests of patient safety there may be exceptional circumstances during **non-contracted time** where minimal essential continuing private treatment may be permitted e.g. reviewing diagnostic results. Prior to undertaking such work during a period of absence the consultant must make every attempt to provide cover by other means e.g. from another Consultant working in the private sector. If this is not possible the Consultant must seek the agreement of the Divisional Director in advance of undertaking private work.

In addition to patient safety reasons there may also be other exceptional circumstances and depending on the reason for the sickness absence which means private practice on **non-contracted days** may be approved by the Health Board whilst the Consultant is absent from NHS employment.

All requests to undertake private work whilst absent from NHS employment on non-contracted days must be discussed with the Divisional Director in advance of undertaking the private work. All decisions will be made in accordance with the Managing Attendance at Work Policy and following discussions with the operational workforce team.

(xii) There may be exceptional circumstances in which consultants may reasonably provide emergency or essential continuing treatment for an existing private patient during NHS time on the basis of clinical need.

In such exceptional circumstances consultants must make alternative arrangements to provide cover for their NHS patients, for example, by arranging to swap shifts with an appropriate colleague.

12. Informing NHS patients about private treatment

12.1. In the course of their duties and responsibilities consultants must not solicit discussions about providing private services for NHS patients, nor must they ask other NHS staff to initiate such discussions on their behalf.

12.2. Where an NHS patient seeks information about the availability of, or waiting times for, NHS and or private services, consultants must ensure that any information provided by them, is accurate and up to date.

12.3. NHS consultants must not advertise their private practice to patients seeking care from the NHS including providing business cards.

12.4. A consultant may provide information about a service in the private sector which is not available on the NHS[4].

13. Transfer of patients between Private Practice and the NHS

13.1. A patient who chooses to be treated privately is entitled to NHS services on exactly the same basis of clinical need as any other patient.

13.2. A private patient is legally entitled to revert to NHS status at any stage during treatment. This may be as a result of an unforeseen change in circumstances, e.g. if a patient is admitted for a minor operation and is then found to be suffering from a different, more serious complaint.

13.3. Any patient changing their status after having been provided with private services should be accepted onto waiting lists according to clinical priorities identified by the referrer and the Health Board.

13.4. If a patient has self-funded their own referral/treatment in the private sector, the Health Board will not fund ongoing treatment in the private sector except as part of an agreed and commissioned pathway of care. To ensure equity, all such requests will be

[4] Further guidance can be found on the BMA website (bma.org.uk).

declined, and the clinician advised to refer the patient to local or commissioned NHS services.

13.5. If, however, there is no local or locally commissioned service provision for the proposed treatment, the request for a referral to an external NHS consultant will be considered, based on the clinical information provided. The patient will be expected to receive all treatment with an NHS provider and must be added to the appropriate waiting list accordingly. This process may fall under the Individual Patient Funding Request (IPFR) process[5].

13.6. Where the patient wishes to change from private to NHS status, the consultant must apply the following principles:

(i) In certain circumstances private patients admitted as an Inpatient/Day case for a procedure and length of stay in a private facility may develop complications and the patient may choose to revert to NHS status, based on the overriding principle of clinical need. Upon transfer as an emergency to an ABUHB facility, they will be managed on the basis of their clinical need, as per NHS status.

(ii) Patients who change their status from private to NHS must have their clinical priority assessed and must not gain advantage over other NHS patients.

(iii) Patients who change status from private to NHS care for treatment for an episode of care cannot revert back to private care to complete that episode of care.

(iv) If a patient wishes to remain in private care but the procedure or intervention needed can only be delivered from an NHS facility the patient will need to meet the full cost of the care. Any such proposal by a consultant must be made on an exceptional, case-by-case, basis. This must be escalated to the Divisional General Manager and Divisional Director for decision on whether to authorise the proposal.

(v) The only exceptions will be when a patient is found to have cancer, or there is a strong suspicion that a patient has cancer, at which stage, onward care in the NHS should be offered, and an USC referral made via the usual NHS route.

14. Use of NHS Resources, Facilities and Staff for Private Practice

14.1. The Health Board does not allow the use of its resources, facilities or staff for private practice. This means that Consultants must not:

[5] IPFR guidance can be found on the Health board intranet site IPFR info

(i) Use Health Board or NHS facilities, resources or staff (nursing, Physician Associates (PAs) secretarial, administrative etc.) for the provision of private services during their contracted NHS duties.

(ii) Use Health Board or NHS facilities or staff for arranging or undertaking the consultant's private activities e.g. secretarial staff arranging appointments, ICT systems, computers or mail systems etc, during their contracted NHS duties.

(iii) Ask NHS staff to support the diagnosis, treatment or administration of private patients, including discussion at MDT.

(iv) Transfer patient information from NHS records to their private records e.g. using email.

14.2. It is recognised that at times consultants will need to undertake some private work or fee paying services which will require access to NHS systems and resources. Where this de minimis non-NHS work e.g. insurance reports, is generated as a direct by-product of NHS duties then it is reasonable to permit use of NHS resources for the completion of that work.[6]

14.3. Care must be taken by NHS staff not to contravene policies and procedures when undertaking approved private patient work (e.g. e-mailing patient information between NHS and home computers, in contravention of Information Governance policies). Such policies and procedures apply equally to both NHS and non-NHS activities when using NHS equipment, systems or other resource.

15. Pathology and Radiology Procedures

15.1 The Health Board does not allow the use of its radiology or pathology resources for private practice outside commissioned pathways.

16. Prescribing following a private consultation

16.1. NHS prescriptions must not be used for private prescribing under any circumstances.

16.2. Consultants who prescribe as part of their private activity must familiarise themselves with their ongoing clinical responsibilities as set out in the All-Wales Guidance (Prescribing Dilemmas – A Guide for Prescribers; AWMSG 2021).

[6] Para 9. 14 & 9.15 of the Amendment to the National Consultant Contract in Wales

17. Monitoring and Effectiveness

17.1. The application and implementation of this policy will be monitored by Internal Audit via regular audit.

17.2. A Consultant's time and use of resources for private practice may be audited via the submission of Declaration of Interests.

18. Review

18.1. This policy will be reviewed every three years.

18.2. This policy will be updated when there is significant change to legislation, standards or in the event of contractual changes or changes in organisational position and any other factors impacting on it, if these occur within the three year review period.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Post Payment Verification Mid-Year Report 1st April 2024 - 30th September 2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe - Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Amanda Legge - All Wales Post Payment Verification Manager

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

Er Sicrwydd/For Assurance

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how Primary Care contractors have been performing and highlighting PPV progress. It also compares the overall performance of the Health Boards against the national PPV visits.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

Cefndir / Background

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

Asesiad / Assessment

In 2023-2024, PPV began recovering from a new General Medical Services (GMS) payment system and a backlog of work and completed 174 GMS routine visits and 29 GMS revisits across Wales. This new financial year we have concentrated on both our revisits that were overdue and routine visits and continue to maintain an excellent level of PPV across all Disciplines, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

The following key points should be noted:

General Medical Services (GMS):

Firstly, in this financial year, we will be concentrating on all outstanding revisits, and if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

In 2024-2025 we have 62 visits due for Aneurin Bevan University Health Board which is made up of 20 routine visits and 42 revisits. Currently, we have 16 visits finalised or in progress. As revisits check 100% of the services triggered from the original routine, they take a longer time to complete.

General Ophthalmic Services (GOS): The visit plan for GOS 2024-2025 is a rolling plan of 3 years. PPV began remote access options last financial year having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful. Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records and we did not manage to complete all the visits that were due.

This new financial year of 2024-2025 we are well on target with 20 visits planned and have 12 either finalised or in progress. We have had to also incorporate physical visits to carry us through this transition period of electronic patient records, which is being encouraged by Welsh Government.

General Pharmacy Services (GPS): In 2024/2025 NWSSP/PPV introduced a new service check after a successful pilot, which was the Collaborative Working Scheme We now verify this service along with the Quality and Safety Scheme remotely.

We are also investigating other avenues for PPV in GPS and beginning another pilot early this year. We have currently 42 visits to complete with 14 visits in progress.

Additional Services: We are progressing with our quarterly dispensing Data checks and are introducing a robust service moving forward which may result in future financial recoveries once agreed by our Health Boards. These will be added to our PPV reports once finalised. From the pilot we carried out and informing practices of the regulations surrounding dispensing eligibility, we have the data which shows the future success of this service.
Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We were planning to conduct a pilot with the Self Assessments for Pharmacies in the next few months in 2024-2025 but this is currently on hold and in discussion.
Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks. We are also investigating other avenues of savings from the provision of Clinical Waste services and now produce a 'non-collection' report to all our Health Boards.
There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. These are beneficial to all parties who attend.
PPV training events continue to be delivered to our Health Boards and contractors, and we facilitate one-on-one training requirements when required, particularly for new practice staff within the Primary Care setting.

Argymhelliad / Recommendation

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Audit Report - 1st April to 30th September 2024 = Aneurin Bevan University Health Board

To Note
Above planned numbers were sent to HB for 2024/2025 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise
Training/support is provided to practices after visit and throughout the year, whenever requested

Summary of themes/findings/issues
Revisits are taking longer that expected due to 100% check of claims
Revisits are normally expected to have higher claim error rates

GMS	Visit Type	HB Annual Visits Due	No. finalised or in progress	No. Recoveries	Value of recoveries	All Wales Visits Due	All Wales No.finalised or in progress	No. Recoveries	All Wales Value of Recoveries
	Routine	20	6	82	£2,499.40	152	37	880	£24,179.91
	Revisit	42	10	236	£6,698.40	241	54	2627	£62,129.84
	TOTAL	**62**	**16**	**318**	**£9,197.80**	**393**	**91**	**3507**	**£86,309.75**

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
PRACTICE 1	Revisit	38	1.94%	£1,213.02
PRACTICE 2	Routine	13	4.63%	£344.93
PRACTICE 2	Revisit	0	0.00%	£0.00
PRACTICE 3	Routine	4	2.05%	£114.17
PRACTICE 3	Revisit	51	2.04%	£2,239.85
PRACTICE 4	Routine	5	3.18%	£50.15
PRACTICE 4	Revisit	2	2.50%	£63.66
PRACTICE 5	Revisit	20	18.35%	£1,436.20
PRACTICE 6	Routine	42	15.33%	£1,574.90
PRACTICE 6	Revisit	4	10.00%	£350.52
PRACTICE 7	Routine	18	9.00%	£415.25
PRACTICE 7	Revisit	119	5.55%	£1,352.21
PRACTICE 8	Revisit	IN PROGRESS		
PRACTICE 9	Revisit	2	1.87%	£42.94
PRACTICE 10	Routine	IN PROGRESS		
PRACTICE 10	Revisit	IN PROGRESS		

GOS	Visit Type	Annual Visits Planned	No. finalised or in progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No.finalised or in progress	No. Recoveries	All Wales Value of Recoveries
	Routine	20	12	23	£859.24	126	59	157	£6,319.56
	Revisit	0	0	0	0	4	0	0	£0.00
	TOTAL	**20**	**12**	**0**	**£859.24**	**130**	**59**	**157**	**£6,319.56**

Summary of themes/findings/issues

As contractors are transistioning to electronic records, remote access and physical visits are progressing well

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Routine	0	0.00%	£0.00
Practice 2	Routine	5	4.85%	£200.46
Practice 3	Routine	2	1.94%	£54.46
Practice 4	Routine	0	0.00%	£0.00
Practice 5	Routine	1	0.97%	£59.30
Practice 6	Routine	3	2.91%	£129.78
Practice 7	Routine	2	1.94%	£148.40
Practice 8	Routine	IN PROGRESS		
Practice 9	Routine	5	4.85%	£124.68
Practice 10	Routine	0	0.00%	£0.00
Practice 11	Routine	0	0.00%	£0.00
Practice 12	Routine	5	4.85%	£142.16

Summary of themes/findings/issues

Nothing to report at this stage

GPS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
Q&S Scheme / Collaborative Working Scheme	Routine	42	14	0	£0.00	238	112	0	£0.00
	TOTAL	**42**							

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

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

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

It also aims to provide reassurance regarding the advancements being made in enhancing risk management within the Health Board.

Cefndir / Background

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

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

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

Asesiad / Assessment

Strategic Risk Register

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

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

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

Table 1

Overarching Strategic Risk Description	Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (9 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**A, B, C & D**	3	1	People	People and Culture Committee
	***E & F**	-	1	Service Delivery	Partnerships, Public Health & Planning Committee
	G	-	1	Financial Sustainability	Finance and Performance Committee
	I	-	1	Compliance and Safety	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**A & B**	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**A**	1	-	Compliance and Safety	Partnerships, Public Health & Planning Committee

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

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

Since the last presentation of this report to the Committee and the subsequent review of all strategic risks, the overall strategic risk environment has remained reasonably stable. However, the Committee should be aware of six sub-risks ***(SRR 001G & I- SRR 002A & B – SRR 004 and SRR 010)*** that remain outside the acceptable risk threshold for their respective domains. These are subject to ongoing discussions with executive leads and responsible officers to determine what additional mitigation measures are required to reduce the likelihood or impact of these potential threats.

Additionally, the approach to risk reporting to Committees has been revised to enhance focused scrutiny. Rather than presenting all risks at each Committee meeting, reports will now focus on one to two priority risks, selected based on their level of exposure relative to the agreed threshold. This targeted focus will enable Committees to conduct in-depth reviews of high-exposure risks, ensuring that they receive comprehensive assurance regarding the management and mitigation of these risks. This approach is designed to support more thorough oversight and informed decision-making.

Risk Exposure

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

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

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

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

'Once for Wales RLDatix Risk Module'

The 'Once for Wales RLDatix Risk Module 'workstream has reached a critical juncture. The national working group recently presented a proposal to the Directors of Corporate Governance Peer Group, recommending the retention of DatixWeb while exploring alternative solutions, given the lack of confidence in transitioning to the latest DatixCloud version. The Peer Group endorsed this recommendation in principle, contingent on DatixWeb's continued availability and the associated costs. Since that meeting, it has been confirmed that DatixWeb will remain available until November 2027, at no additional cost.

The national working group determined that DatixCloud would represent a step back from the current DatixWeb system. DatixCloud lacks essential functionality, usability, and reporting capabilities compared to DatixWeb, with specific concerns regarding its complex interface, unclear field labels, limited search features, absence of audit tracking, and ineffective risk categorisation. Additionally, DatixCloud's separation of action modules and limited integration with other system modules further reduces its utility.

The Welsh Risk Pool has requested a readiness/position report to determine which organisations will transition to DatixCloud. This report, appended as **Appendix C**, will

be reviewed by the Executive Committee on 07 November 2024, and submitted to the Welsh Risk Pool by 08 November 2024. Notably, only one health body (Powys Teaching Health Board) has opted to adopt DatixCloud, primarily because it previously did not use DatixWeb and lacked a dedicated risk management system.

While the Health Board intends to continue using DatixWeb through 2025-2027 while investigating alternative options. The Working Group and Health Board remains open to collaborating with NHS Wales on future system specifications.

Consequently, efforts are now focused on enhancing DatixWeb to better align with the Risk Management Framework. Ongoing work with divisions to cleanse and optimise the current DatixWeb system will be critical to ensuring a functional and reliable risk management system during this interim period.

Embedding of the Risk Management Framework

Since the Board's agreement on the new risk management framework in January 2024, substantial efforts have gone into promoting and embedding the framework within the Health Board. These initiatives have been amplified through ABPulse, leveraging Executive Directors to foster widespread engagement across teams, which has been instrumental in generating interest and active participation. There has been a growing number of requests for training sessions and additional support.

Training has so far reached a diverse range of areas, including the Surgical and Clinical Support, Mental Health & Learning Disabilities (LD), Complex Care divisions, Medical Registrars, Primary Care teams, Information Governance, to name a few. These sessions cover critical components of the risk management framework, such as understanding the Board's risk appetite, differentiating between risks and issues, and using DatixWeb effectively for recording and managing risks. Each training session underscores the significance of a structured approach to risk, equipping teams with essential tools for active risk oversight.

Steady progress is becoming evident through improvements in risk management practices documented on Datix. Risk is increasingly becoming a central theme in agendas, sparking more focused and proactive discussions across the Health Board. The consistent efforts are therefore reinforcing a culture where risk awareness and management actively shape organisational priorities and decision-making.

The Corporate Governance Directorate acknowledges that significant work remains before risk management is fully embedded into everyday practices. However, the dedication to advancing the Health Board's risk management maturity is steadfast, with a clear goal of establishing the health Board as an exemplar in risk management across Wales. This ongoing commitment underpins all efforts to build a robust culture of risk awareness and resilience, ensuring that risk management becomes a fundamental part of daily operations at every level.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **NOTE** the Strategic Risk Register and the Risk Assessments for the 19 sub-risks, acknowledging the comprehensive review and ongoing management of these risks;
- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report;
- **NOTE** the risks that remain outside of the agreed-upon appetite for their respective risk domains, recognising the ongoing efforts to mitigate these risks and bring them within acceptable levels;
- **NOTE** the position of the 'Once for Wales Risk Management Module',
- **NOTE** the continued work to mature and enhance risk management within the Health Board

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

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

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

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

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
	People & Culture Committee	People	Director of Workforce and Organisational Development		a)Due to an inability to recruit and retain staff across all disciplines and specialities.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reliance on agency and bank staff •Litigation & Financial Penalties	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Staff Attendance: Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work., "Hot spot" areas identified and plans in place to support. Recruitment: Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor, Annual programme of Apprentice recruitment, Overseas Nursing (All Wales), Nursing Workforce Strategy, Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) , Partnerships with employability schemes such as Kickstart and Restart, Actively working with Local Authorities to promote joint recruitment activities and Registration – Temporary register extended for 2 years to enable staff to return to practice. Retention: Development of career pathways (e.g., non-clinical to clinical), Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR, Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts, Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return, Agency reduction and Plan in place to monitor and review all agency, bank pay incentives supply and demand. E-Systems: Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff, Development of alternative and new roles , Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP, Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. and Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. Training: The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies, HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy, Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 Staff: Vacancy Numbers and establishment control Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies and Development of ESR establishments commenced on a national basis w/c 03/09/23.	Medium	3	2	6	Low	01/09/2024	01/10/2024
					b) Due to a deterioration in, and a failure to improve, the well-being of our staff	•High absence levels, with some sustained long periods •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reputational damage to the health board as an employer •Work-related industrial injury claims •Moral injury	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars)., Increase wellbeing initiatives: Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites, Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders), Train Mediators so there is team and organisational resilience and network, Regular Schwartz rounds arranged across the Health Board, Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. Close links with the Arts in Health programme, Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. Chaplaincy service for staff , Re-launching Chill out in the Chapel, Recruitment of staff counsellors, Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being , Scope, design and deliver a programme of research 'Healthy Working Day', Enhanced our financial well-being offer. Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management, Drafting of a 10-year plan focusing on optimising the employee experience of work , The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. Occupational Health Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes, Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted, Support equality and diversity of workforce Review of staff diversity networks, Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. Other Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC, Reducing fatigue poster developed	Medium	3	3	9	Moderate	01/09/2024	01/12/2024

SRR 001				There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	c) Due to insufficient and ineffective leadership levels throughout the organisation.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Poor levels of accountability and delivery •Reputational damage to the health board as an employer •Adverse impacts on staff recruitment and retention	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Talent and Succession Planning lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. Development leadership capabilities Designing learning journeys and access to Gwella Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Medium	3	2	6	Low	01/09/2024	01/12/2024
					d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Litigation & Financial Penalties •Reputational damage to the health board and loss of public confidence	3	4	12	High	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Services Business continuity plans in place. All Wales training sessions provide by legal and risk to support industrial action. Ensure early identification of mandated Statutory, and core critical clinical services. Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. Reducing impact on patients - Support for early supported discharge prior to industrial action. Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). Establish WOD hub with emergency planning to stand up as required Ensure early identification of mandated Statutory, and core critical clinical services. Review of business continuity plans Map services and staff provision and impacts of industrial action. Assess variable pay usage in case of work to rule applies. Assess current vacancies. Working with partners in Gwent on a system wide basis. Implementation of business continuity plans. Communication plans. Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	Medium	2	4	8	Moderate	01/09/2024	01/12/2024
					e)Due to inadequate strategic plans which respond to population health and socio-economic needs	•Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to train teams in multi-morbidity management •Failure to comply with the Wellbeing of Future Generations Act (Wales) •Reputational damage and loss of public confidence	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	Medium	2	3	6	Low	01/09/2024	01/03/2025

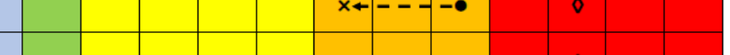
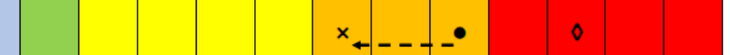
	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Strategy, Planning and Partnerships.		f) Due to unsustainable service models	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes • Failure to deliver health board priorities, required improvements and achieve sustainability • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	Medium	2	3	6	Low	01/09/2024	01/03/2025
	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	• Breach of statutory duty to breakeven over 3 years • Instigation of NHS Wales Escalation & Intervention Arrangements • Non – delivery of health board priorities, required improvements and achieve longer-term sustainability • Prioritisation and possible disinvestment in service delivery • Reputational damage and loss of public confidence	5	4	20	Extreme	Above Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	Medium	2	4	8	Moderate	01/09/2024	01/10/2024
	Partnerships, Public Health & Planning Committee	Compliance and Safety	Director of Public Health and Strategic Partnerships		I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications	4	4	16	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Performance Management and Assurance Framework Executive Accountability letters – to be issued by the end of May 2024 Divisional Directors Accountability letters – to be issued by the end of May 2024 Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reporting through to the Finance and Performance Committee via Executives Specific areas of focus are discussed at the Value & Sustainability Board System-wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. Embed in the regional programmes of work i.e. ophthalmology, diagnostics, and orthopaedics.	Medium	2	4	8	Moderate	01/06/2024	01/07/2024

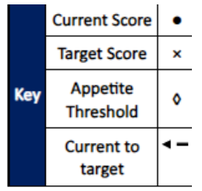
SRR 002	Partnerships, Public Health & Planning Committee	Compliance and Safety	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation & Financial Penalties	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	At this stage, the controls in place are appropriate and practicable to monitor the issues and prepare medium-term responses in line with the timelines within the expert report.	Medium	1	2	2	Very Low	01/06/2024	01/07/2024
					b) Due to significant levels of backlog maintenance and Structural Impairment	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.	Medium	3	2	6	Low	01/04/2024	01/07/2024
SRR 004	Partnerships, Public Health & Planning Committee	Compliance & Safety	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Harm or injury to patients and/or staff •Health Board breaches statutory duties under the Civil Contingencies Act 2004 •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Testing programme of business continuity plans. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. Joint planning with PH response in response to infection disease and public health incidence. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. Continue to promote awareness in a timely manner. Continue to promote awareness of the requirement for BC across the Health Board. A tabletop BC exercise is planned for the 10th of October 2023. Continuing participation in multi-agency exercises. Programme plan to be developed to address the weaknesses in business continuity planning. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Development of Pandemic Plan.	Medium	2	3	6	Low	01/05/2024	01/08/2024

SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	• Avoidable deaths or significant harm • Delays in releasing ambulances from hospital sites back into the community • Delayed discharges from acute and non-acute settings resulting in deteriorating patients • Litigation & Financial Penalties • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	01/04/2024	01/07/2024
SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Implement the recommendations from Templar report: • Outline a step by step process of how the proposed risk treatments need to be implemented. This should include the activities to be performed, who is responsible and deadlines for completion. • Complete any outstanding policy and process development, ensuring there is engagement with non ICT teams including the SIRO and board • Ensure ICT disaster recovery policies are complete and refer to any system specific recovery processes. • Ensure non ICT teams are aware of disaster recovery policies and processes and engaged in developing system breach/failure response definition. • Complete a policy and process review after each incident to identify if anything could be improved in detection, resolution or prevention of a cyber security incident. Also, ensure the same is done whenever there are significant system changes. • Develop the policy and processes for identity and access management to ensure that privileged and critical system accounts are reviewed periodically e.g. 6 to 12 months, with other accounts reviewed through joiners/starters, movers and leavers processes. • Investigate circumstances where dedicated devices can be used for critical system access • Consider plans for certification of users and devices and how those certifications can be used. • Consider how to monitor privileged accounts e.g. with additional logs managing not just by exception but random and planned audits • Assess whether MFA can be implemented for privileged user accounts • Review any critical system logs that are created • Update systems or request updates to create additional logs where possible and include creation of logs on user devices in any investigation • Investigate a means of alerting for specific log conditions • Consider collective identification of appropriate tools and working with other OES within NHS Wales to identify appropriate tools.	Medium	2	4	8	Moderate	01/06/2024	01/07/2024
					B) Due to an adverse impact on service delivery in the implementation of new digital systems	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success	Medium	2	3	6	Low	07/04/2024	01/07/2024

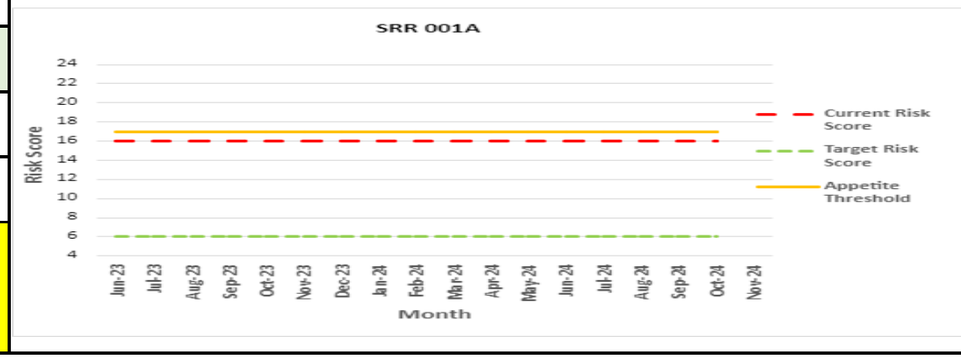
					c) Due to a failure to develop digital solutions that are sustainable and fit for the future	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities	Medium	2	4	8	Moderate	07/04/2024	01/07/2024
SRR 007	Partnerships, Public Health & Planning Committee	Transformation and Partnership Working	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	•Unmet patient need resulting in harm •Ineffective use of combined resources •Delayed decision making •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach. .	Medium	2	2	4	Low	10/04/2024	10/07/2024
					Changes of regional flow in an unplanned way Additional demand on UHB workforce to support fragile services							The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a recent review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with							

					b) Due to the impact of fragile services across the regional and supra regional geography	Unmet patient need resulting in harm Ineffective use of combined resources Delayed decision making Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence	3	3	9	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	recognition that these need to be 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions. Discussion to be had at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	Reasonable	2	2	4	Low	16/04/2024	16/07/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	Medium	2	2	4	Low	01/07/2024	01/10/2024
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Safety of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	01/08/2024	01/10/2024

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



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

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

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing and HCSW). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Workforce planning supported by Compendium of new roles to support innovative workforce models. • Recruitment KPI's. • IMTP (Integrated Medium-Term Plan) Educational Commissioning. • Workforce Establishment controls national working group has been instigated. • Value and Sustainability Board. • Collective Agreement (Non-Pay Deal) 2022/24 • **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales Recruitment programme) • Nursing Workforce Strategy agreed. • Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) • Partnerships with employability schemes and FE/HE to widen access. • Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. **Retention**	**Retention** • Development of career pathways (e.g., non-clinical to clinical). • NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 • Short project in progress with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis is underway with a 5 year past dataset shared. **Variable Pay Reduction** • Development of action plan based on WHC to support the reduction in bank and agency usage. **E- Systems** • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. • Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill. • Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. • Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles. **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. • Looking to increase Assistant band 4 in Community/Mental Health. • Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. • Increasing consultant therapy and nurse practitioners.

- Retention lead appointed with programme action plan in place for the next two years.
- Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR.
- Week of events planned to support retention agenda in June 2024. This will include a mixed method of online webinars, videos and retention materials.
- Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.
- Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked**.**
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.

Variable pay reduction

- Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board.

E- Systems

- Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all 'live' and rolled out within the Health Board.
- E-Rostering is planned to go live shortly following ESR interface testing.
- Development of alternative and new roles
- A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent, and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care
- The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management.

Training

- The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2024 and beyond which are required to support turnover and existing vacancies.
- The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice.
- HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.
- RCN Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (12 supported so far this year, with 3 more to interview)
- Cadet Nursing programme in place (20 candidates last year)
- K102 bridging model now being offered to support HCSW pathways into registered nursing.
- Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) is in its second year. Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024. Nursing and Midwifery Academy for senior level nurses and midwifes, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff.

Vacancy Numbers and establishment control

- Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period August 2024 there were circa 636 WTE vacancies. No change from figures reported March 24.
- Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan has been developed and approved by Executive Committee in April 2024. Project workstream established and work commenced. National work programme proposal is also in development.

- RCN introduction of Registered Nurse Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027.
- Development of new roles and career pathways to support hard to fill roles in Health Visiting.
- Re-design of the Health Board's work experience programme with 246 applicants since March 2024 and 75 placements confirmed

Training

- HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy
- Workforce planning training prospectus of local and online training launched September 2024
- Development opportunity being scoped for Business support staff.
- Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. 236 attendees in July 2024.
- Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire.
- Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies.
- A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention.

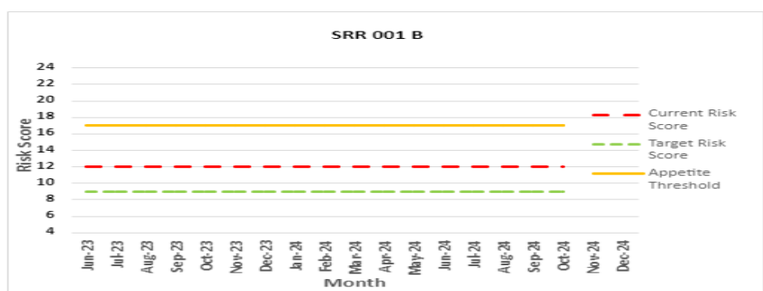
Staff attendance • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support	

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

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Positive Assurance**

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



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

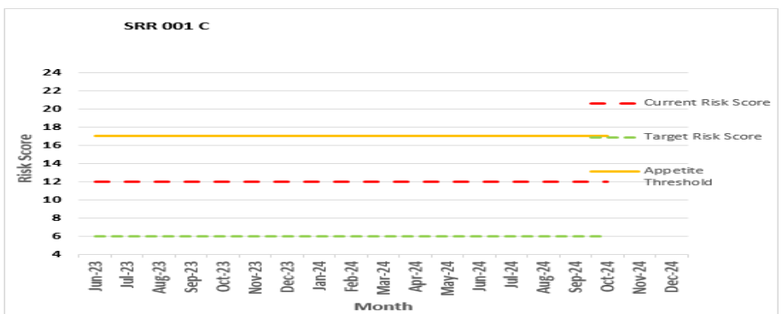
• The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. • an externally commissioned SUS hotline will be piloted in September 2024. • An external Employee Assistance Programme (Vivup) has been commissioned for 12 months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

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

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Positive Assurance**

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



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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• WOD Divisional reporting • Evaluation of internal leadership programmes and regular review of our internal offer		

Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Reporting to People and Culture Committee - progress against People Plan 22-25		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit Review • Talent and Succession Board		

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Positive Assurance**

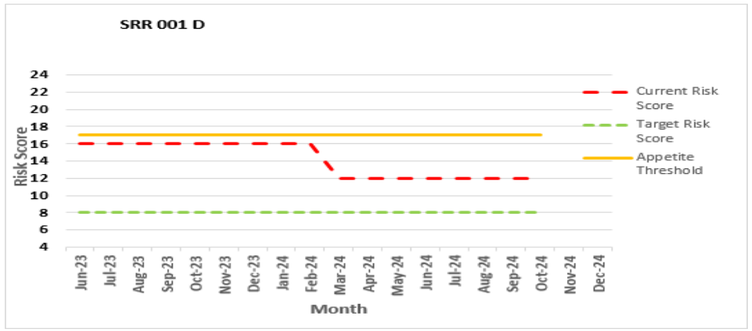
RISK THEME	PEOPLE				
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Strategic Threat	**d.** Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level				
Impact	• Adverse impacts on delivery of care to patients across acute and non-acute settings • Non-compliance with safe staffing principles and standards • Litigation & Financial Penalties • Reputational damage to the health board and loss of public confidence				
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**4** *(Major)*	
Last Reviewed	01 September 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review (Quarterly based on risk score)	01 December 2024				

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below.
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –



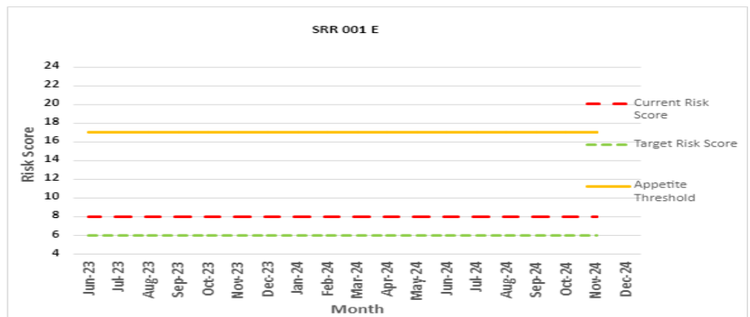
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) • Trade Union Partnership meetings		• Further industrial action
Level 2 Organisational *(Executed by risk management and compliance functions)*		

• Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• All Wales IA group and Welsh Government planning group. • Debriefing session planned to reflect and capture learning for any potential future action		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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

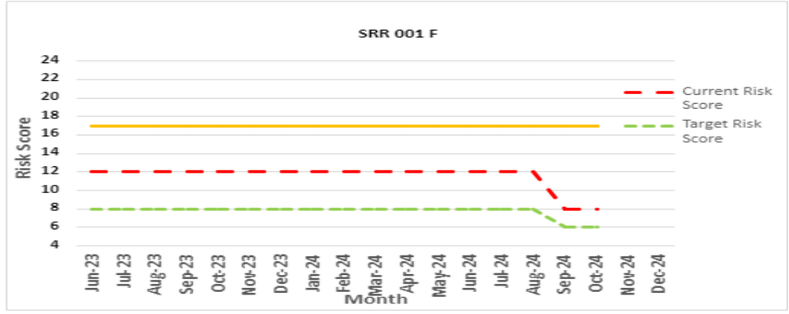


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

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

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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

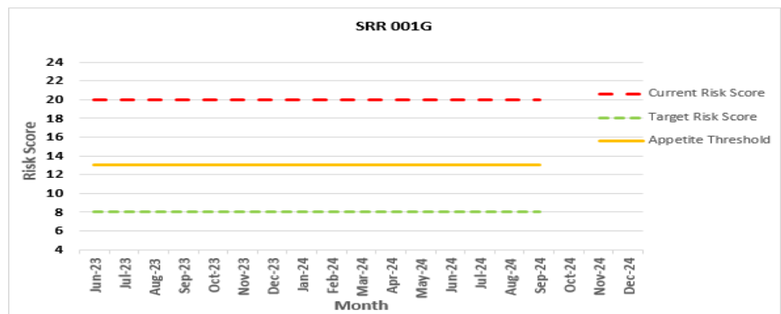


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information.		• Evidence of individual arrangements in place to deliver service plans.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.		• Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan

Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• **Internal Audit Reviews 2023-24** • IMTP planning Q1. **Outcome – Reasonable Assurance.** • **Internal Audit Reviews 2024-25** • IMTP – Service Plans (Q2)		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

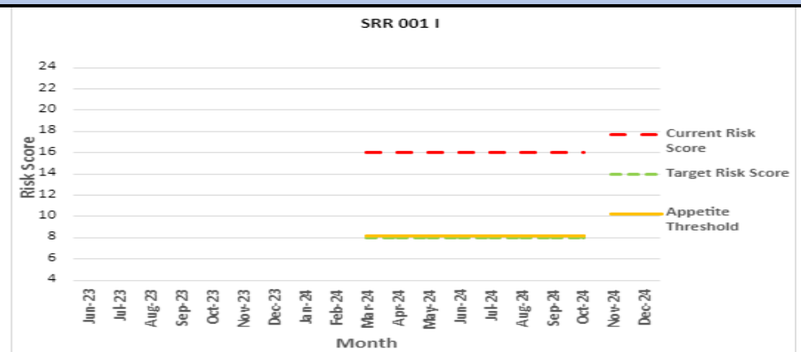
RISK THEME	FINANCIAL SUSTAINABILITY					
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				**Publication Status**	**Public**
Strategic Threat	**G. Due to the failure to deliver a sustainable financial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

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

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

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY					
SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				**Publication Status**	**Public**
Strategic Threat	**i.** Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.				**Risk Appetite Level - MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact	• Unintended patient harm • Negative patient/public experience • Loss of patient/public trust and confidence • Reduced staff morale leading to potential absence from work • Scrutiny from external organisations (AW/HIW/WG) • Punitive Action • Adverse publicity • Financial implications				**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
					SUMMARY The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning & Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	**Expected Date Target Score will be Achieved –**	
Monitoring Committee	Finance & Performance Committee	**Likelihood**	***4** (Likely)* x	2 *(Unlikely)* x		
Initial Date of Assessment	19 April 2024	**Impact**	4 *(Major)*	**4** *(Major)*		
Last Reviewed	01 September2024	**Risk rating**	**= 16** *(Extreme)*	**= 8** *(Moderate)*		
Next Review (Monthly based on risk score)	01 November 2024					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Performance Management and Assurance Framework • Executive Accountability letters • Divisional Directors Accountability letters • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off • Reporting through to Finance and Performance Committee via Executives • Specific areas of focus are discussed at Value and Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. • External scrutiny via Welsh Government and NHS Executive	• 6-month review of Performance Management and Assurance • Alignment of internal mechanisms to national escalation • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Appropriate Business Partnering Support and analytical support • Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates	• Capacity to run the performance framework and reporting requirements. • If Business Partnering Support and analytical support is in the appropriate areas, will be reviewed as part of 12-month Performance Management Framework review in the Autumn	**Internal Audit 2024/25 Plan** • Findings and recommendations from the Divisional Governance Arrangements (Q2) • Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)

Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety Committee • Established reporting to the Board • Routine reporting through the IQPD process		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan • Directorate Review - Mental Health and Learning Disabilities (Q2) • Divisional Governance Arrangements (Q2) • HIW Inspections • Llais for feedback		•

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

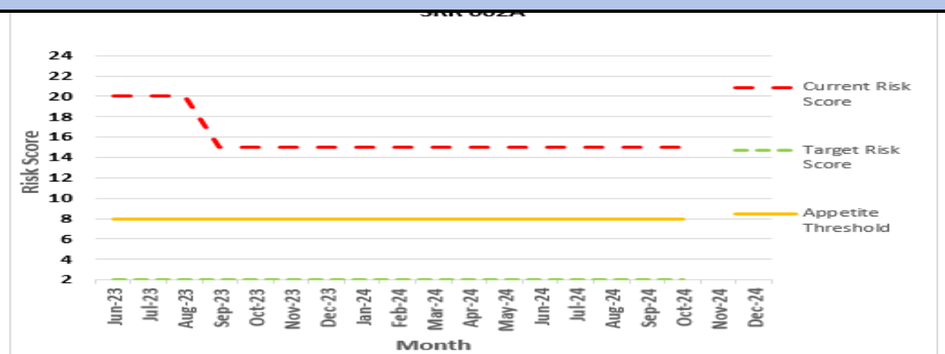
RISK THEME	COMPLIANCE AND SAFETY				
SRR 002	**There is a risk that there will be significant failure of the Health Boards Estates.**			**Publication Status**	**Public**
Strategic Threat	a. Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.				
Impact	• Harm or injury to patients and/or staff. • Adverse impacts on the delivery of care to patients across acute and non-acute settings. • Non-compliance with health and safety legislation. • Loss of estate • Litigation and financial penalties				
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare)* x	
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*	
Last Reviewed	01 September 2024	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*	
Next Review (Monthly based on risk score)	01 November 2024				

Risk Appetite Level - MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold

Expected Date Target Score will be Achieved –



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Work to assess the risk has been undertaken with expert external surveyor advice and repeat surveys have recently been completed. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas • Controlled access to roof areas • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. *Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations* • Links with NHS England and other Health Boards in Wales for shared learning. • Fortnightly dialogue with Welsh Government and Shared Services Estates.	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Fortnightly checks in place for the props in place • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) scheduled for June 2024		• Ongoing management of the issues.
• **Level 2 Organisational** *(Executed by risk management and compliance functions)*		
• Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment • Formal reporting to the Board • Formal update to the PPHPC in July with full SOC end of Q3.		
• **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • Nevill Hall RAAC (Q1) – In progress Welsh Government oversight	• Latest local survey saw a reduction in staff wellbeing	• Repeat surveys have been completed and additional more specific and technical surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues. **Internal Audit 2024/25 Plan** • Nevill Hall RAAC (Q1) - Outcome Reasonable Assurance. Reported to November ARAC

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

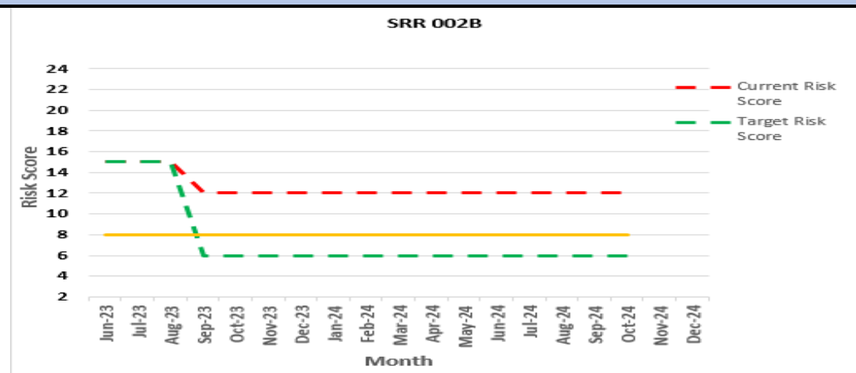
RISK THEME	COMPLIENCE AND SAFETY			
SRR 002	**There is a risk that there will be significant failure of the Health Boards Estates.**		**Publication Status**	**Public**
Strategic Threat	b. Due to significant levels of backlog maintenance and structural impairment.			
Impact	• Harm or injury to patients and/or staff. • Adverse impacts on the delivery of care to patients across acute and non-acute settings. • Non-compliance with health and safety legislation. • Litigation and financial penalties. • Loss of estate			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** (*Minor)*
Last Reviewed	01 September 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Next Review (Quarterly based on risk score)	01 December 2024			

Risk Appetite Level – MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –



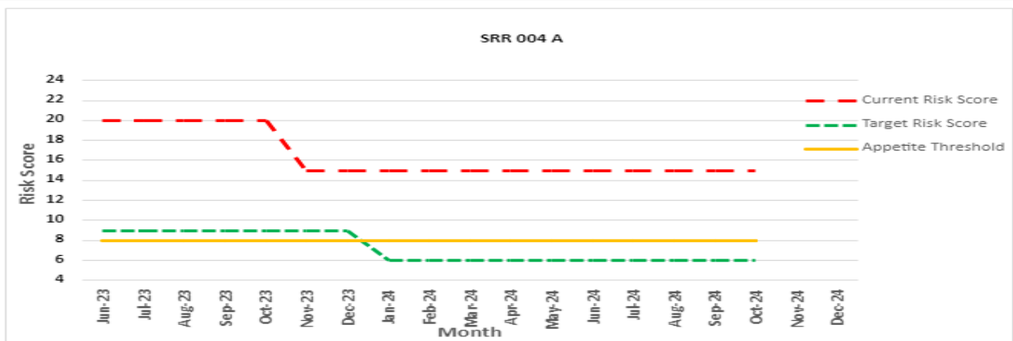
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • Outcome of the Asbestos reinspection programme	• If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	• Performance reporting

Level 2 Organisational *(Executed by risk management and compliance functions)*		
• The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023- 24 Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and Finance and Performance Committee **Internal Audit Plan 2024-25** Estates Assurance – Energy Management (Q2) **Outcome = Reasonable Assurance**. Reported to the November ARAC. • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level		•

Assurance Rating (*Overall Assessment of controls and assurances)*

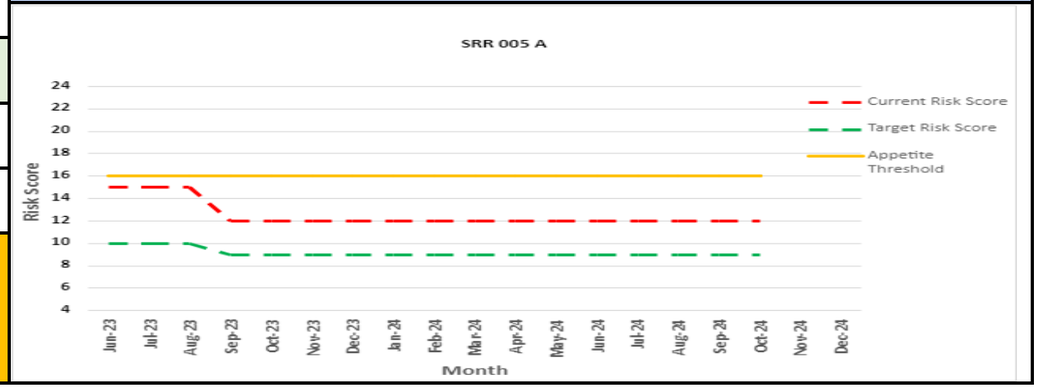
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
Major Incident • Major Incident Plan • Local/Divisional action cards are in place. • Training undertaken service-specific relating to local response. **Business Continuity (BC) /Critical Incident** • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents. • EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. • Awareness raising of the requirement for BC across the Health Board through various training programmes **Infectious Diseases** • Joint plan with PH in response to infectious diseases and public health incidence response. **Overall** • Internal strategic on call training • Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	• Major Incident Exercise 'Euclid' planned for 20th June 2024 – Faculty in place to plan scope and detail of exercise. • Testing programme of business continuity plans. • Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Develop further training programmes to support staff preparedness to response to an incident. • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. (as this is not fully implemented, it is still being worked through thus would make it additional control until in place)

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

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY					
SRR 005	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**				**Publication Status**	**Public**
Strategic Threat	**B.** Due to inadequate arrangements to support system-wide patient flow				**Risk Appetite Level - Open** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	• Avoidable deaths or significant harm • Delays in releasing ambulances from hospital sites back into the community • Delayed discharges from acute and non-acute settings resulting in deteriorating patients; • Litigation & Financial Penalties • Reputational damage and loss of public confidence				**Risk Appetite Threshold – Open SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	**3** *(Possible)* X	**3** *(Possible)* X		
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Catastrophic)*	**3** *(Minor)*		
Last Reviewed	01 July 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*		
Next Review (Quarterly based on risk score)	01 October 2024					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.	• Operational framework – Being revamped through operational framework ahead of next winter. • Improve regional acceptance of flow processes with neighbouring Health Boards. • Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. • External inspections/visits.		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

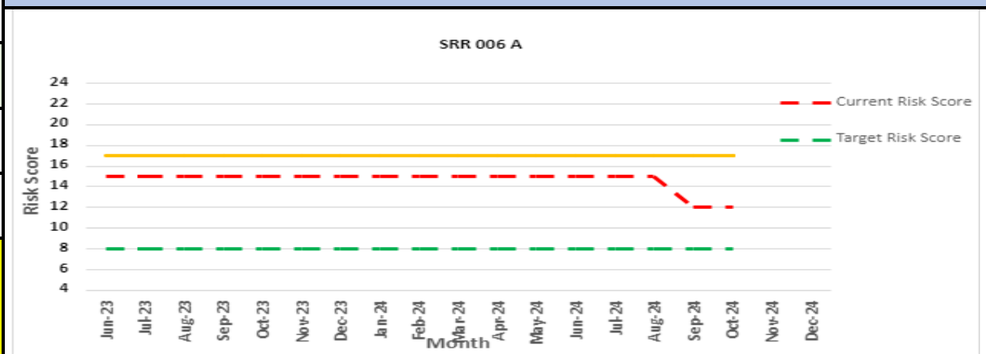
RISK THEME	SERVICE DELIVERY					
SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.				Publication Status	Public
Strategic Threat	a. **Due to the full or partial failure of existing digital infrastructure and systems.**					
Impact	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence					
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Finance & Performance Committee	Likelihood	**3** *(Possible)* x	**2** *(Unlikely)* x		
Initial Date of Assessment	01 June 2023	Impact	**4** *(Major)*	**4** *(Major)*		
Last Reviewed	01 September 2024	Risk rating	**= 12** *(High)*	**= 8** *(Moderate)*		
Next Review (Quarterly based on risk score)	01 December 2024					

Risk Appetite Level - OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –



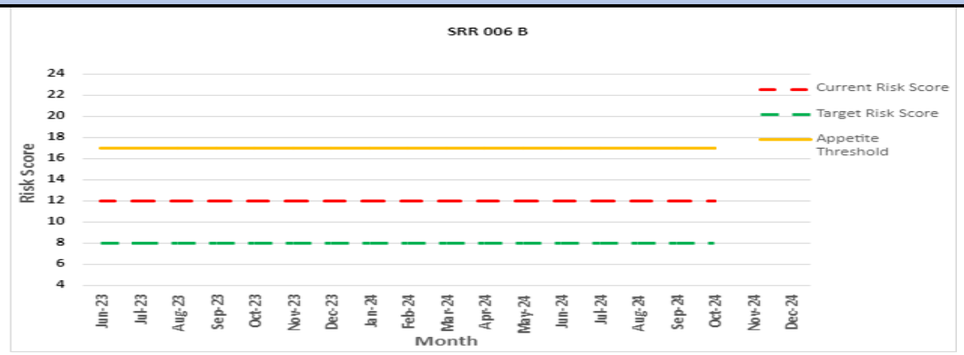
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

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

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

Assurance Rating (*Overall Assessment of controls and assurances)*

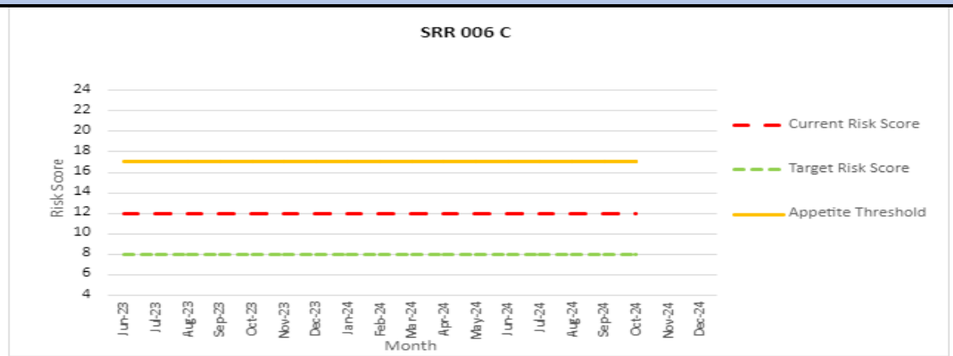
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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

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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• . Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Project Boards meet monthly and report into the quarterly Digital Portfolio Progress Group • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework	• Uncertainty of where work programmes are reported and how progress is measured	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
• **Level 2 Organisational** *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee		
• **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)*		
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit 2023/24** • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance **Internal Audit 2024/25** • Implementation of the Welsh Intensive Care System – planned for Q1		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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

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

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

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

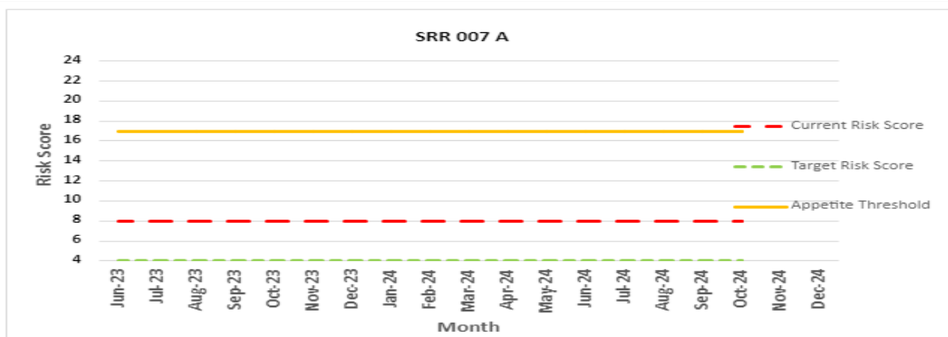
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			**Publication Status**	**Public**
Strategic Threat	**A.** Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.				
Impact	• Unmet patient need resulting in harm • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence				
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)* x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*	
Last Reviewed	01 September 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Low)*	
Next Review (Six monthly based on risk score)	01 March 2025				

Risk Appetite Level - OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold - **SCORE 17 AND BELOW**
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –



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

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

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

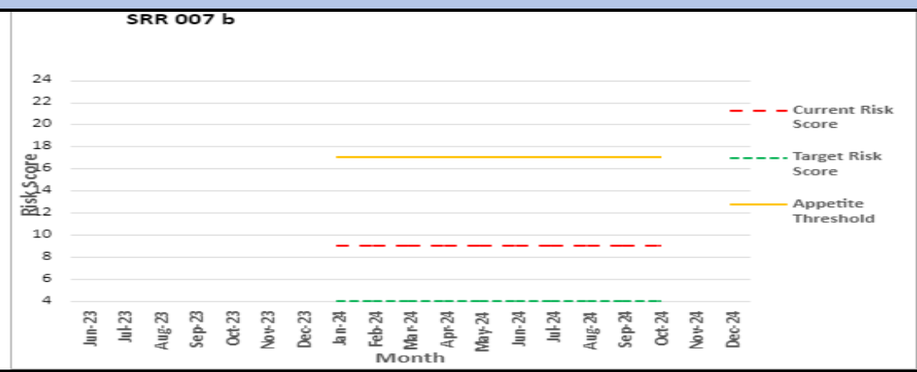
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			**Publication Status**	**Public**
Strategic Threat	B. **Due to the impact of fragile services across the regional and supra regional geography**				
Impact	• Unmet patient need resulting in harm • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence				
Lead Director	Director of Strategy Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	04 January 2024	**Impact**	*3 (Moderate)*	2 *(Minor)*	
Last Reviewed	01 September 2024	**Risk rating**	***= 9*** *(High)*	**= 4** *(Low)*	
Next Review (Quarterly based on risk score)	01 December 2024				

Risk Appetite Level - OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold - **SCORE 17 AND BELOW**
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Expected Date Target Score will be Achieved –

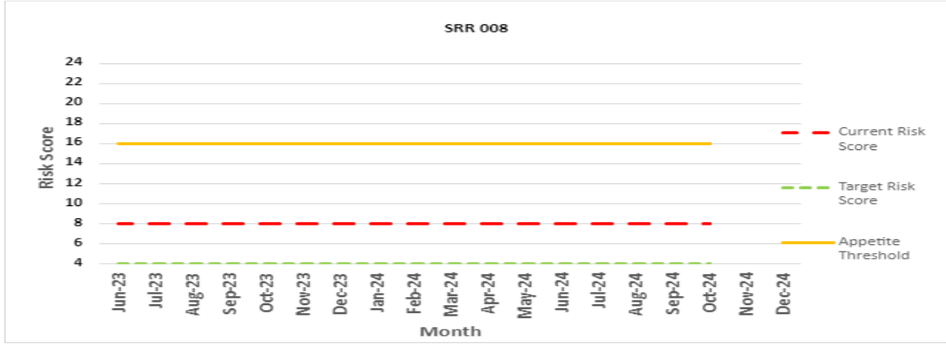


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

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

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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



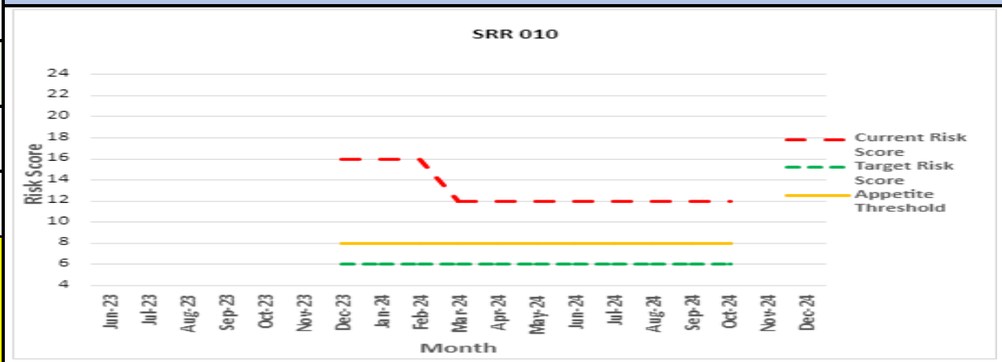
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation • Immediate feedback and escalation to clinical teams following PALS queries and concerns	• No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.	• Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms.

		• Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• LLais Reports • HIW inspections • Advocacy reports		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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



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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Health and Safety compliance data extracted from ESR and Datix and reported	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan

Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • H&S processes • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Negative Assurance**

Internal Audit Progress Report

Audit, Risk and Assurance Committee

November 2024

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2024/25 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the November 2024 Audit, Risk and Assurance Committee (the 'Committee');
- provide an update on the scheduling of the Welsh Intensive Care System audit; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against 2024/25 Internal Audit Plan

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

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

Number of audits in plan:	31
Less audit merger	(1)
Revised total	30
Number of audits at final report stage	5
Number of audits at draft report stage	2
Number of audits work in progress	8
Number of audits at planning stage	6
Number of audits not started	9

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

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Facilities Stock	Reasonable
Providing Care to Asylum Seekers and Refugees	Reasonable
Nevill Hall RAAC	Reasonable
Estates Assurance – Energy Management	Reasonable
Newport East HWBC	Reasonable

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

3. Summary of Findings

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

Facilities Stock (reasonable assurance)

The audit was a dedicated follow-up review over the implementation progress of the recommendations raised within the 2023/24 audit.

Significant work has been completed since our previous audit of this area in October 2023. The majority of the previous actions raised have been completed and assurance has been provided, through the new divisional governance processes established.

However, the divisional stock management risk has not yet been fully mitigated, as further actions are still in progress. Whilst there are actions still to be implemented, there are several mitigating steps embedded that are reducing the overall risk (e.g. frequent stock checks). Nonetheless, there may be further decisions required over the stock management system, in line with Health Board's risk appetite.

Overall, whilst good progress has been made, the following matters still require management's attention:

- there has been an improvement with the divisional catering stock processes, with a reduction in catering stock expenditure. However, the current stock management system does not have the capabilities for stocktakes to follow the process set out within the Health Board's financial control procedure; and
- training on stock processes and awareness of the new standing operating procedures should be monitored.

Providing Care to Asylum Seekers and Refugees (reasonable assurance)

We reviewed the arrangements in place for providing care to asylum seekers and refugees, including whether the applicable guidance is being adhered to.

The Health Inclusion Service (HIS) is a nurse led primary and community care service that responds to the health needs of socially at risk, vulnerable and excluded people living within the Health Board's region. We found the HIS provides a strong support mechanism of services and engages with many different services.

However, we found that the Blue Book assessments for refugees and asylum seekers are not always completed within the HIS internal target timeframe of three days, to make contact and 14 days to complete the assessment. As this is not documented, there should be agreement over if this is deemed to be a reasonable timeframe, as required within the Welsh Government Policy Guidance.

Furthermore, there is a lack of staff training / awareness provided to the relevant tiers within the Health Board.

Nevill Hall RAAC (reasonable assurance)

The audit sought to evaluate the arrangements in place to manage/mitigate the risks associated with the presence of RAAC found within Nevill Hall Hospital (NHH).

Welsh Government awarded funding up to £1.158m (including VAT) over the 2023/24 and 2024/25 financial years to support RAAC remedial works at NHH.

A corporate risk relating to RAAC was introduced in June 2023; with regular and ongoing reporting evident at multiple Health Board committees including the Board and Population Health and Planning Committee. There had also been regular communication with NWSSP: Specialist Estates Services – acting as agents of Welsh Government relating to the ongoing management and planning arrangements for RAAC across the NHS Wales estate.

Recommendations have been made for refinement and/or further development in certain areas, such as:

- the development of a management strategy;
- increased assurance around the achievability of the corporate risk target score; and
- a review of the procurement/ contractual approval arrangement.

An overall reasonable assurance was determined due to the positive controls in place to manage the risks associated with the presence of RAAC at NHH. However, given the potential inherent risk, the short to medium term arrangements require close monitoring.

Estates Assurance – Energy Management (reasonable assurance)

The Health Board's energy consumption represents 17% of the NHS Wales total, with costs of £6.7m for gas and £10.2m for electricity reported for 2023/24. Therefore, we assessed the energy management arrangements within the Health Board.

Energy is procured centrally on behalf of NHS Wales by NWSSP: Procurement Services, with new contractual arrangements in place from October 2023. We found appropriate governance arrangements were in place, including an experienced Energy Team, reporting into the Decarbonisation Programme governance structure.

In addition, we found that the Energy Team had established robust systems for data capture, validation and payments: ensuring that management received comprehensive, accurate and timely data for review. Optimisation of the Building Management Systems provided demonstrable cost and CO_2 savings, with investment approved to modernise the oldest systems.

The move to the new NHS Wales energy contract in 2023 has caused national disruption. This included difficulties in providing accurate energy forecasts to participating organisations, and additional resource required in the Energy Team to resolve account queries. Recognising the robust data processes operated at the Health Board, the impact of the national issues has not been as significant as seen elsewhere.

Newport East HWBC (reasonable assurance)

The audit was undertaken to review the delivery and management arrangements in place to progress the Newport East Health & Wellbeing Centre project, and the performance to date against its key delivery objectives. This was the second audit of the project and covered the period from the last review in January 2023 to April 2024 (the previous review having determined reasonable assurance).

The project's contract completion date has been extended (through the issue of formal Compensation Events) from 25th November 2024 to 13th January 2025. The Supply Chain Partner's current delivery programme showed forecast completion being achieved on 22nd April 2025 i.e. an approximate 14-week delay against the revised contract completion date.

Furthermore, the latest cost analysis reviewed within the audit (March 2024) identified a best realistic outturn cost ranging between £406k and £620k overspend. This represents a 1.44% - 2.2% increase against the original Welsh Government approval.

We also raised recommendations over:

- improvements required at the governance and scrutiny arrangements, applied at both the Project Board and Community and Engagement Steering Group;
- compliance with the project's (and contractual) change management arrangements; and
- the consistent completion of key project information (change control).

Whilst noting the above, an overall reasonable assurance was determined. This assessment acknowledges that whilst the project is currently progressing outside of the key time /cost parameters, cost pressures are currently being managed within discretionary allocations, and the successful application for IRCF funding would positively impact on the project (together with the pressures / impact on the Health Board's discretionary programme).

At the time of reporting, the delay to the programme was not significantly impacting on patient services. Management acknowledge that these time and cost pressures will need to be carefully managed through to completion and handover, and further deterioration in the reported position would impact on the overall assurance provided. These issues will be further considered at the scheduled 2024/25 review (approved within the FBC).

4. Welsh Intensive Care System

The funding arrangements are still to be confirmed by the Welsh Government for the Welsh Intensive Care System. Consequently, we will commence the audit following the conclusion of this process, as this may impact the audit scope. We may need to reconsider the timing and audit approach in the short to medium term, but will update the Committee, accordingly.

5. Other Activity

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

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

6. Recommendation

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

Appendix A: Progress against 2024/25 Internal Audit Plan

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

Appendix B: Audit Assurance Ratings

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

Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Energy Management
Final Internal Audit Report

October 2024

Aneurin Bevan University Health Board

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

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

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Review reference:	ABU-SSU-2425-27
Report status:	Final
Fieldwork commencement:	24th June 2024
Fieldwork completion:	16th September 2024
Debrief meeting:	7th October 2024
Draft report issued:	8th October 2024
Management response received:	23rd October 2024
Final report issued:	24th October 2024
Auditors:	NWSSP: Audit & Assurance - Specialist Services Unit (SSu)
Executive sign-off:	Leanne Watkins, Chief Operating Officer
Distribution:	Jamie Marchant, Director of Estates & Facilities Justin Jones, Assistant Head of Estate, Capital & Property Management Matthew Lane, Energy Manager Daniel Hern, Decision Support Accountant – Facilities Rani Dash, Director of Corporate Governance
Committee:	Audit, Risk and Assurance Committee

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

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

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

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

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

Executive Summary

Purpose

Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

Overview

We have determined **reasonable assurance** in this area.

The UHB's energy consumption represents 17% of the NHS Wales total, with costs of £6.7m for gas and £10.2m for electricity reported for 2023/24 (see Appendix B).

Energy is procured centrally on behalf of NHS Wales by NWSSP: Procurement Services, with new contractual arrangements in place from October 2023.

Appropriate governance arrangements were in place, including an experienced Energy Team, reporting into the Decarbonisation Programme governance structure.

We evidenced that the Energy Team had established robust systems for data capture, validation and payments: ensuring that management received comprehensive, accurate and timely data for review.

Optimisation of the Building Management Systems provided demonstrable cost and CO_2 savings, with investment approved to modernise the oldest systems.

The move to the new NHS Wales energy contract in 2023 has caused national disruption. This included difficulties in providing accurate energy forecasts to participating organisations, and additional resource required in the Energy Team to resolve account queries. Recognising the robust data processes operated at Aneurin Bevan UHB, the impact of the national issues has not been as significant as seen elsewhere.

Recommendations / advisory points are within the detail of the report, with no significant matters raised.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance	Reasonable
2	Contracts	Substantial
3	Data Capture	Reasonable
4	Data Validation	Substantial
5	Monitoring & Reporting	Reasonable
6	Energy Awareness	Reasonable
7	Payments	Reasonable
8	Risk Management	Substantial

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	The Energy Team's Work Plan should be finalised, with a process in place to monitor delivery.	1	Design	Medium
2	Achievable and measurable plans should be developed in respect of the Energy Team's priorities for system efficiencies.	3	Design	Medium
3	The Energy Team should ensure they are appropriately engaged when determining rental charges to third parties.	3	Design	Medium
4	Out of hours site walk-arounds should be re-introduced.	5	Operation	Medium
6	Take-up data for energy-related ESR training modules should be reviewed.	6	Operation	Medium
7	The Energy Team should liaise with NWSSP Accounts Payable in respect of late invoice payment.	7	Design	Medium

1. Introduction

1.1 This audit originates from the 2024/25 audit plan, agreed with management, and approved by the University Health Board's (UHB's) Audit & Risk Committee.

1.2 Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

1.3 NHS Wales energy data provided by NWSSP: Procurement Services in respect of the all-Wales energy contract (see **Appendix B**) indicates the UHB is the 3rd largest consumer of gas, and 2nd largest consumer of electricity in NHS Wales – representing 17% of total consumption.

1.4 The risks considered during the review included:

- Accountability had not been assigned for Energy management.
- Energy consumption variances were not understood/ addressed.
- Associated risks were not reported/ escalated in accordance with established risk management procedures.
- Energy was not managed efficiently.

2. Detailed Audit Findings

Governance: *Assurance that key roles had been assigned and responsibilities of key staff were understood. An appropriate forum had been assigned with responsibility and accountability for overseeing Energy efficiency/ consumption.*

2.1 Key roles to deliver the energy management function had been clearly defined, including an Energy Manager, Energy Admin Officer and Estates Officer (with responsibility for optimisation of the Building Management Systems (BMS)).

2.2 The Estates Officer role in respect of BMS optimisation provided demonstrable cost and CO_2 emission savings, however, it was noted that this was the only post within the UHB with sufficient experience to effectively deliver this role.

2.3 Energy performance was reported to the Decarbonisation Programme Board and Estates sub-group, with an appropriate range of reporting evidenced to enable oversight and scrutiny. Decarbonisation (including energy) was reported to the Finance and Performance Committee.

2.4 The Welsh Health Environmental Forum (WHEF) Energy sub-group had recently reconvened following a hiatus, and this will provide a national (NHS Wales) forum for the sharing of knowledge and good practice.

2.5 The Energy Team had developed a Work Plan, setting out targeted improvements and cyclical tasks for 2024/25. This was still in draft at the time of review, and it had not been determined how progress against the Plan would be monitored (**MA1**).

2.6 Recognising the above, **reasonable assurance** has been determined in respect of governance arrangements.

Contracts: *Recognising the national contracts in place, to obtain assurance that the Health Board obligations under the national contract arrangements were fully understood and applied.*

2.7 The UHB entered into the new all-Wales (NHS) energy contract (for gas and electricity) in October 2023, with Crown Commercial Services (CCS). Arrangements were centrally managed by NWSSP: Procurement Services.

2.8 The change was driven by the previous supplier (British Gas) withdrawing from the larger customer market, and significant market volatility (both financially and with regards continuity of supply) since 2021.

2.9 Two new central governance forums were initiated to oversee the arrangements:

- Welsh Energy Group (WEG) – Responsible for establishing the strategy for energy procurement and determining basket choices from the CCS framework. Membership included Directors of Finance representing each organisation.
- Welsh Energy Operational Group (WEOG) – Responsible for establishing a common model for supplier management and best working practices across NHS Wales. Membership included operational energy and finance colleagues from member organisations.

2.10 The central governance arrangements managed by NWSSP have previously been reviewed by Internal Audit (see *Energy Cost Management* report, January 2024), delivering Substantial Assurance.

2.11 The implementation of the new CCS contract has seen issues across NHS Wales, both in the closure of the British Gas accounts and the commencement of relationships with the new gas and electricity suppliers under the CCS framework. These difficulties have impacted all organisations, to varying degrees, in for example the availability of accurate data (for both forecasting and validation of invoices) and input of additional resource to resolve issues. At the time of review, Aneurin Bevan UHB were managing a robust data set taken from regular manual meter readings (see *Data Capture* objective) and had also implemented 6-weekly account reviews with the suppliers to discuss overdue payments (see *Payments* objective), and so were less impacted than some other organisations in these areas.

2.12 The handover issues were being discussed and managed centrally at the WEOG.

2.13 Recognising the importance of both the WEG and WEOG in managing the new contracts, we evidenced appropriate attendance by the UHB at both forums, maximising the UHB's opportunity to influence the central decision-making processes and feed into the supplier management activity.

2.14 We also evidenced engagement (by both the Energy and Finance teams) with the periodic forecasting data issued by NWSSP: Procurement Services, ensuring UHB data was reviewed and updated where necessary.

2.15 Recognising the above, **substantial assurance** is determined in this area.

Data Capture: *Appropriate systems were in place to capture data on energy consumption in a timely manner.*

2.16 The UHB uses the Systems Link energy management system to capture energy data, including manual meter readings, Automatic Meter Reads (AMR) and invoice data.

2.17 A robust programme of monthly manual meter readings operated across the estate, supplemented by AMR data from the larger sites.

2.18 Audit testing from a sample of five sites, between April and June 2024, found all data to have been input correctly to Systems Link, and in a timely manner.

2.19 Whilst recognising the above process provides the UHB with a comprehensive, timely and accurate data set, and has ensured a degree of protection from the impact of the contract handover issues experienced by some other NHS Wales organisations (see *Contracts* objective), it is manually intensive. The Energy team have identified a number of opportunities for improved efficiency, e.g. through increased provision of AMRs, and introducing electronic data transfer processes. Noting these have been under consideration for some time, achievable and measurable plans should now be developed to take these forward where feasible (**MA2**).

2.20 Noting some UHB premises are leased to third parties, including commercial organisations, we did not evidence the recent engagement of the Energy Manager in determining an appropriate rent charge, to incorporate accurate forecasting of energy costs (**MA3**).

2.21 Noting only a few areas for potential improvement of data processes, **reasonable assurance** has been determined.

Data Validation: *Adequate checks were undertaken to verify the quality/ reliability of the data – with any anomalies fully investigated.*

2.22 The Systems Link energy management system incorporates built in data validation tools, using parameters determined by the Energy team. Validation takes place for a range of data inputs, e.g. meter readings and unit rates.

2.23 Monthly report outputs from the system are also reviewed for unexpected variances, which may indicate inaccurate data entry. This process is discussed further in the *Monitoring and Reporting* objective.

2.24 Sample audit testing identified no occurrences of data input error, in either meter readings or invoice data.

2.25 **Substantial assurance** is therefore determined in respect of data validation.

Monitoring & Reporting: *A review of resulting internal / external monitoring and reporting arrangements, to ensure that anomalies were understood, benchmarking was undertaken where appropriate, and any resulting management action was appropriately tracked.*

2.26 We evidenced good practice in BMS optimisation activity, with a dedicated Estates Officer responsible for managing the systems across the estate. Detailed records were maintained of controls applied/enhanced, with equivalent cost savings of £136k documented for 2023/24.

2.27 Recognising some of the older BMS had scope for improvement, £120k has been allocated for system upgrades at Royal Gwent and Nevill Hall Hospitals. Further investment was being considered via the Re:Fit Cymru programme (a national public sector programme supported by Welsh Government, to help make buildings more energy efficient).

2.28 The Energy Manager produced comprehensive monthly reports from Systems Link, showing consumption and cost at site level, which were reviewed to identify any unexpected variances requiring investigation. The reports were also shared with the Facilities Division Accountant, to facilitate financial monitoring.

2.29 Additional site performance data was available from the Display Energy Certificate (DEC) process, for which the Energy Manager was an accredited assessor. The DEC process utilised Chartered Institute of Building Services Engineers (CIBSE) benchmarking data, to measure site performance against national industry data.

2.30 The UHB inputs energy data to the all-Wales Estates & Facilities Performance Management System (EFPMS), which NWSSP: Specialist Estates Services (SES) shares across NHS Wales. The UHB should utilise this data to undertake performance benchmarking with similar organisations and sites (**MA4**).

2.31 The DEC process requires annual site visits, providing opportunity for the Energy Manager to observe site-based practices and identify areas for improvement. There was however scope to undertake walk-arounds in both winter and summer, to observe varying practices in different seasons (**MA5**).

2.32 The audit included two site visits, to Nevill Hall Hospital and Ysbyty Ystrad Fawr, to assess for any visible instances of energy inefficiency. General good practice was observed on both sites, including use of LED lights, motion sensors and general switch off of equipment and lights when rooms were not in use. There were some instances of lights left on in empty spaces (for example Outpatients) at Nevill Hall Hospital, and this has been addressed in the *Energy Awareness* objective in terms of training (see **MA6**).

2.33 **Reasonable Assurance** has therefore been determined in this area.

Energy Awareness: *That appropriate training had been established for general and key energy staff focused on increasing awareness of obligations and requirements. Assessment of any other initiatives established to increase awareness e.g. intranet pages, staff circulars, team briefings etc.*

2.34 In assessing energy awareness measures, it is recognised that the Decarbonisation agenda (separately audited in 2023/24) now encompasses targeted activity in staff communication and training. The Decarbonisation action plan and progress against the same has not been re-audited here.

2.35 Whilst noting the above, there are two energy-related training modules provided via the ESR system. Whilst these are not mandatory, the Energy Manager did not have uptake data with which to assess participation. As the site visit observations identified potential for improved light switch-off, it is advisable to review the uptake of training to assess if enhancing communication about this learning method would be beneficial (**MA6**).

2.36 Energy management practices were shared through the UHB's Green Healthcare intranet, with staff engagement opportunities such as Green Champion roles. Recent site roadshows had also been conducted, but these were managed by the Decarbonisation Team, as opposed to the Energy Team.

2.37 Noting the above, **reasonable assurance** has been determined in respect of energy awareness.

Payments: *Energy related billing was verified, authorised, and processed in accordance with contractual payment terms.*

2.38 As discussed in the *Data Capture* objective, areas for improved efficiency in data capture (including invoice data) have been recommended (see **MA3**).

2.39 Notwithstanding potential for improved efficiency, audit sample testing identified a robust process of invoice review, data input and validation by the Energy Team.

2.40 The Energy Team did advise, however, that as discussed in the 6-weekly account meetings with the energy suppliers, a number of invoices have been paid by NWSSP Accounts Payable outside of the defined contract terms. It is recommended the Energy team liaise with NWSSP Accounts Payable to identify any potential improvements in the invoice transfer process, which may help improve timeliness of payment (**MA7**).

2.41 **Reasonable assurance** is therefore determined in this area.

Risk Management: *A review of the systems and controls in place to manage energy-related risks, and assurance that risks were escalated as appropriate – to include evaluation of risk mitigation strategies, ensuring compliance with regulations, and addressing any risk exposure.*

2.42 The consideration of energy risks within the UHB was evidenced through a number of channels, including:

- Financial risks monitored and reported by the Director of Finance in his monthly finance report to the Finance & Performance Committee;
- Decarbonisation risks monitored by the Decarbonisation Programme Board; and
- Estate infrastructure risks (including for example heating/cooling plant, BMS etc). captured in the backlog maintenance risk register.

2.43 Whilst noting the energy team itself had not documented and assessed energy risks within their remit, it is recognised these would be limited to management/resource matters, such as those considered within this report, and would be considered low risk.

2.44 Recognising that risks have been assessed and reported through appropriate channels, **substantial assurance** has been determined.

Appendix A: Management Action Plan

Matter Arising 1: Governance – Energy Team Work Plan (Design)			**Impact**
A Work Plan for the Energy Team had been prepared by the Energy Manager. The plan set out a number of targeted improvements / efficiencies, along with routine / cyclical required tasks, for 2024/25. The Plan was however still in draft at the time of the audit. As the plan had not yet been finalised and agreed, we could not evidence how progress would be monitored. See also **MA3** in respect of specific areas of focus within the Work Plan.			Potential risk of: • Targeted improvements in energy management are not achieved.
Recommendations			**Priority**
1.1	The Energy Team's Work Plan should be finalised and agreed with management as soon as possible. A process for monitoring progress / achievement against the same should be agreed.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	AGREED – the draft Energy Work Plan shall be considered and developed in a "workshop" style session to be arranged for November 24. The developed plan will be passed through the Estates Decarbonisation Group for comment and any actions resulting from the workshop will be monitored via the same peer group. The plan will cover the remainder of 2024/25 as well as financial year 2025/26.	31st December 2024	Energy Manager

Matter Arising 2: Data Capture (Design)		**Impact**
Whilst the energy data held by the UHB was comprehensive, the current data capture process of taking manual meter reads, entering data manually to the system (both from manually read meter data, AMR consumption data and invoice data) is time consuming. The energy management system (Systems Link) allows for electronic data transfer, which would free up time for the Energy Team to focus on other areas of energy management. It is noted the Energy Team Work Plan incorporates the migration to electronic methods, however it is also noted that these activities have been under consideration for a number of years with limited progress to date. It is recognised that the change to new suppliers under the new All Wales Energy Contract in October 2023 has impacted progress. There were also inconsistencies in the manual meter reading process, in the proformas used and the approach to taking manual reads where AMR data was also available. This could cause confusion should less experienced staff join the Estates or Energy teams.		Potential risk of: • Time spent on manual data entry could be better spent on energy-saving activities.
Recommendations		**Priority**
2.1	Recognising the UHB has already identified scope for improvements in the efficiency of data capture processes (as captured in the Energy Team's Work Plan – see **MA1**), it should be ensured that achievable and measurable plans be developed, including identification of any associated monetary costs, in the following areas: • Roll-out of AMRs to sites currently without; • Electronic download of Stark data into Systems Link; • Data connection between Systems Link and the energy suppliers; • Generation of electronic data file to upload to Oracle.	**Medium**

2.2	To ensure consistency and clarity, the manual meter reading proformas should be standardised. Consideration should be given to applying a consistent approach to which meters require manual reading, where AMR data is also available.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1	AGREED – The reinstatement of electronic data collection following the change in suppliers is one of the areas for improvement in the Work Plan, to improve functionality and reporting capability. Liaison will be made with the energy suppliers to identify meters not yet AMR/Smart enabled and to plan a suitable roll-out	31st March 2025	Energy Manager
2.2	AGREED – As part of the Work Plan, there will be a re-formatting of the manual meter read sheets to standardise and make easier for estates operatives to understand and complete accurately. Development of these templates will be done with the Energy Team and estates stakeholders	31st March 2025	Energy Manager

Matter Arising 3: Data Capture – Leased premises (Design)			**Impact**
NWSSP: Specialist Estates Services (SES) Property Team advise us that when negotiating rents on behalf of health boards, if premises are not sub-metered, they request input from the respective Estates teams to inform the determination of a suitable utility cost to incorporate into the rental charge. We were advised that Aneurin Bevan UHB premises leased to third parties (e.g. commercial organisations such as coffee shops) are not sub-metered, and that the Energy Manager has not been involved in the preparation of forecast utility costs to inform rental charges. There is a risk that charges levied are not sufficient to cover the cost of current or forecast energy costs.			Potential risk of: • The UHB may not recoup energy costs from third parties.
Recommendations			**Priority**
3.1	The Energy Manager should liaise with the Estates team to establish how utility-cost elements of lease charges to third parties are determined, and whether there is benefit to improved engagement at future leases to ensure forecast UHB energy costs are sufficiently incorporated.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	AGREED – The Energy Team is now integrated into the Capital Projects & Property Management section; which will facilitate communication and understanding of lease requirements and potential arrangements to recharge utilities if deemed appropriate under the wider lease agreements. Discussions on a case by case basis on potential for submetering will take place with relevant internal and external stakeholders.	Completed	Energy Manager Asst. Head of Estate, Capital & Property Management

Matter Arising 4: Monitoring & Reporting - Benchmarking (Operation)			**Impact**
The UHB submits energy data annually via the national NHS Wales Estates & Facilities Performance Management System (EFPMS) system. NWSSP: Specialist Estates Services (SES) advise that, whilst benchmarking dashboards haven't been published in recent years, raw EFPMS data is shared with all NHS Wales organisations, which would facilitate internal data review and benchmarking against other health boards.			Potential risk of: • Available performance data is not utilised to aid the UHB's benchmarking activities. Areas for improvement are not identified or appropriately prioritised.
Recommendations			**Priority**
4.1	The UHB should utilise the NHS Wales EFPMS data to benchmark energy performance against similar organisations / sites.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	AGREED – the output from the national EFPMS report has not been sufficient to support detailed analysis and benchmarking by Health Boards. SES have advised that the output from this year's submission (submitted in September) will provide more information to assist, which will be greatly welcomed by the Division Estates and Facilities. The delivery of this analysis and the timeline is dependent upon the SES releasing the report and the data which underpins this for analysis.	31st March 2025 (subject to data provision of output from SES)	Energy Manager

Matter Arising 5: Monitoring & Reporting – Site Walk-Arounds (Operation)			**Impact**
HTM 07-02 (EnCO$_2$de) Part A: '*Policy & Management'* (section 3.5) recommends: *"At least once a year… the energy manager should conduct an energy walk-around. It is worth perhaps doing this ….during both winter and summer seasons, because different issues are likely to be identified…."* Whilst annual site visits were undertaken in relation to DEC assessments, there was opportunity to introduce additional visits to capture both winter and summer practices.			Potential risk of: • Visible matters of energy inefficiency are not identified.
Recommendations			**Priority**
5.1	The Energy Manager should undertake energy walk-arounds in both winter and summer.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	AGREED – The annual site walk-rounds have been in place for the DEC assessment process but additional walk arounds will be reinstated. Additionally walk-rounds will be carried out in summer and winter for the largest hospital sites (this will also satisfy / compliment the ISO14001 audit requirements). These will be reinstated by end of financial year.	31st March 2025	Energy Manager

Matter Arising 6: Energy Awareness – ESR training (Operation)			**Impact**
The ESR system includes two energy/environmental training modules. Whilst the Energy team have requested whether these could be made mandatory, this has not been agreed by Workforce (similar to the position observed in other Health Boards). The Energy Manager did not have any data in relation to take-up of these modules, so could not assess the effectiveness of their reach. It was also noted the "Green Healthcare" intranet pages did not signpost to the ESR modules in the Learning section.			Potential risk of: • Missed opportunities for energy savings.
Recommendations			**Priority**
6.1	Take-up data for the energy-related ESR training modules should be obtained and reviewed. If take up has been poor, communication should be increased to promote the training/awareness opportunities.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	AGREED – this issue will be raised at the Decarbonisation Programme Board, requesting that the relevant sub-group of the Programme be tasked with updating AB Pulse Intranet content / links to sign-post users of the "Green Healthcare" pages to the additional ESR learning modules.	31st December 2024	Energy Manager

Matter Arising 7: Invoice Payments (Design)	**Impact**
The UHB operated a robust process of reviewing invoices, entering the data to Systems Link and passing them for payment in a timely manner. We identified no errors in our sample review of invoices processed. The Energy Team hold 6-weekly meetings with the new energy suppliers to review outstanding accounts. Overdue payments typically relate to either accounts in query, or delayed payment once invoices have been passed to NWSSP Accounts Payable. The delayed payments place the Energy team under pressure in terms of time taken to identify the missed invoices and send reminders (which sometimes happens more than once for the same invoice), and risks late payment charges being levied by the energy supplier (which we are aware has occurred with at least one other NHS Wales organisation). There may be scope for improvement in the process and the Energy Team should liaise with Accounts Payable to identify any such opportunities.	Potential risk of: • Late payment charges may be incurred. • Additional Energy team resource are required to resolve issues.

Recommendations		**Priority**
7.1	The UHB should liaise with NWSSP Accounts Payable to identify whether the current invoice payment process can be improved.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
7.1	AGREED – ways to streamline the invoice payment process shall be identified and developed in the Energy Work Plan, with input from Finance and Accounts Payable as required. Meetings with energy suppliers shall continue, so that account queries can be rectified quickly and issues with payment delays	31st December 2024	Energy Manager

Appendix B: NHS Wales Energy Contract Data

NHS Wales energy data has been provided by NWSSP: Procurement Services, in relation to the all-Wales energy contract. Recognising validated actual data was not currently available (noting the change in contract in October 2023), forecast data is instead presented to allow for consistency. It is acknowledged that internally reported UHB figures may therefore vary.

Gas

Organisation	FY 2022/23 Forecast Gas Volume (kWh)*	FY 2023/24 Forecast Gas Volume (kWh)**	% kWh change 2022/23 to 2023/24	FY 2022/23 Forecast Gas Spend (£m)*	FY 2023/24 Forecast Gas Spend (£m)***	% £ change 2022/23 to 2023/24
Organisation 1: ABUHB	100,009,689	97,129,621	-3%	£11.038	£6.664	-40%
Organisation 2	127,252,445	122,650,537	-4%	£14.078	£8.290	-41%
Organisation 3	129,043,608	121,409,206	-6%	£14.046	£8.171	-42%
Organisation 4	68,770,371	65,960,925	-4%	£7.465	£4.498	-40%
Organisation 5	N/A	89,263	N/A	N/A	£0.007	N/A
Organisation 6	393,467	422,061	7%	£0.044	£0.030	-31%
Organisation 7	59,913,625	55,062,596	-8%	£6.565	£3.451	-47%
Organisation 8	776,638	767,893	-1%	£0.094	£0.060	-36%
Organisation 9	14,025,741	13,914,315	-1%	£1.562	£1.001	-36%
Organisation 10	486,961	481,825	-1%	£0.056	£0.038	-33%
Organisation 11	69,471,602	89,841,575	29%	£7.612	£5.648	-26%
Organisation 12	4,777,016	4,193,267	-12%	£0.529	£0.308	-42%
Organisation 13	4,646,468	3,301,582	-29%	£0.545	£0.260	-52%
TOTAL	**579,567,630**	**575,224,668**	-1%	**£63.635**	**£38.427**	-40%
ABUHB % of total NHS Wales	**17%**	**17%**		**17%**	**17%**	

Electricity

Organisation	FY 2022/23 Forecast Power Volume (kWh)*	FY 2023/24 Forecast Power Volume (kWh)**	% kWh change 2022/23 to 2023/24	FY 2022/23 Forecast Power Spend (£m)*	FY 2023/24 Forecast Power Spend (£m)***	% £ change 2022/23 to 2023/24
Organisation 1: ABUHB	32,355,160	33,132,344	2%	£9.831	£10.229	4%
Organisation 2	42,699,685	43,647,228	2%	£13.663	£12.242	-10%
Organisation 3	29,289,871	28,966,858	-1%	£8.594	£8.315	-3%
Organisation 4	24,165,155	26,570,034	10%	£6.908	£7.509	9%
Organisation 5	489,608	547,111	12%	£0.146	£0.153	5%
Organisation 6	313,332	346,665	11%	£0.089	£0.099	12%
Organisation 7	19,564,960	22,523,727	15%	£6.065	£6.305	4%
Organisation 8	774,367	723,459	-7%	£0.242	£0.323	33%
Organisation 9	3,604,037	3,575,626	-1%	£1.114	£1.032	-7%
Organisation 10	789,295	746,481	-5%	£0.266	£0.221	-17%
Organisation 11	28,839,202	25,565,791	-11%	£8.571	£8.448	-1%
Organisation 12	5,404,916	5,611,966	4%	£1.582	£1.546	-2%
Organisation 13	2,156,282	2,346,048	9%	£0.797	£0.779	-2%
TOTAL	**190,445,869**	**194,303,339**	2%	**£57.868**	**£57.200**	-1%
ABUHB % of total NHS Wales	**17%**	**17%**		**17%**	**18%**	

** Volume/Value Source: Forecast_(Gas/Power)_Apr 22-Mar 23_20032023 provided by BG 21st March 2023.*
***Volume Source: Forecast_(Gas/Power)_Apr '23-Mar '24_18092023 provided by BG 18th September 2023.*
****Value Source: 2023-24 Energy Forecast circulated to DDoFs 05.02.2024 (BG and EDF (power)/TE (gas) combined).*

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Reinforced Autoclaved Aerated Concrete – Nevill Hall Hospital

Final Internal Audit Report

October 2024

Aneurin Bevan University Health Board

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

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

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Review reference:	ABU-SSU-2425-26
Report status:	Final
Fieldwork commencement:	1 July 2024
Fieldwork completion:	10 September 2024
Debrief meeting:	10 September 2024
Draft report issued:	23 September 2024
Management response received:	23 October 2024
Final report issued:	24 October 2024
Auditors:	NWSSP: Audit & Assurance - Specialist Services Unit (SSu)
Executive sign-off:	Leanne Watkins, Chief Operating Officer
Distribution:	Jamie Marchant, Director Estates & Facilities Division Justin Jones, Assistant Head of Estate, Capital & Property Management Rani Dash, Director of Corporate Governance
Committee:	Audit, Risk and Assurance Committee

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

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

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

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

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

Executive Summary

Purpose

Reinforced Autoclaved Aerated Concrete (RAAC) is a form of lightweight concrete used in construction in many buildings between the 1950s and 1990s and has only recently been identified as posing a significant risk to the structural integrity of buildings.

The audit sought to evaluate the arrangements in place to manage/mitigate the risks associated with the presence of RAAC found within Nevill Hall Hospital (NHH).

Overview

Welsh Government awarded funding up to £1.158m (including VAT) over the 2023/24 and 2024/25 financial years to support RAAC remedial works at NHH.

A corporate risk relating to RAAC was introduced in June 2023; with regular and ongoing reporting evident at multiple Health Board committees including the Board and Population Health and Planning Committee. There had also been regular communication with NWSSP: Specialist Estates Services – acting as agents of Welsh Government relating to the ongoing management and planning arrangements for RAAC across the NHS Wales estate.

Recommendations have been made for refinement and/or further development in certain areas, such as:

- the development of a management strategy,
- increased assurance around the achievability of the corporate risk target score, and
- a review of the procurement/ contractual approval arrangement (see Appendix A).

An overall **reasonable assurance** has been determined due to the positive controls in place to manage the risks associated with the presence of RAAC at NHH. However, given the potential inherent risk, the short to medium term arrangements require close monitoring,

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance Arrangements	Reasonable
2	Surveys	Substantial
3	Remedial Action	Reasonable
4	Risk Management	Reasonable
5	Procurement	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	A concise RACC management strategy should be developed and appropriately monitored.	1	Design	Medium
2	Retrospective approval should be obtained for the one award identified that exceeded the measured term contract maximum value.	3	Operation	Medium
3	Increased assurance should be obtained regarding the achievability of the RACC corporate risk target score.	4	Operation	Medium
6	Key Performance Indicators should be defined within Service Level Agreements.	5	Operation	Medium

Future Matters Arising		Objective	Control Design or Operation	Recommendation Priority
4	Approvals to appoint advisers should be in accordance with corporate requirements regarding delegated limits.	5	Operation	Medium
5	Variations to contractual awards beyond the original scope of work should be subject to advice from NWSSP Procurement services and assessed to demonstrate value for money.	5	Operation	Medium

Future assurance matters are for management action at future (appropriate) instances. Noting current action cannot be taken at this audit, the Audit, Risk and Assurance Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report.

1. Introduction

1.1 This audit originates from the 2024/25 audit plan, agreed with management, and approved by the Audit & Risk Committee.

1.2 Reinforced Autoclave Aerated Concrete (RAAC) was a material used in construction in many buildings between the 1960s and 1990s. Its presence has been confirmed in a range of National Health Service (NHS) properties across the United Kingdom (UK). RAAC is predominantly found as precast panels in roofs, commonly found in flat roofs, and occasionally in floors and walls.

1.3 In February 2022, in light of concerns on the structural integrity of RAAC, an alert was received from Welsh Government, requesting that all Health Boards and Trusts undertake a desktop review to determine if there was any RAAC present within the NHS estate. The review confirmed that RAAC was present at the Nevill Hall Hospital site.

1.4 Following an initial desktop review of the Health Board's estate, it was concluded that a further level of investigation was required to provide health organisations and Welsh Government with assurances that the extent of RAAC was fully understood and that appropriate measures were in place to manage the issue and associated risks in the short, medium and longer term.

1.5 The risks considered during the review included:

- Health and Safety risks associated with RAAC were not being appropriately identified via structural integrity assessments.
- Associated risks had not been reported/ escalated in accordance with established risk management procedures.
- Compliance and reputational risks associated with procurement activities and execution of contracts were not in line with Health Board's policies/Standard Financial Instructions.

2. Detailed Audit Findings

Governance Arrangements: *Assurance that adequate governance arrangements were applied given the potential Health and Safety, Patient Safety and Financial Risks associated with the presence of RAAC; including monitoring, reporting and escalation arrangements.*

2.1 A RACC working group was established during 2023/24 and was chaired by the Director, Estates & Facilities Division. This group brings together various departments including Estate, Health and Safety etc to provide updates on current activities.

2.2 The working group met regularly (two-weekly basis), with a rolling action log maintained. However, no formal terms of reference were in place, identifying membership, roles and responsibilities etc (see **MA1**)

2.3 Management had been taking proactive steps and reviewing the RAAC governance arrangements with advice from their advisers who have provided similar expertise with RAAC works within NHS England (August 2024).

2.4 We note that elements of a RAAC management strategy were in place, but a formal/succinct strategy document would bring together all ongoing activities to ensure patient safety and operational continuity (see **MA1**).

2.5 The Board had received multiple update reports during 2023/24 on the RAAC position at NHH. This included results for the detailed survey (September 2023). Update reports were also received at the Population Health and Planning Committee which was the committee assigned to oversee the corporate risk relating to RAAC at NHH.

2.6 Recognising the need to act at pace to establish the governance mechanism for RAAC within the Health Board, **reasonable assurance** has been determined.

Surveys: *Assurance that effective mechanisms were in place for initial and ongoing identification/deterioration of RAAC.*

2.7 In February 2023, the Health Board appointed an external adviser to undertake a desktop review of all Health Board premises which were constructed between 1950s-1990s. Any premises which had been identified as containing RAAC. The Health Board subsequently appointed an additional adviser to complete detailed surveys.

2.8 The actions listed above had been undertaken by a suitably qualified organisation with the results being shared at the September 2023 Board Meeting. The results highlighted that RAAC was essentially present throughout NHH A total of 94% of panels were inspected; with 4.8% assessed High- Critical and 22.8% High risk.

2.9 Following the survey results, it was recommended to undertake regular reviews of the identified RAAC (6 monthly) areas due to its nature and potential further deterioration. Arrangements had been put in place for this and are further noted within the procurement section of this report.

2.10 Recognising the need to act at pace to determine the level of RAAC within the Health Board, **substantial assurance** has been determined in relation to the survey arrangements applied.

Remedial Action: *Assurance that appropriate actions were carried out in a timely manner to mitigate any high/critical risk RAAC areas. To include a review of any programme of work, quality control measures in place etc.*

2.11 Following advice from its advisers (structural engineers); immediate management action was required to address areas identified requiring propping to reinforce the integrity of NHH. This was undertaken on a timely basis and regular prop inspection reports had been provided on a bi-weekly basis to management. A sample of 5 inspection reports were reviewed and no issues had been identified for remedial action. We were assured by management that if any action was needed it would be undertaken immediately.

2.12 Health and Safety/fire assessments had been undertaken in areas affected by RAAC; with assessment logged on to the Datix system. Where adjustments were required to working practices in departments, those were set out by the Health and Safety function, e.g. putting foam around the props to avoid injury were recommended and this had been promptly actioned.

2.13 Welsh Government funding was made available to the Health Board of up to £1.158m (including VAT) over the 2023/24 and 2024/25 financial years to support RAAC Remedial Works at Nevill Hall Hospital. The funding was to support the following:

- Regular six-monthly inspections of areas containing RAAC by structural engineers;
- Weekly prop inspections;
- Further in-depth investigations in discussion with structural engineers;
- Address high risk areas over the next 12 months as per report;
- Weekly meetings with Welsh Government and NHS Wales Specialist Estates Services; plus,
- Engagement with NHS England to discuss their approach to RAAC to inform the Health Board's planning and response.

2.14 Monies had also been allocated within the funding for the Satellite Radiotherapy Centre (SRU) project. Works to be undertaken to the link corridor containing RAAC between the new SRU project currently on site and the main NHH building (£401K). The SRU project had been separately audited and reported to the Audit and Risk Assurance Committee, therefore did not fall within scope of this report.

2.15 Other remedial works had been required during 2023-24 (excluding the need for surveys and propping). This included works to the chapel, restaurant and roofing works.

2.16 The UHB's Measured Term Contract (MTC) arrangements were utilised to contractually agree the scope of works. However, one of the orders placed under this contract exceeded the specified upper limit within the MTC's contract's parameters (see **MA2**), i.e. a contract value of approximately £144,000 but an order limit of £120,000.

2.17 Recognising the need to act at pace following the RAAC survey results, **reasonable assurance** has been determined in relation to the remedial action observed.

Risk Management: *Appropriate arrangements were in place to assess and manage risks, including the identification of appropriate management ownership and actions. To ensure that risks were reported and escalated in accordance with internal requirements.*

2.18 The Health Board's Strategic Risk Register entry SRR 002A associated with RAAC was first recorded in June 2023. The risk had been assigned an executive lead officer – The Chief Operating Officer and assigned to the Partnership, Public Health and Planning Committee for monitoring.

2.19 Regular risk updates had been provided through the RAAC working group onto the 'Strategic Risk Report' that was submitted to the Board/Sub Committee. The July 2024 update highlighted a current risk score of 15 (Extreme), risk appetite of 8 and target score of 2. The risk score had remained at 15 since September 2023 with no adjustments, highlighting those actions taken had mitigated any further deterioration i.e. managing the current position. However, increased assurance was required from the information contained within the 'Strategic Risk Reports' surrounding the Health Board's ability to achieve the target score in the short to medium term (see **MA3**).

2.20 Recognising the need to provide increased assurance on the ability to achieve the target risk score, **reasonable assurance** has been determined in relation to the risk management arrangements observed.

Procurement: To obtain Assurance that appropriate arrangements were in place to appoint key parties e.g. structural engineers, contractors etc.

2.21 The Estates and Facilities division conducted the procurement exercise to appoint an external adviser to deliver detailed RAAC surveys through a direct call-off from the Shared Business Services Framework (SBS). In January 2024, the adviser? provided a detailed fee proposal outlining the services and associated costs for the surveys at NHH, with an initial cost of£35,719.88. This proposal was formally approved and signed by a manager within the Estates and Facilities Division in April 2024. However, the approval process did not adhere to comply with the Health Board's delegated limits, similarly there was a lack of segregation of duties within the procurement process applied. Specifically, the individual responsible for procuring the adviser was also the one authorising the expenditure (see **MA4**).

2.22 During 2023/24, multiple variations to the original adviser's fee proposal were needed to accommodate out-of-hours work within clinical theatres, avoiding disruption to medical activities. In February 2024, a variation request was made for work beyond the initial scope outlined in the January 2024 offer letter. Despite this additional work, no market testing was carried out, nor any advice sought from colleagues in NHS Wales Shared Services Partnership Procurement Services (see **MA5**).

2.23 In Q4 of 2023/24, a new Service Level Agreement (SLA) was set up for RAAC consulting services, starting in 2024/25 utilising the SBS framework. However, this agreement was neither signed nor dated by an authorised Health Board representative, and sections, including the Key Performance Indicators (KPIs), were not completed (see **MA6**).

2.24 Although the urgency of procuring external advisory service for structural engineers was acknowledged, the management of the procurement and contract variations processes applied required review. Accordingly, limited Assurance has been determined in relation to the procurement activities.

Appendix A: Management Action Plan

Matter Arising 1: Governance – Management Strategy (Design)	**Impact**
A RAAC working group was established during 2023/24 and was chaired by the Director, Estates & Facilities Division. The working group meets on a two-weekly basis with a rolling action log maintained, However, there were no formal terms of reference that would detail membership, roles and responsibilities etc. Management had been engaging with their advisers and were undertaking a self-assessment on the management of RAAC; which included a review of the Health Board's governance arrangements. In terms of additional governance documents, we did not identify a RAAC management strategy. A RAAC management strategy would typically include the following elements: 1. RAAC Identification and Assessment: Conducting a thorough survey of hospital buildings to identify areas containing RAAC, which was prone to structural degradation. 2. Risk Assessment: Evaluating the risk of RAAC-related failure in identified areas, considering the age, condition, and location of RAAC panels, and their potential impact on operations. 3. Monitoring and Inspections: Implementing a regular inspection regime to monitor the condition of RAAC structures, including checking for cracks, water ingress, and other signs of deterioration. 4. Maintenance and Repairs: Planning for proactive maintenance, repair, or reinforcement of affected areas to mitigate risk. This might include temporary measures such as shoring up structures or more permanent solutions like panel replacement. 5. Contingency Planning: Developing contingency plans in case of RAAC failure, ensuring continuity of critical hospital services, including emergency evacuation protocols and the relocation of vulnerable patients. 6. Stakeholder Communication: Keeping staff, patients, and the public informed about RAAC-related issues and the hospital's plans for managing these risks.	Potential risk of: • Ineffective governance can lead to failure in identifying, assessing, and mitigating risks associated with deteriorating RAAC. Delays or poor decision-making could result in unsafe conditions in hospital buildings.

7. Financial Planning: Allocating budget for RAAC management, including potential costs for ongoing inspections, maintenance, and structural reinforcement or replacement.

However, it was clear that many elements of a strategy were in place, including RAAC identification and inspection, risk assessments, maintenance and repairs, financial planning etc. A formal strategy would aim to bring together all ongoing activities to ensure patient safety, operational continuity, and compliance with legal obligations regarding RAAC.

Recommendations		Priority
1.1	A concise RAAC management strategy should be developed to provide assurance that the Health Board safeguards its infrastructure and the safety of its occupants.	**Medium**
1.2	The RAAC working groups should be more formalised with terms of reference established that identifies membership, roles and responsibilities etc.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	AGREED - The concept of a RAAC Management Plan was already being scoped with the Health Board's professional external advisors, prior to the fieldwork for this Internal Audit. The scope of this plan is being finalised with our advisors who will lead the production of this for the Health Board. This recommendation from the Internal Audit will inform the production implementation the Plan	31st December 2024	Director Estates and Facilities Division
1.2	AGREED - These will be reviewed in line with the above Management Plan to consider additional members and any clarity necessary for roles and responsibilities	31st January 2025	Director Estates and Facilities Division

Matter Arising 2: Remedial Action – Measured Term Contracts (Operation)	**Impact**
During the 2023/24 financial year, the Health Board utilised a Measured Term Contract to carry out various remedial works associated with RAAC. According to the contract particulars, specifically clause 2.4, the contract stipulated a minimum order value of £1 and a maximum order value of £120,000. We note that there was a caveat in the preliminaries/general condition section that states "Note this value may occasionally be exceeded" One of the orders placed under this contract exceeded the specified upper limit, with a value of approximately £144,000. Upon review, we were unable to locate any documented internal approval that authorised this deviation from the established contractual terms and conditions. This lack of verification raises concerns about potential non-compliance with the contract's provisions and the absence of appropriate oversight in the approval process.	Potential risk of: • Exceeding the contractual order threshold without proper approval could be considered a breach of contract.

Recommendations		**Priority**
2	Retrospective approval for this specific award should be documented.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	AGREED - This was a specific issue in relation to the cumulative cost of the regular scaffolding inspections. Retrospective approval will be actioned through the Director Estates and Facilities division and upwards in line with delegated limits.	30th November 2024	Assistant Head of Estates, Capital and Property Management

Matter Arising 3: Risk Management– Increased Assurance (Operation)	**Impact**
The Health Board had Strategic Risk Register entry SRR 002A associated with RAAC that was first included in June 2023. The risk has been assigned to the Chief Operating Officer and is actively monitored at the Partnership, Public Health and Planning Committee. The risk was also reported to the Board on a regular basis. The Strategic Risk Report documents the original score (June 2023) was 20 and was reduced during 2023/24 to an overall score is 15 (June 2024). The reduction was due to steps taken by the Health Board such as propping high-risk areas to control the risk. The risk appetite of 8 and a target of 2 had been set in line with Health Board requirements. The plan to enhance control involves undertaking additional surveys, but it was unclear how this would reduce the risk to the stated target. In the key control section, there was mention of remediation work in high-risk areas. However, there was no information on the progress or assurance that these works have been completed or on the planned works that would lead to risk reduction. It may be the case that the risk will remain high until full remediation works are completed due to the nature of RAAC. If so, further discussions may be required surrounding the risk appetite and if the Health Board are willing to accept that the risk was being managed, but it will be unlikely to reduce in the short to medium term.	Potential risk of: • Assurances not being effectively provided through the Health Boards risk management processes.

Recommendations		**Priority**
3	Increased assurance should be provided within the Strategic Risk Report on the actions to be taken to manage/mitigate the risk and how this was linked to the achievability of the target score.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3	AGREED – the risk score is set at 15 and will remain as a constant until alternative solutions to the estate are in place. This will be subject to service modelling and the submission of the full business case to Welsh Government. The agreed approach is reliant upon routine monitoring and the risk score will be expanded upon in the next Committee or Board update.	30th November 2024	Director of Estates and Facilities Division

Matter Arising 4: Procurement – Consultants 2023/24 (Operation)	**Impact**
The procurement for an adviser to undertake detailed RAAC surveys was undertaken within the Estates and Facilities division. The procurement method was via a direct call off from the Shared Business Services Framework (SBS). A detailed fee proposal was provided by the adviser in January 2024 that set out the proposed services and fees for undertaking the detailed RAAC surveys at NHH. The cost of this initial survey was £35,719.88. This proposal was signed April 2024 by management within the Estates and Facilities division. However, this not compliant with the Health Board's delegated limits. There was also no segregation of duties as the individual undertaking the procurement was also the individual authorising the commitment to expenditure. We note that there was a subsequent approval to commit expenditure for detailed surveys etc in August 2024 via a chair's action for up to £250,000 expenditure. However, survey work had been undertaken prior to this approval.	Potential risk of: • Non-compliance with the Health Boards delegated limits for commitment of expenditure.

	Recommendations	**Priority**
4.1	The approval to appoint any future advisers and commit expenditure should be undertaken in a timely manner and authorised in line with the Health Board's delegated limits.	**Medium**
4.2	For any future awards, there should be appropriate segregation of duties i.e. the individual undertaking the procurement exercise should not be the person authorising the award.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4.1	See action for 4.2		

4.2	AGREED - Future appointments will cover off two separate strands of work including support relating to ongoing monitoring and management of the present RAAC and secondly feasibility work relating to the case for future estate and model design. The former will be appointed by the Director of Estates and Facilities and the latter will be appointed by the Associate Director of Capital Projects. Any additional approvals, associated with the financial quantum of the award will be followed in accordance delegated limits.	Future action as necessary	Assistant Head of Estates, Capital and Property Management

Matter Arising 5: Procurement- Variations to Awards (Operation)	**Impact**
During the 2023/24 period, several variations were required to the original fee proposal from the advisers, particularly to perform out-of-hours work in clinical theatres, ensuring minimal disruption to ongoing medical activities. In February 2024, a specific variation was issued, requesting a quotation for work beyond the initial scope defined in the offer letter from January 6, 2024. This additional work, valued at £35,300, encompassed tasks such as those outlined below: • Producing a RIBA Stage 2 Order of Cost Estimate for RAAC remedial works on an area-by-area basis. • Developing a RIBA Stage 3 Cost Estimate for RAAC remedial works. • Creating a procurement strategy with various options for engaging Supply Chain Partners. Despite the significance of this additional work, no market testing was conducted and given that the variation was beyond the original scope, a value-for-money exercise should have been performed. Moreover, no advice was sought from NWSSP procurement services regarding the appropriateness of this variation, raising concerns about whether an additional procurement process was necessary for this work.	Potential risk of: • Without market testing or a value-for-money assessment, there's a risk of overpaying for additional work, which could strain the project budget • Failure to consult with procurement services could result in non-compliance with procurement regulations,

Recommendations		**Priority**
5.1	For any future variations, especially those that significantly extend beyond the original scope, management should ensure that a market testing process was conducted. This will help ascertain whether the additional work was competitively priced and ensure value for money.	**Medium**
5.2	Prior to implementing any future variations that exceed the original scope, the Health Board should consult with NWSSP procurement services, to determine whether an additional procurement exercise was necessary.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

5.1	AGREED - Variations were undertaken using the Shared Business Services (SBS) Consultancy Framework (from NHS England) using agreed hourly rates. Formal and explicit engagement and advice from NWSSP will continue to take place for future variations in line with new procurement regulations/guidance.	Future action as necessary	Director Estates and Facilities Division and Associate Director Capital Planning
5.2	AGREED - Procurement of the services was in line with capital procedures and normal working practices linked to the use of Frameworks. Formal and explicit engagement and advice from NWSSP will continue to take place for future variations in line with new procurement regulations/guidance.	Future action as necessary	Director Estates and Facilities Division and Associate Director Capital Planning

Matter Arising 6: Procurement – Adviser Arrangements 2024/25 (Operation)	**Impact**
During Q4 of 2023/24, a new arrangement was established for utilising the services of an external adviser for work commencing in 2024/25, under a Service Level Agreement (SLA) through the SBS framework. However, this agreement was not signed or dated by an authorised signatory within the Health Board. Additionally, we observed that key sections of the SLA, such as the Key Performance Indicator (KPI) section, were left blank. KPIs ensure that the adviser's performance would be measurable, consistent, and aligned with the Health Board's expectations.	Potential risk of: • Non-compliance with the Health Boards Delegated limits for commitment of expenditure. • Without KPIs it may be difficult to measure the performance of consultants against specific, agreed-upon standards. This lack of accountability could lead to underperformance, as there are no clear benchmarks to assess against.

Recommendations		**Priority**
6.1	Management should ensure that the SLA are promptly signed by an authorised signatory within the Health Board.	**Medium**
6.2	Management should establish Key Performance Indicators within the adviser's SLA. This should include clear, measurable metrics that align with the Health Board's expectations for any consultant's performance	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	AGREED - Previous delays were linked to confirmation of funding being awaited but it is aimed to minimise any such delays in future. The specific SLA identified in the field work has now been signed by the Director of Estates and Facilities.	Completed	N/A

6.2	AGREED - This had not been considered to date bearing in mind the nature of the work but this for future awards KPIs linked to the Framework for such services has been added in.	Completed	N/A

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Providing Care to Asylum seekers and Refugees

Final Internal Audit Report

October 2024

Aneurin Bevan University Health Board

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Review reference:	AB-2324-16
Report status:	Final
Fieldwork commencement:	10th July 2024
Fieldwork completion:	13th August 2024
Debrief meeting:	11th September 2024
Draft report issued:	17th September 2024 and 11th October 2024
Management response received:	24th October 2024
Final report issued:	25th October 2024
Auditors:	Stephen Chaney, Interim Head of Internal Audit Rhian Gard, Audit Manager
Executive sign-off:	Leeanne Watkins, Chief Operating Officer
Distribution:	Lucy Kings, Head of Nursing Lorraine Rowlands, Directorate Manager PCCS Star Moyo, Senior Nurse for Health Inclusion Service
Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To provide an opinion over the arrangements in place within Aneurin Bevan University Health Board (the 'Health Board') for providing care to asylum seekers and refugees, including that applicable guidance is being adhered to.

Overview

We have issued reasonable assurance on this area.

The Health Inclusion Service (HIS) is a nurse led primary and community care service that responds to the health needs of socially at risk, vulnerable and excluded people living within the Health Board's region.

We found the HIS provides a strong support mechanism of services and engages with many different services. They strive to ensure refugees and asylum seekers receive the free patient care that they are entitled to.

The matters requiring management attention include:

- The Blue Book assessments for refugees and asylum seekers are not always completed within the HIS internal target timeframe of three days[1] to make contact and 14 days to complete the assessment. As this is not documented, there should be agreement over if this is deemed to be a reasonable timeframe, as required within the Welsh Government Policy Guidance.
- There is a lack of staff training / awareness provided to the relevant tiers within the Health Board, although we recognise that this is because of the limited resource capacity.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Co-ordination	Substantial
2	Services available	Reasonable
3	Staff Training	Reasonable

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

[1] Welsh Government: Policy Implementation Guidance; Health and Wellbeing provision for refugees and asylum seekers (December 2018)

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Services Available	2	Design	Medium
2	Staff Training	3	Design	Medium

1. Introduction

1.1 The review of Providing care to Asylum seekers and Refugees was completed in line with the 2023/24 Internal Audit Plan.

1.2 The risks considered include:

- a lack of awareness of how refugees and asylum seekers access the NHS;
- lack of understanding of issues, rights and entitlements by health professionals;
- lack of training for NHS staff; and
- reputational risk to the Health Board.

2. Detailed Audit Findings

Objective 1: There is a named person who leads and acts as co-ordinator for the refugee and asylum seekers agenda and within this role provides a source of advice to staff and patients

2.1 The Health Inclusion Service (HIS) is a nurse led Primary & Community Care service that responds to the health needs of socially at risk, vulnerable and excluded people living within the Health Board's region by providing holistic healthcare assessments, screening, and outreach to improve access, outcomes and reduce health inequalities.

2.2 The Senior Nurse for the service is considered the main point of contact and co-ordinator for the refugee and asylum seekers agenda, alongside other vulnerable groups. The staffing establishment of the service is set as;

1.0 wte 8a Senior Nurse [due to service demand undertakes clinical activity]

1.0 wte band 7 Mental health Practitioner [Maternity Leave]

2.8 wte Band 6 [0.8 wte vacant post]

1.8 wte band 3 HCSW [1.0 wte long term sickness]

1.0 wte Band 3 Admin Support

2.3 As part of the audit, we completed testing and walkthroughs to gain an understanding of what the service provides to refugees and asylum seekers. We observed a great deal of co-ordination and engagement with other services to ensure patient care is provided or organized.

Conclusion:

2.4 The HIS offer advice to staff and patients, alongside working with other vulnerable groups. The main point of contact is the Senior Nurse who is the coordinator for the refugee and asylum seekers agenda. We observed this process in action, as we accompanied staff on several patient visits. Therefore, we have provided **substantial assurance** for this objective.

Objective 2: Services available to refugees and asylum seekers are promoted by staff to ensure patients access the care that they are entitled to

2.5 The HIS receives referrals from the Clearsprings portal and the Home Office. The referrals are then discussed and allocated to staff in weekly team meetings. All referrals are registered with GPs, and this is completed by NHS Wales Shared Services Partnership (NWSSP) Primary Care Services. This information is recorded as part of the Blue Book assessment and once completed, information is forwarded to the respective GP for their records. As part of the referral process, staff contact the patient and arrange a meeting for the completion of the Blue Book. This document is completed detailing the health and immunisation assessments of the patient. Within this process the patient is then signposted or supported in accessing the health care they need.

2.6 The Blue Book is completed either during a visit to the family, meeting the individual at the Welsh Refugee Council or a suitable clinical environment. They are often conducted with the assistance of LanguageLine UK[2]. We were informed that all referrals are screened, by reviewing medical records, to ensure staff are not put at risk and that they adhere to the Lone Worker Policy and Guidance.

2.7 According to the Welsh Government Policy Guidance: *Health and wellbeing provision for Refugees and asylum seekers* (December 2018) the Blue Book *"should be reviewed within a reasonable timescale, informed by the national needs assessment and other research currently underway, to reflect the issues and needs affecting the RAS population arriving in Wales, with due regard to safeguarding concerns such as potential trafficking, sexual exploitation, Female Genital Mutilation (FGM)."*

2.8 The HIS offers support and engagement to help build trust with patients, as well as assisting them in navigating their way through the health services available.

2.9 The service strives to contact the patient within three days of receiving the referral and to complete the assessment within 14 days. We tested a sample of 10 referrals and all, but one had been completed within 14 days. However, the remaining referrals had still taken approximately 14 days to complete. The above points are included within **matter arising one.**

2.10 We were informed that due to the complexities of the role and the experiences of the patients that this has impacted on staff turnover and sickness rates. Whilst we sought to quantify this position, the team have been unable to easily source the information required. Consequently, we have been unable to determine the degree of impact. However, the increasing length of time for the completion of the Blue Book assessments highlights a potential service provision / capacity risk and thus, a resource review should be completed to establish the level of risk. We were further informed that this has impacted in delivering services as part of the agenda. However, we observed a range of initiatives to provide support to the team with their wellbeing. The above points are included within **matter arising one.**

[2] Provision of interpretation and translation services

2.11 As part of the referral process all information is captured on the database which was introduced during 2020; which totals 1,474 patients. This total includes all vulnerable groups e.g. refugees, asylum seekers, Gypsy and Roma Travellers, sex workers and homeless. Between March 2023 and April 2024 there have been 347 refugees and asylum seekers recorded on the database.

2.12 The ABUHB Inclusion Health Steering Group (the 'Group') has recently been established, with other teams across the Health Board including Primary and Community Care and Public Health. The purpose of the Group is to act as a multiprofessional tool by providing strategic direction and cross-divisional collaboration across public health and health service care provision. Currently, a work plan for HIS is being developed.

2.13 Our testing did not identify any significant promotion of the services provided to asylum seekers and refugees, with the exception of an intranet page detailing a leaflet, with the HIS contact details and description of services they provide. However, we were informed that the HIS provide presentations and information, when requested, to Neighbourhood Care Networks (NCNs) and third sector organisations such as the Gap Centre and housing associations. Typically, the service is often contacted when staff require assistance engaging refugees and asylum seekers, rather than advice and support on what they can do to help the patient.

Conclusion:

2.14 The HIS react to referrals and ensure the Blue Book assessment is completed as soon as possible. However, due to complex patient needs (e.g. trauma experienced), this may take up to several visits. We were informed of the staff turnover and retention challenges, and consequently, alongside this we have observed the completion timeframe increase to c.14 days, instead of the previous internal target of three days. The HIS work to engage with refugees and asylum seekers and ensure they understand what care they are entitled to and often signpost them in the direction required. We were informed that during the last four years there has been significant staff turnover in the service, which has impacted the delivery of the refugee and asylum seeker agenda and the promotion of services. Therefore, we have provided **reasonable assurance** for this objective.

Objective 3: Staff training is completed to ensure all staff understand the principles of the refugees and asylum seekers agenda.

2.15 We found currently there are no training or awareness sessions being delivered for Health Board staff on the refugee and asylum seekers agenda. According to the Welsh Guidance mentioned above: "*Health boards should consider the training needs of staff at all tiers of provision and encompassing all those who will come into contact with RAS, including administration and other staff and not just limited to clinical staff.*" The training of all tiers of staff would benefit the service by increasing awareness of the team's role and responsibilities. Whilst presentations are provided, these are on an ad-hoc basis. The above points are included within **matter arising two.**

Conclusion:

2.16 As part of the refugee and asylum seekers agenda training should be provided to the relevant tiers of staff throughout the Health Board. This would assist the team in gaining visibility and helping to provide understanding of the service across the Health Board. It would also help in the promotion of the refugee and asylum seekers agenda and ensure staff are aware of it when it comes to delivering patient care and support to individuals who are entitled to it. Therefore, we have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Services Available (Design)	**Impact**
The Health Inclusion Service (HIS) is a nurse led Primary & Community Care service that responds to the health needs of socially at risk, vulnerable and excluded people living in the Health Board's region, by providing healthcare assessments, screening, and outreach to improve access, outcomes and reduce health inequalities. The service aids asylum seekers and refugees through completing their Blue Book assessment, which documents their health and immunisation assessments and directing patients towards accessing healthcare services required. The database was implemented during 2020, with 1,474 patients from vulnerable groups accessing the service, 347 of which are refugees and asylum seekers who have entered the service between March 2023 - April 2024. We were informed that due to staff turnover, sickness, difficulty in filling short term funded vacancies and an increase in patient complexities, this has increased the length of time for the Blue Book assessment to be completed. Whilst we have not been able to quantify this position, we have observed the Blue Book assessment taking c.14 days to completed, whereas previously, the intention was to complete the assessment within three days. The team now focus on making contact within the first three days and completion of the assessment within 14 days.	Potential risk of: • Significant impact to Refugee and Asylum seekers patients who may need health assistance. • Well-being and resilience of staff within the team.

Recommendations		**Priority**
1.1	The Health Board should undertake a service review based on the requirements of vulnerable groups within the Health Inclusion Service to determine if the workforce / resource position required remains appropriate. As part of the review, future demand and the level of patient support required should be considered alongside the requirement to build a resilient workforce and deliver the service in accordance with the Policy.	**Medium**

1.2	The timescale of when a Blue Book assessment is completed should be reviewed and the timeframe formally agreed and documented within a procedure.	**Low**

Agreed Management Action		Target Date	Responsible Officer
1.1	The Health Board will undertake a review to scope the demand and capacity requirements of Asylum Seekers and Refugees from initial arrival to settlement in Gwent to establish the workforce / resource requirements to sustain the service. The review will scope demand and capacity since service was developed in 2019 to current position, taking into account population needs assessment and changing legislation i.e. S98, supporting those fleeing conflict.	April 2025	Directorate Manager -Additional Clinical Services
1.2	A standardised timeframe for completion of the Blue book assessment is not in place nationally. The service will seek best practice in terms of completion of the blue book nationally and establish a standard completion date, using this as a baseline measure for the service.	January 2025	Directorate Manager -Additional Clinical Services

Matter Arising 2: Staff Training (Operation)	**Impact**
Currently there are no training or awareness sessions regarding the Refugees and Asylum Seekers agenda across the Health Board. However, Welsh Government Guidance: Health and Wellbeing Provision for Refugees and Asylum Seekers (December 2018) states: *"Health boards should consider the training needs of staff at all tiers of provision and encompassing all those who will come into contact with RAS, including administration and other staff and not just limited to clinical staff. "* The introduction of training or awareness sessions would assist staff across the Health Board with awareness, in delivering the refugee and asylum seekers agenda.	Potential risk of: • Staff are not aware that refugees and asylum seekers are entitled to free patient care. • Staff are not aware of the role of the HIS with regards the refugee and asylum seekers agenda.

	Recommendations	**Priority**
2.1	The Health Board should review the current staff training/awareness sessions across the Health Board to assist with the refugee and asylum seekers agenda. This should be incorporated into training for other vulnerable patient groups, including in conjunction with existing statutory and mandatory training.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
2.1	The Health Board will review existing online training resources available for staff across the Health Board, to include independent contractors, with a view to developing an electronic e-learning session that provides all staff with an understanding of Asylum Seekers and Refugees support, the cultural differences between the UK and individuals home countries, along with the types of barriers they face when accessing services in the UK. Opportunities for this training to be a mandatory awareness session for all Health Board staff and independent contractors will be explored for viability and appropriateness with the Corporate Human Resources and Education and Training teams.	September 2025	Directorate Manager -Additional Clinical Services

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Newport East Health & Wellbeing Centre

Final Internal Audit Report

October 2024

Aneurin Bevan University Health Board

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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Review reference:	ABUHB-SSU-2324-05
Report status:	Final
Fieldwork commencement:	25 February 2024
Fieldwork completion:	15 April 2024
Draft report issued:	13 June 2024, 18 June 2024
Draft report meeting:	1 July 2024 & 12 August 2024
Management response received:	17 October 2024
Final report issued:	28 October 2024
Auditors:	NWSSP Audit & Assurance – Specialist Services Unit
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Committee:	Audit, Risk & Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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

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

Executive Summary

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the Newport East Health & Wellbeing Centre project, and the performance to date against its key delivery objectives. This was the second audit of the project and covered the period from the last review in January 2023 to April 2024 (the previous review having determined Reasonable Assurance).

Overall Audit Opinion and Overview

At the time of concluding the fieldwork at the current audit (March/April 2024), the project's contract completion date had been extended (through the issue of formal Compensation Events) from 25th November 2024 to 13th January 2025.

The Supply Chain Partner's current delivery programme showed forecast completion being achieved on 22nd April 2025 i.e. an approximate 14-week delay against the revised contract completion date.

The latest cost analysis (March 2024) identified a best realistic outturn cost ranging between £406k and £620k overspend. This represents a 1.44% - 2.2% increase against the original Welsh Government approval.

Other key matters arising at the project include:

- Improvements required at the governance and scrutiny arrangements applied at both the Project Board and Community and Engagement Steering Group.
- Compliance with the project's (and contractual) change management arrangements; and
- The consistent completion of key project information (change control).
- Whilst noting the above, an overall **Reasonable Assurance** has been determined. This assessment acknowledges that whilst the project is currently progressing outside of the key time/cost parameters, cost pressures are currently being managed within discretionary allocations, and the successful application for IRCF funding would positively impact on the project (together with the pressures/impact on the UHB's discretionary programme). At the time of reporting, the delay to the programme was not significantly impacting on patient services. Management acknowledge that these time and cost pressures will need to be carefully managed through to completion and handover, and further deterioration in the reported position would impact on the overall assurance provided. These issues will be further considered at the scheduled 2024/25 review (approved within the FBC).

Other recommendations are within the detail of the report.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend 2022/23

Assurance summary [1]

	Assurance objectives	Assurance
1	Project Performance (time/cost/quality)	Limited
2	Validation of Management Action	Reasonable
3	Project Governance	Reasonable
4	Cost Management	Reasonable
5	Validation of Costs	Substantial
6	Change Management	Reasonable
7	Quality – Role of the Supervisor	Substantial

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Project Board governance arrangements should be reviewed and updated to reflect good practice.	3	Design	Medium
2	Community and Engagement Steering Group governance arrangements should reflect good practice.	3	Design	Medium
4	Progress against Gateway recommendations should be reported regularly to the Project Board.	3	Operation	Medium
5	The Project Board should re-examine the remaining risks and sufficiency of remaining contingency sums (demonstrating ongoing scrutiny and management of the project risks) through to completion.	4	Operation	Medium
5	The Capital and Estates Board should be advised on the potential impact (and further consequences if additional monies are required) on the discretionary programme, any reduction in other targeted investment priorities and associated risks in the event of additional Welsh government funding not being provided.	4	Operation	Medium
6 & 7	Project Control Forms should be consistently completed and appropriately authorised.	6	Operation	Medium

1. Introduction

1.1 The audit reviewed the management arrangements in place to progress the Newport East Health & Wellbeing Centre project. This audit was commissioned in accordance with the agreed Audit Plan (and associated fee) provided within the approved Full Business Case (FBC) for the project.

1.2 The project aims to deliver the co-location and increased collaboration of Ringland Medical Practice and Park Surgery, and to improve the integration of wider health and wellbeing services within the Newport East Neighbourhood Care Network.

1.3 The potential risks considered in this review included:

- Failure to address previously identified control weaknesses.
- Failure to achieve key project objectives (e.g., delivery to time, cost, and quality).
- Failure to achieve key project objectives through poor governance and project management controls.
- Project costs may escalate uncontrollably through an absence of adequate cost control, monitoring and reporting.
- Value for money may not be achieved through the appropriate application of contract control mechanisms.
- Quality issues may not be identified and rectified in a timely manner.

1.4 Welsh Government (WG) approved the FBC in May 2022, with work commencing on site in June 2022. Delivered activities to date include the construction of the Multi-Use Games Areas (MUGA), demolition of the existing doctor's surgery and the commissioning of the temporary accommodation.

2. Detailed Audit Findings

Project Performance: Summary of the achievement of the project's key delivery objectives (time, cost and quality) to date.

2.1 At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review are suitably designed and applied effectively.

2.2 At this second audit of the Newport East H&WC project, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.3 The FBC envisaged WG approval in March 2022, with a start on site in April 2022 and completion in August 2024. However, approval was not received until May 2022, with the commencement of works consequently delayed until June 2022.

2.4 The current (revised) contract completion date was the 13 January 2025, with the current anticipated completion date (as per the latest accepted programme), being 22nd April 2025. A total of 15 weeks' extension to the contract programme has been requested (+ 5.2 weeks on the most recent programme revision), with a total 5 weeks agreed by the Project Manager to date. i.e. at the time of the current review the project was approximately 21 months into the extended 31-month contract period.

Figure 1: Project Performance

	October 2022 Business Case	28 October 2022 7 weeks into construction (previous audit)	15 April 2024 72 weeks into construction (current audit)
FBC approval	March 2022		
Construction Commencement Date:	April 2022	20 June 2022	20 June 2022
Agreed Delay to Completion Date:	0 weeks	3 weeks, mitigated to 2 weeks	5 weeks
Construction Period/ Revised planned duration:	126 weeks	128 weeks	133 weeks
Contract Completion	31 August 2024	25 November 2024	13 January 2025
Anticipated Completion Date:	31 August 2024	9 December 2024	22 April 2025
Reporting against Accepted Programme Version:	N/A	Rev 2.1	Rev 10.2

Management advised that the programme delays were not currently adversely impacting on patient services – noting the ongoing service delivery at existing/temporary premises.

Cost

2.5 The forecast outturn cost, as of March 2024, was reported as follows:

Costs	WG Approvals £m	Forecast Outturn November 2022 £m	Forecast Outturn March 2024 £m
Works	19,056,293	19,190,627	19,190,627
Adjustments		55,430	568,639
Total anticipated works costs	19,056,293	19,246,057	19,759,266
Stage 2 & 3 design fees	1,504,026	1,630,588	1,630,588
Health Board fees	802,584	789,537	907,825
Non-works costs	1,269,755	1,238,632	1,244,322
Equipment	542,134	542,134	542,134
Balance of contingency	601,986	414,218	255,632
AWE Forecast	0	0	50,000
Total	**28,199,630**	**28,217,686**	**28,605,630**
Anticipated (over) / underspend	**0**	**(18,056)**	**(406,001)**

2.6 The reported forecast project outturn was anticipated to be £406,001 overspent by the end of the contract. The overspend was principally being attributed to additional Planning Authority requirements, additional utility and asbestos decontamination costs, together with additional inflationary pressures experienced during the period since the approval of the FBC. It is acknowledged that these issues were largely outside of the direct control of the UHB. Additional UHB advisor fees are anticipated, attributed to the prolongation of the construction programme.

2.7 As indicated above, at the time of the current review the construction was progressing on site and approximately 21-months into the extended 31-month contract period i.e. 68% complete. Approximately £255k (42%) of the original £602k project contingency remained. Recognising the same, and the current stage of construction (mechanical and electrical installation progressing), it may be considered that the remaining construction risks and the associated contingency requirements through to completion appears reasonable. However, the costed project risks remained high at £371,800 exceeding the remaining contingency balance by £116,168 (**MA5)**.

2.5 At the time of the current review, the anticipated overspends had been fully allocated from with the UHB's annual discretionary capital programme (reported to the Capital and Estates Board). This inevitably negatively impacts on the UHB's ability to deliver other benefits through its capital programme. However, whilst noting the same, WG representatives have been advised that an additional request

for WG funding was to be submitted (to the IRCF) for around £620,000 to consider the forecast deficit and other anticipated issues). The timing of the submission (during 2024/25) had also been discussed with WG representatives. The successful application would positively impact on the UHB's discretionary programme provisions. In either scenario, project costs will need to be carefully monitored and controlled throughout the remainder of the works (**MA5**).

2.6 Management advised that the above cost issues have been communicated to the wider UHB Executive (via the Capital and Estates Board) and WG at Capital Resource Limit (CRL) meetings.

Quality

2.7 Noting the project was at a mid-stage of construction, there had been several key deliverables achieved to date:

- the completion of the Multi-Use Games Area (MUGA).
- the doctor's surgery had been relocated to temporary buildings adjacent to the new build.
- the provision of the staff parking for the new build.
- the old doctor's surgery building had been demolished.
- the new build steel frame construction had been constructed for the new build.
- installation of windows and cladding; and
- the commencement of the Mechanical and Electrical service installation.

2.8 The UHB's Supervisor reported that the above works had been completed to a satisfactory standard.

2.9 There was a significant delay relating to the dental trench works information. The UHB confirmed to the SCP their specifications and the required work was being undertaken at the time of the audit, however the agreement of an associated compensation event in relation to this issue was still in dispute.

2.10 The UHB received monthly Supervisor reports, based on routine site visits, which will continue to identify any quality issues in the construction works going forward.

Conclusion

2.11 Recognising the current stage of construction, there were evident cost pressures and programme delays being experienced. These time and cost pressures will need to be carefully managed through to completion and handover. Recognising the competing pressures on the discretionary capital programme and the availability of additional IRCF funding etc., **limited assurance** has been determined in respect of project performance.

2.12 The following sections of the report further outline the key observations that have contributed to the above – matters which require management attention, with low to moderate impact on residual risk exposure until resolved.

Validation of Management Action: An assessment of progress against the agreed management actions from the prior audit report.

2.13 The status of previously agreed management actions from the prior audit report (issued November 2022) can be summarised as follows:

Original Priority Rating	Number of Recommendations	Implemented	Partially Implemented/ Ongoing	Outstanding/ ** Future Project Matters	Superseded *
High	1	0	0	0	1*
Medium	7	3	0	1**	3*
Low	7	5	0	2**	0
Total	**15**	**8**	**0**	**3**	**4**

** Superseded, - primarily associated with the disbandment of the Programme Board and the obligations of the Project Board.*

Noting progress to address previously agreed recommendations, **reasonable assurance** has been determined.

Project Governance: Assurance that appropriate governance arrangements were in place for the current project phase, including operation of effective reporting and accountability lines and that appropriate approvals were in place.

2.14 The established governance structure at the previous audit included oversight by the Primary Care & Community Estates Programme Board ('the Programme Board'), operational management by the Project Team and technical support from the Commercial Team.

2.15 The key project roles of Senior Responsible Officer (Interim Executive Director of Primary Care, Community & Mental Health) and Project Director (Capital and Estates Programme Director) had been appropriately assigned.

2.16 The Programme Board was disbanded early in 2023 as the other key project being progressed at the time (Tredegar Health and Wellbeing Centre) was completed. The Newport East Health and Wellbeing Centre Project Board (the Project Board) was established in October 2023, after a summer hiatus. The Community and Engagement Steering Group (another key project forum) recognised the impact of the project within the community and wider UHB services.

2.17 Recognising the range of responsibilities assigned to the Community and Engagement Steering Group, alongside the Project Board, there was limited attendance at both forums. Limited reporting was provided to the Community Engagement Steering Group, with both forums relying heavily on specific attendees. **(MA1 & MA2)**

2.18 The minutes of the Project Board indicated limited focus on change control, risk, and cost management issues. The constitution and capacity (and associated effectiveness) of the Project Board should be reviewed to ensure it can provide appropriate scrutiny and challenge as the project progresses, recognising also the changes that have been seen in key personnel within the UHB. **(MA1 & MA5)**

2.19 Whilst noting the above, the Project and Commercial Teams' responsibilities were well defined, with the Terms of Reference for both recently reviewed. The forums met with the required frequency and with acceptable attendance during the period reviewed. It was noted that external advisors played key roles in driving the meeting content and actions.

2.20 The Gateway 3 review ('Investment Decision'), undertaken in October 2021, raised several governance issues. Additionally, the previous audit recommended that the Programme Board should receive updates against each recommendation to ensure appropriate plans were in place to address all outstanding matters. These issues remained to be addressed at the time of the current review. **(MA4)**

2.21 Whilst noting improvements had been made to the information provided to the Project Board, there were areas identified at the audit for further enhancement. Accordingly, **reasonable assurance** has been determined in this area.

Cost Management: Adequate cost control and reporting systems were operated, both internally and by the External Cost Adviser. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds.

2.22 The contract 'Not-to-Exceed' (NTE) figure included within the FBC was agreed in the sum of £20,082,443. After FBC approval, the target cost increased by £157,688, primarily in relation to the re-tender of the groundworks package.

2.23 Throughout 2023, the reported forecast overspend fluctuated between £250,000 and £325,000, with overspend on works costs generally being offset against underspends against the non-cost and other UHB costs categories.

2.24 By December 2023 the forecast overspend was reported as £284,448. The first quarter of 2024 saw some stability in the financial position which was additionally favourably impacted by a Value Engineering exercise which was undertaken to determine whether specification and changes within the works information and planned changes could be amended to obtain better value for money. This resulted in the redaction, where not enacted, of three items within the works information amounting to a £37,100 saving.

2.25 Whilst there has been a clear culture of challenge and scrutiny of the costs incurred by the Cost Advisor, there was limited documentary evidence of scrutiny by the UHB. The Commercial and Progress Meetings were combined, and this enabled oversight by some levels of the Project Team, (similarly the cost report was provided to Project Board attendees), but there was little evidence of discussion related to project finances at the Project Board. The Commercial Meetings have had a dominant advisor and SCP presence. **(MA1)**

2.26 The March 2024 cost report anticipated a forecast outturn circa £406k over the approved budget allocation. This may be further adversely impacted by a dispute with the SCP relating to dental trench works information, which at the time of the audit remained unresolved. As a consequence, the Cost Advisor advised that there was an expectation that the anticipated project outturn would be circa £620k over the current approved funding provision.

2.27 Management advised that it intended to submit an application for additional IRCF funding from the Welsh Government to address the forecast overspend **(MA5)**. The additional funding request would seek to fund items which were considered (by management) to be outside of the scope of the original Welsh Government funding provisions and were largely out of the control of the Project Management team, including:

- £63k – Delays in the demolition of the old medical centre due to utilities meters not being delivered by supplier.
- £141k - Asbestos found during demolition of old Medical Surgery, and not identifiable in initial surveying; and
- £176k - Inflationary burden to February 2024

2.28 As indicated above, as of March 2024, the project's costed risks exceeded available contingency by £62,328, with 42.5% contingency remaining.

2.29 The Project Director confirmed that funding provision for the forecast overspend had been allocated from within the UHB's 2024/25 discretionary capital programme. Additional WG (IRCF) funding was also to be sought during the current financial year.

2.30 Whilst acknowledging the strong financial monitoring controls applied by the external Cost Advisor (leading on this on behalf of the UHB), the absence of Project Board scrutiny should be addressed. The actions taken by management to address the forecast overspend are recognised (although impacting on wider UHB investment opportunities). Accordingly **reasonable assurance** has been determined in this area.

Validation of Costs: That costs incurred to date were appropriately validated in accordance with the NEC Option C contract applied at the project.

2.31 Sampling of the February 2024 valuation evidenced challenge and scrutiny by the external Cost Advisor. Evidence was provided showing correspondence between the Cost Advisor, the SCP and their sub-contractors, which both challenging the submission of timesheets and materials and had also reminded external parties of their obligations under the NEC contract.

2.32 No errors in the calculations of the cost submissions were identified (which had not previously been identified by the Cost Advisor).

2.33 At the time of the current audit, there were a limited number of Mechanical and Electrical (M&E) invoices submitted for materials. The Cost Advisor had notified that M&E specialists were due to join the commercial meetings as the M&E work started to increase. This aligned with the early stage of M&E installation observed at the point of the site visit.

2.34 The project bank account, after a delay in implementation, was being applied.

2.35 Noting the above, **substantial assurance** has been determined.

Change Management: Appropriate internal and contractual change control mechanisms were applied at the project.

2.36 The change management protocols were adequately detailed within the Project Execution Plan (PEP). Appropriate delegated limits were established for the Project Director (£50k) and the Associate Project Director (£25k), further delegation was not extended to the Project Manager.

2.37 Approvals were recorded using Project Control Forms (PCFs), in addition to the Project Manager Instructions (PMIs). A sample of 13 PMIs (and associated documents) with a combined total of £239k were examined at the current audit and the following points were observed:

- Sampled PMIs were generally complete, although all approval signatures were not dated, and PMI forms failed to identify corresponding RFQ/ PCF/ CE forms. **(MA6)**
- Approvals were evidenced in accordance with the scheme of delegation in most cases, however, the largest compensation event issued to date (£141k), had not been fully approved until after the works had already been instructed by the Project Manager – in this instance it is recognised that the nature of the works i.e. asbestos identification and removal, necessitated the expediency of progression **(MA6).**

- It was evident that the previously agreed audit recommendation: "*Project Control Forms should be authorised in accordance with the Standing Orders (Scheme of Delegation)"* had not been fully implemented. **(MA7)**
- Fields on change control forms designed to demonstrate Value for Money (VfM), had not been completed sufficiently. **(MA8)**

2.38 Noting the above, **reasonable assurance** has been determined at this time.

Quality: The role of the Supervisor was appropriately executed to support effective management of the quality of construction activities.

2.39 NHS Building for Wales requires 6-monthly Key Performance Indicators (KPIs) to be submitted by all parties. The Project Execution Plan (PEP) also states "*The standard Framework KPI templates will be utilised in accordance with the framework procedures for the following KPI's, at each relevant stage:*

- *Project Manager Performance*
- *SCP Performance*
- *Cost Advisor Performance*
- *Supervisor Performance*
- *Health Board Performance"*

2.40 Completed KPIs were not evidenced for the Supervisor role. The KPIs were completed by the Project Director and, as a result, Project Director KPI's had not been completed. The completion of KPI's relating to the performance of the Project Director have been recommended. **(MA9)**

2.41 It was observed that the NEC Supervisor had provided timely and informative reports (which were attached to the Highlight Report submitted to the Project Board and the Progress meetings). The reports referred to progress reports issued through their SnagR portal and had produced a range of photographic narrative.

2.42 It was expected that the BREEAM rating of the building will be excellent, whilst the building has been designed and built in line with Passivhaus principles.

2.43 Noting the above, **substantial assurance** has been determined.

Appendix A: Management Action Plan

Matter Arising 1: Governance – Project Board (Design)	**Impact**
The Primary Care & Community Estates Programme Board previously fulfilled the role of Project Board for this project, together with the Tredegar Health & Wellbeing Centre project, with the respective Project Teams for each project reporting into the Programme Board. The Programme Board was disbanded in April 2023 as other projects within the programme completed. In the previous audit, 3 recommendations (MA2.1, MA2.2 & MA2.3) were made regarding the Programme Board i.e.: • The roles and responsibilities of the Primary Care & Community Estates Programme Board should be clearly defined within the Terms of Reference. • The Primary Care & Community Estates Programme Board should meet with the agreed frequency (6-weekly) as a minimum to ensure sufficiently regular oversight of the major projects within its remit. • The constitution and capacity of the Primary Care & Community Estates Programme Board to effectively execute the Project Board role for all the Primary Care projects within its remit should be reviewed and confirmed. These recommendations should now be applied to the Project Board e.g. • During the period of review and since the establishment of the Project Board in October 2023, regular meetings were observed, however attendance was minimal. The Project Board of the 6 March 2024 was terminated due to the non-quorate nature of the meeting (including the absence of the Health Board's Executive Director and Project Manager).	Potential risk of: • Insufficient oversight and scrutiny of project performance by the Project Board and Health Board Executive. • Central project documentation does not adequately document key discussions/ decisions.

• The Project Board Terms of Reference had been maintained. looking ahead and the imminent departure of the Project Director (March 2024), and anticipated personnel and organisational structure changes (March 2024), the Project Board Terms of Reference will need to be updated to reflect changes. It may be appropriate at that stage to review the current structure, including the constitution and capacity of the Project Board to scrutinise, challenge and approve issues etc. • The current structure, including the constitution and capacity of the Project Board to scrutinise, challenge and approve, should be reviewed and confirmed. The Gateway 3: Investment Decision review, undertaken in October 2021, raised similar concerns regarding the Project Board function within the wider Programme Board. Whilst recognising the nature of the Project Board has been reviewed and updated since that time, as above, issues remain over the clarity of expectations, and the capacity of the Project Board. Whilst there has been a clear culture of challenge and scrutiny of the costs applied by the Cost Advisor and the SCP, there was limited documentary evidence of discussion and scrutiny of project finances by the Project Board (incl. approvals, key decisions etc.). The detailed minuting and recording of key project forums (including the Project Board) is essential to ensure a robust audit trail is maintained of key decisions, approvals and evidence of project scrutiny.	

Recommendations		**Priority**
1.1	The Project Board governance arrangements should be reviewed including: • The constitution and capacity of the Project Board to effectively execute its remit within the Health Board should be reviewed from a resource perspective (noting quoracy and attendance issues). • The agenda should be amended to formally include project finance as an agenda item.	**Medium**

	• All Project Board minutes/action plans (as appropriate) should ensure that key scrutiny issues, decisions and approvals are detailed.		
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Accepted The Terms of Refence for the Project Board have been updated to reflect changes in key personnel, with the final draft being presented to Project Board in October. The cancellation of the Project Board on the 6 March was an isolated occurrence and the Project Board has subsequently continued to meet as per the programme meeting schedule and quoracy. Standard agenda has now been amended to include finance as a formal agenda item Minutes will be reflective of key decision and actions and Action Logs will be completed and updated as part the Project Board discussions.	31st October 2024	Project Director

Matter Arising 2: Governance – Communication and Engagement Steering Group (Design)	**Impact**
The Community and Engagement Steering Group recognises the impact of the project within the community and wider UHB services. It recognises the transformation of a standalone medical surgery into a Wellbeing Centre linked to the community hub building and providing pharmacy, dental and community health facilities in addition to housing a medical surgery. Recognising the range of responsibilities assigned to the Community and Engagement Steering Group, alongside the Project Board, there appeared to be a lack of commitment to attendance for both forums. Limited reporting was distributed to the Community Engagement Steering Group, and both meetings place a heavy reliance on specific attendees for updates. The minutes of the Community and Engagement Steering Group for 15 January 2024 noted that "there was no update from the programme team" as the UHB Project Manager was absent. The Community and Engagement Steering Group membership met in July 2023 and had only subsequently met on four occasions (Nov 23, Jan 24, Feb 24, Mar 24). Recognising the Steering Group's diverse and multi-disciplined membership, appropriate Terms of Reference and appropriate reporting, is crucial to enable challenge and productive scrutiny at the meetings. It was recognised that the Highlight report which was provided to the Progress Meeting and Project Board, now has several key documents attached including cost reports, change control registers, and SCP and Project Manager's reports. Whilst all information contained within the Highlight report may not be appropriate for dissemination at the Community and Engagement Steering Group, appropriate project progress information should be presented to enable consistency of reporting and facilitate improved scrutiny and challenge.	Potential risk of: • Insufficient oversight and scrutiny by key community and service stakeholders.

Recommendations		Priority
2.1	Governance of the Community and Engagement Steering Group should reflect good practice including addressing the following issues: • The update of the Terms of Reference to reflect recent changes in roles and responsibilities of the Community and Engagement Steering Group. • The importance of Community and Engagement Steering Group attendance should be reiterated. Future meetings should be quorate and continue to meet regularly. • The Community and Engagement Steering Group should receive appropriate project progress reports to facilitate appropriate scrutiny and challenge.	**Medium**

Agreed Management Action	Target Date	Responsible Officer

2.1	Accepted During quarter 4 23/24 the Terms of Reference for the Communications and Engagement group were refreshed, and the Head of Corporate Communications also became a standing member of the group to provide support. This also ensured that all documentation such as the highlight reports went through the Communications and Engagement Group for both awareness and action where needed. The Communications and Engagement Group Report is also shared with other groups and Project Board to improve flow of information and decision making. Attendance at the Communication and Engagement Group has been raised to the Project Board and the Board is reaffirming the importance to all members that attendance is crucial.	31st October 2024	Project Communication and Engagement Manager

Matter Arising 3: Governance – Project Execution Plan (Operation)			**Impact**
A recommendation was made at the previous audit (MA1) to ensure the Project Execution Plan (PEP) was up to date. A revision was undertaken, but it is recommended that the PEP is re-reviewed in the light of forthcoming changes in key personnel.			Potential risk of: • Central project documentation does not provide current guidance.
Recommendations			**Priority**
3.1	***Future Assurance*** The Project Execution Plan (PEP) should be updated to reflect current roles and responsibilities.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Complete – updated PEP provided to Audit on 10.09.2024	31st October 2024	Project Director

Matter Arising 4: Governance – Gateway Report (Operation)	**Impact**
The previous audit considered the Gateway Review 3, *'Investment Decision,'* which was undertaken in October 2021 (pre-FBC submission), with the report determining an Amber / Green rating *("Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.")* Recommendations were made within the Gateway report (and the previous audit): "A report should be tabled at the next Primary Care & Community Estates Programme Board meeting, presenting an update against each Gateway recommendation, and identifying any actions still outstanding." The target completion was January 2023. This was not addressed until the 7th of February 2024 Project Board when a Health and Wellbeing plan was presented. However, although it directly related to progress against FBC objectives, it did not refer to the associated Gateway recommendations, but led to a comment by the Project Director who noted: *"no feedback was received from the group regarding the gateway review. A couple of the recommendations need to be considered as another gateway review is due to take place towards end of 2024".*	Potential risk of: • Previously identified weaknesses are not addressed.

Recommendations		**Priority**
4.1	The Project Board should receive regular progress updates against Gateway recommendations, clearly identifying any actions still outstanding.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	Accepted Progress against the Gateway recommendations will be a standing agenda item for update and discussion at Project Board	31st October 2024	Project Director

Matter Arising 5: Cost Management (Operation)	**Impact**
The NHS Wales Infrastructure Investment Guidance (2018) states: *"The importance of gaining accurate information on spend cannot be emphasised enough. It is essential that organisations ensure that the information from Supply Chain Partners is up to date and contains realistic forecasts in terms of completed works and valuations. Early warning of any issues needs to be identified to the Deputy Director of Capital, Estates & Facilities Division. Careful attention needs to be given to underspend at all times throughout the project timeline."* At the time of the current review, the Cost Advisor indicated that there was an expectation that the project would be delivered circa £620k over the approved funding allocation. It was recognised that, at the time of the audit, the cost implications associated with the dental trench issue remained unresolved. Management advised that the overspend was primarily associated with: • Two large compensation events: ○ £141k for asbestos disposal that was identified within original surveys of the old medical surgery; and ○ the impact of a 2-day delay to a 3rd Party delivery which then adversely impacted on the availability of installers (by a further two weeks) circa £63k.	Potential risk of: • Cashflow risk – that the project and UHB will not be able to meet their debt obligations as they become due. • Insufficient scrutiny of key project costs; and potential impact on UHB of requiring discretionary funding.

• Circa £177k inflationary pressures. • Additional design (£127k) and advisor fees (105k) • Other lower value Compensation Events (CEs). Acknowledging that the construction was approximately 21-months into the extended 31-month contract period i.e. 68% complete, approximately £255k (42%) of the original £602k project contingency remained In addition to the above, at the time of the current review, the costed project risks remained high at £371,800, exceeding the remaining contingency balance by £116,168. Whilst it may be considered that the remaining construction risks and the associated contingency requirements through to completion appears reasonable, it will require careful management and ongoing scrutiny by the Project Board through to completion. The Project Director has confirmed that there is capacity to fund the current forecast project overspend through the annual discretionary programme provisions. However, this inevitably adversely impacts on the UHB's discretionary capital priorities and the ability to deliver other benefits for the UHB. Management advised that it also intended to apply for additional IRCF funding from the WG to address the anticipated project overspend and that the timing of the submission (during 2024/25) had been discussed with WG representatives. Recognising the current discretionary provisions, the Capital and Estates Group should be advised on the potential impact on the discretionary programme, reduction in other targeted investment priorities and any associated risks in the event of additional Welsh Government funding not being provided. These time and cost pressures will need to be carefully managed through to completion/handover.	

Recommendations		Priority
5.1	The Project Board should re-examine the remaining risks and sufficiency of remaining contingency sums (demonstrating ongoing scrutiny and management of the project risks) through to completion.	**Medium**
5.2	The Capital and Estates Board should be advised on the potential impact (and further consequences if additional monies are required) on the discretionary programme, any reduction in other targeted investment priorities and associated risks in the event of additional Welsh government funding not being provided.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
5.1	The Construction Risk Register is revised regularly on a monthly basis and is led by the Projects Cost Advisor. Risks are robustly scrutinised with appropriate funding allocated against each risk. Due to the robustness of this process, the overspend on the project has been significantly reduced to £120k. Whilst recognising the project is still over committed, the risk has reduced substantially to the financial position which was being recorded at the start of the project, due to unforeseen risks to the project.	30th November 2024	Project Director/ Capital Finance Manager
5.2	The financial position is discussed through the capital and estates group and is also reported and discussed at the Capital Review Meeting with Welsh Government. Financial position is also included as part of the financial reporting	30th November 2024	Project Director/ Capital Finance Manager

Matter Arising 6: Change Control Forms (Design & Operation)		**Impact**
A lack of cross-referenceable data on different change control forms (principally Compensation Event and Project Control Forms (PCFs)) in use across the change process, risks lack of oversight, and difficulty determining complete information. It was difficult to reconcile descriptions and forms to the Change Control Register. Initial Change Request Forms were noted to lack information regarding expected impact with description of risk to service or to the construction, stated as "Delay and increased costs" and "Furniture delivery delayed" on some forms sampled, which did not demonstrate Value for Money (VfM). Several control forms were applied at the project e.g. Change Control Forms and Project Control Forms (instigated by the external Project Manager); Request Quote Form's (RQF) issued by the SCP; and Project Manager's Instructions issued to the SCP. A sample of 13 Project Management Instructions (PMIs) were reviewed at the current audit. The PMIs were generally complete, with the Project Manager's signature inserted electronically at all PMIs. Although not all approval signatures were dated, all forms were dated. The PMI forms did not always identify corresponding RFQ/ PCF/ CE forms. Noting the nature of the electronic signature applied, it was not possible to verify its integrity as a version-controlled document management system (such as Adobe sign or Docusign etc) was not utilised. However, it is recognised that in each instance the final approval was sought from the Project Director in the form of an email (containing the electronically signed PMI) for all PCFs examined.		Potential risk of: • Inadequate cost control – execution of financial orders without ability to scrutinise adequately • Ambiguous change management information could lead to misinformed decisions being made
Recommendations		**Priority**
6.1	All project control forms should be consistently completed and appropriately authorised incl. cross references, date of signature etc., and identifiable at the Change Control Register.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
6.1	Accepted The consistency of the project control forms has been addressed in line with the recommendation.	31st October 2024	Project Director

Matter Arising 7: Change Control – Scheme of Delegation (Operation)	**Impact**
The previous audit recommended (MA 6.2): "Project Control Forms should be authorised in accordance with the Standing Orders (Scheme of Delegation)". Approvals were generally evidenced in accordance with the scheme of delegation. However, in the case of the largest compensation event at the project to date (£141k) the following was observed: • 3rd April 2023 - work commenced by the SCP. • 15th May 2023 – PMI issued by the external Project Manager • 18th May 2023 - PCF approved by the Project Director, UHB Chief Executive Officer and Chair. Communication from the Project Director did not provide sufficient clarity as to whether the PCF was approved i.e. the email responses to the approval requests only documented "Thank you". No approvals were provided at the respective PMI/PCF proforma. Noting the same, it was acknowledged that the above PCF related to unforeseen asbestos works. It is acknowledged that action was required to address the affected areas of the construction works as soon as asbestos was identified. Costs associated with the same could only be affirmed on completion of works within the affected areas. Additionally, at 6 of the 8 PCFs sampled, the control form attached to the email did not have the "Approved" box ticked. Whilst verbally it was confirmed that the response was the approval, there was ambiguity within the document trail.	Potential risk of: • Inadequate cost control – execution of financial orders without scrutiny or approval. Non-compliance with the Scheme of Delegation.

Recommendations		**Priority**
7.1	All Project Control Forms should be adequately completed to demonstrate authorisation and approvals in accordance with the Standing Orders (Scheme of Delegation) and/or project delegation limits prior to the issue.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
7.1	Accepted The Project Control forms are completed in line with the Health Board Scheme of Delegation, but also in line with requirements under the NEC contract. Whilst acknowledging that the email provided with the signed document lacked detail, as advised there were number of meetings and discussions which took place to inform the decision to sign the PCF.	31st October 2024	Project Director

Matter Arising 8: Change Control - Value for Money (Operation)			**Impact**
Initial Change Request Forms were noted to lack information regarding expected impact with description of risk to service or to the construction, stated as "Delay and increased costs" and "Furniture delivery delayed" on some forms sampled, which did not demonstrate Value for Money (VfM).			Potential risk of: • Inadequate change control – execution of financial orders without sufficient scrutiny or approval.
Recommendations			**Priority**
8.1	Project Control Forms should be completed with detailed descriptions that demonstrate Value for Money (VfM) and support informed decision making.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
8.1	Agreed. More detail will be included in the detail to support more informed decision making.	31st October 2024	Project Director

Matter Arising 9: Quality – Designed for Life KPIs (Operation)	**Impact**
The Designed for Life Framework requires 6-monthly Key Performance Indicators (KPIs) to be submitted by all parties. At the previous audit it was noted that despite the October 2022 return having been submitted, the April 2022 KPI's had not been. Whilst the KPI returns for April and October 2023 were provided during this review, the date on both returns, was the same, albeit the KPI content was specific to the 6-month period. (MA11) The KPIs were completed by a Project Director who has since left the organisation, which caused a small delay to the submission for April 2024. The KPIs relating to the performance of the Project Director were also, as a result, not completed in 2023.	Potential risk of: • Inaccurate or incomplete reporting required under the Designed for Life framework. • Lack of monitoring of quality elements of project performance could lead to failure to achieve project objectives.

Recommendations		**Priority**
9.1	The UHB should ensure the consistent and timely submission of KPI's, for all parties including Project Director and Supervisor.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
9.1	Accepted The Health Board will ensure that KPI's are completed within timely manner and will include the Supervisor scores. It is not practical however to include Project Director scores as they will be evaluating themselves. This score however will be provided by other partners within the project.	30th November 2024	Project Director

Appendix B: Previous Audit Recommendations

Ref	Area	Previously Agreed Action	Current Status	Responsibility & Timescale	Priority
1.1	Governance	The Project Execution Plan should be updated to reflect current governance arrangements.	Implemented – the PEP had been updated.	N/A	**Low**
2.1	Governance	The role and responsibilities of the Primary Care & Community Estates Programme Board, in acting as the Project Board for major Primary Care projects, should be clearly defined in the Terms of Reference.	Implemented – the ToR had been updated.	N/A	**Medium**
2.2	Governance	The Primary Care & Community Estates Programme Board should meet with the agreed frequency (6-weekly) as a minimum to ensure sufficiently regular oversight of the major projects within its remit.	Superseded: The Programme Board disbanded in Apr '23, Project board then met in Oct 23, they were then held Jan to Mar 24. A recommendation has been raised regarding the current Project Board.	N/A	**Medium**
2.3	Governance	The constitution and capacity of the Primary Care & Community Estates Programme Board to effectively execute the Project Board role for all the Primary	Implemented: a revised ToR was implemented in Jan 2024; however, it has been highlighted that changes in personnel will necessitate further revision.	N/A	**Medium**

Ref	Area	Previously Agreed Action	Current Status	Responsibility & Timescale	Priority
		Care projects within its remit should be reviewed and confirmed.			
3.1	Governance	A standard and consistent range of project reports should be submitted to the Primary Care & Community Estates Programme Board, to support the 'project board' role and responsibilities of the forum (to be defined as per recommendation 2.1).	Implemented: The wider programme board has been disbanded; the Project Board are receiving reports attached to the agenda.	N/A	**Low**
3.2	Governance	Project Team meetings should be supported by a standard agenda, including submission of a standard and consistent range of project reports. This should include the Cost Report and external PM's progress report for information (albeit recognising the full detail of these technical reports may not be reviewed during the meetings).	Implemented: The highlight report includes a range of reports; however, the reports cannot be saved down by members as they are not editable from the highlight report.	N/A	**Low**
4.1	Governance	The UHB Service risk register should be developed as soon as possible, with key risks reported to the Project Team and Programme Board on a routine basis (see also MA2).	Implemented.	N/A	**Medium**

Ref	Area	Previously Agreed Action	Current Status	Responsibility & Timescale	Priority
5.1	Governance	A report should be tabled at the next Primary Care & Community Estates Programme Board meeting, presenting an update against each Gateway recommendation, and identifying any actions still outstanding.	Superseded: A Health and Wellbeing plan was presented at the February 24 Project Board meeting. Although it directly relates to progress against FBC objectives, it did not refer to Gateway recommendations.	N/A	**Medium**
6.2	Target Cost	Project Control Forms should be authorised in accordance with the Standing Orders (Scheme of Delegation).	Superseded: PCFs were in use for all change events sampled, all had been approved via email, however instances where approvals had been actioned after the PMI was issued and work undertaken were identified. The approval process could be streamlined, and the approval be completed through a document management programme such as adobe sign or DocuSign.	N/A	**Medium**
7.1	Contract Documentation	At future projects: Contracts should be executed before works / duties commence.	N/A future projects	Project Director At future projects	**Low**
7.2	Contract Documentation	At future projects: Contracts should be dated.	N/A future projects	Director of Corporate Governance	**Low**

Ref	Area	Previously Agreed Action	Current Status	Responsibility & Timescale	Priority
				At future projects	
7.3	Contract Documentation	At future projects: Contracts over £100k in value should be signed by both the Chief Executive & Chair in line with the Standing Orders (Scheme of Delegation).	N/A future projects.	Director of Corporate Governance At future projects	**Medium**
8.1	Financial Assurance	The UHB should ensure cost information is adequately scrutinised and understood in a timely manner to feed into routine WG updates (via the PPR process), and to allow for timely exception reporting if required.	Superseded: The Cost Advisor does not attend the project board but does attend the Commercial meetings and the report was distributed to the HB Project Manager monthly. There was little evidence of visibility or awareness of cost positions, outside of the Cost Advisor and the Project Director who has now left the UHB. The minutes of the Project Board do not evidence any cost-based discussion. The PPR has been completed appropriately since this recommendation.	N/A	**High**
9.1	Financial Assurance	The Project Bank Account should be implemented as soon as possible.	Implemented: The Cost Adviser confirmed that this was being operated.	N/A	**Low**

Ref	Area	Previously Agreed Action	Current Status	Responsibility & Timescale	Priority
10.1	Advisers	KPIs should be submitted as required by the D4L Framework.	Implemented: KPI's were completed for April and October 2023, however the date stated on both was the same. The actual submissions could not be sourced from the UHB as the person who completed them had subsequently left the UHB.	N/A	**Low**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Facilities Stock

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board

Reasonable Assurance

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Review Reference	ABU-2425-18
Fieldwork	September - October 2024
Executive Sign Off	Leanne Watkins
Audit Committee	November 2024
Executive Lead	Leanne Watkins
Head of Internal Audit	Stephen Chaney
Deputy Head of Internal Audit	N/A

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

Executive Summary

Purpose

A dedicated follow-up review over the implementation progress of the Facilities stock recommendations raised within the 2023/24 audit.

Background

We have concluded **reasonable assurance** on this area. Significant work has been completed since our previous audit of this area in October 2023. The majority of the previous actions raised have been completed and assurance has been provided, through the new divisional governance processes established. Nonetheless, the divisional stock management risk has not yet been fully mitigated, as further actions are still in progress. However, we recognise that decisions may be required over the risk / benefit cost, in line with Health Board's risk appetite. Consequently, this may inform the next steps to be taken by the division. Overall, whilst good progress has been made, the following matters still require management's attention:

- There has been an improvement with the divisional catering stock processes, with a reduction in catering stock expenditure. However, the current stock management system does not have the capabilities for stocktakes to follow the process set out within the Health Board's financial control procedure. Without investment in a new stock management system or increasing the capabilities of the current system the risks remain. The Health Board may wish to assess the risks and benefits with this approach before continuing, considering the updated arrangements.
- Training on stock processes and awareness of the new standing operating procedures should be monitored.

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

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Follow up on the actions raised within the 2023/24 Facilities audit, to determine the implementation status of each of them and to ensure that each is being progressed in a timely manner.	1 & 2	**Reasonable**

Summary of Management Actions

1	1
High Priority	**Medium Priority**
Performance Monitoring [Control Design]	Training & Development [Control Design]

Control **Design** Issues: Inadequate or poorly designed controls that do not address risks	**2**
Control **Operation** Issues: Controls that are not executed correctly or consistently	**0**

Facilities Stock- At a Glance

Areas covered during previous Facilities stock audit	Has there been improvement identified during this follow up audit	Comments
Stock ordering	**Yes**	-
Stock level	**Yes**	-
Stock take	**Partial improvement**	The Health Board does not utilise a stock management system that allows for stock takes to be undertaken, in accordance with the Health Board's financial control procedure. Whilst the system utilised has not changed since our previous audit, actions have been completed to identify modules currently unused within the system that could reduce control gaps. Furthermore, there has been an increase in the number of stock counts taking place.
Stock receipting	**Yes**	-
Security	**Yes**	-
Food Waste	**Yes**	-
Governance	**Yes**	-
Stock management system	**No**	As per the stock take comment above.
Training	**No evidence**	There was no evidence training had been delivered to staff when we completed our testing. Steps to rectify this are already underway.

We identified the following areas of significant improvement:

Culture – During our testing staff were more open to challenge and opportunities of improvement. We entered a more amenable and engaging environment than when we completed the 2023/24 internal audit. Staff interviewed commented on how they feel more comfortable raising concerns around processes / areas for improvement.

Governance – Operational managers have been reassigned to manage different sites since our last audit. The Head of Facilities has also implemented monthly reporting of stock, including but not limited to provisioning, stock takes, waste and risks. These changes have improved the governance regarding stock.

Provisioning – Spend on provisioning has decreased year on year despite food prices generally continuing to rise. Reviewing the August 2023 expenditure, compared with August 2024 we confirmed significant provisioning drops with the five biggest reductions being St. Woolos - 66%, Royal Gwent Hospital (retail) - 57%, Ysbyty'r Tri Chwm - 51%, Maindiff Court Hospital - 34%, Ysbyty Aneurin Bevan - 28%.

Findings & Agreed Action Plan

Objective 1: Follow Up	**Reasonable**

We found an improved position of stock management within the Facilities division. The Health Board's stock financial control procedure (FCP) details an effective stock management process, which has been utilised to develop divisional standard operating procedures (SOPs). Staff were aware of the new procedures, which have been implemented since our last visit. Additionally, a new monthly report is presented by the operational manager of each Health Board site which includes the monitoring of stock processes.

All stock is ordered via Oracle. Since our last visit, these new processes have led to a significant reduction in provisioning expenditure year on year. This was further evidenced on our site visits, where stock rooms that had previously been inaccessible / full due to the level of stock held had visible reductions in the number of items stored. The reduction was significant in some areas, that the stock rooms had been re-purposed into offices.

However, the area of greatest risk remains with the stock management system. Currently, the Health Board utilises Synbiotix as their food management software. The modules available to the Health Board do not allow for sufficient monitoring of stock. For example, there is no functionality to monitor product usage, which will impede management's ability to effectively monitor key processes, such as stock levels and waste. Without this functionality staff are unable to undertake reconciliatory stock counts in line with the Health Board's procedures. Furthermore, we noted that staff still only count stock on the shelves with no further investigation or agreement to stock records. Therefore, management are unable to accurately identify reasons for waste, which may include patient waste or for other associated reasons – e.g. overordering, stock expiring, or a lack of portion control. Currently, there is no way to effectively monitor this. Management is aware of the risk and have already identified the required modules within Synbiotix to rectify the control gaps.

Furthermore, we found that stock receipting has improved, and order sheets and delivery notes are no longer being disposed of. There was evidence during site visits of records created detailing items missing or substitutions during delivery and communication back to the staff responsible for ordering.

Additionally, we found that the security of stock was more controlled during our latest site visits. There was no evidence of consumed stock on site unlike our previous visit and keys were kept secure. We were also challenged during our visit to the Grange University Hospital (GUH) regarding our presence within the stock area. Stock rooms at the Royal Gwent Hospital are not restricted, however, and remain unlocked during the day. There are no cameras in this area. However, we were challenged during our site visit by multiple staff whilst in the stock area. We were informed that a privacy impact assessment regarding the use of CCTV cameras has been carried out and management are currently considering the viability of additional cameras.

The training of staff regarding the stock management process and each staff members responsibilities was raised as a management action during the last audit. We were unable to confirm if this training has been fully completed because training records are not kept. However, during interviews with staff, whilst on site, we found that they had a good understanding of their roles and responsibilities, suggesting informal training may have taken place.

Key Findings		Risk & Impact	Agreed Management Action
1	**Stocktakes and stock management system** Stocktakes are not being completed in accordance with the Health Board's financial control procedure. We found staff were counting the number of items within the stock rooms and noting this figure. No further analysis, investigation or reconciliation was being completed. Whilst this provides the stock total at that point in time, it does not identify any discrepancies with the expected stock levels.	Potential risk of: • Misappropriation of stock • Unknown stock levels • Financial loss to the Health Board.	Agreed Action: The agreed action will follow an assessment of the three options available: Option 1 - Continue current processes which has resulted in reasonable assurance and proactively monitor **(immediately)** Option 2 – Improve the functionality of the existing system to deliver end to end stock management **(discussions with the system provider are on-going)**

	We found that staff are counting stock on a regular basis, and this is being reported to the Facilities monthly management meeting. However, as the current stock management system does not monitor the usage of stock, the Health Board must either accept the risk of not have an effective stock management system or invest in purchasing in a system which has the necessary functionalities or adopt a manual approach. The exception to this is Apetito (supplier) orders within the GUH. As they are prepacked, the system does have the functionality to monitor usage fully and this has been monitored in the past. Management should utilise this function to complete stock takes in line with procedures.		Option 3 –Source an alternative system Expected Evidence of Implementation: Reduced or maintained cost levels, continued stock counts with the focus on adherence to the Stock Financial Control Procedure (FCP) (as far as current system allows). Stock takes for Apetito orders should not deviate from process noted in FCP. Alongside this, consider options 2 and 3 taking into account cost benefit analysis.
		High Priority	Officer: Rhys Shorney, Head of Facilities Date: 30th November 2024 (for option 1)
	Theme: Financial Management & Control	Control Design	
2	**Training** Management actions from the previous audit included the training of staff over their responsibilities of stock ordering, receipting, delivery and management process (where appropriate). However, there is no evidence that this has taken place and staff interviewed said no additional formal training had been provided. However, the improvement in stock processes on site, such as stock receipting, suggest informal training may have taken place. Management are aware of this lack of monitoring and already have in development a training package to formally monitor training within the division, including stock management. We suggest the Health Board continues and implements this training package.	Potential risk of: • Staff being unaware of their responsibilities leading mismanagement of stock potentially causing financial damage.	Agreed Action: • Implement and maintain training records (immediately) • Ensure all SOPs are version controlled, assessed for training needs and formally acknowledged by staff (immediately) Expected Evidence of Implementation: Readily available training records, SOPs and improved training uptake.
		Medium Priority	Officer: Rhys Shorney, Head of Facilities Date: 30th November 2024
	Theme: Training & Development	Control Design	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Archwilio Cymru
Audit Wales

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

Date issued: November 2024

Document reference: 3997A2024

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

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About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Charitable Fund Accounts 2023-24	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Underway	Nov 2024 – Audit Plan Nov/Dec - Testing Jan 2025 - Audit of Accounts report
Audit of Accounts 2024-25	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the Health Board.	Not started	To be confirmed

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment – Deep dive on financial efficiencies	Chief Executive Officer	In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.	Report in clearance with Health Board	January 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Part 1 – Regional report in external clearance Part 2 – Management response received, and report will be moving to final soon	January 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2024 - Core	Chief Executive Officer	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Report in draft	January 2025
Quality Governance Review Follow up (Local Work)	Executive Director of Nursing Medical Director Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Report in draft	January 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork in progress	March 2025
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Chief Executive Officer	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	March 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Eye Care Review (Local Work)	Chief Operating Officer	The precise focus of this work is still to be determined but will look to assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.	Scoping	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
The National Fraud Initiative in Wales 2022-23	**October 2024**
Welsh Language Report 2023-24	**September 2024**
Active Travel	**September 2024**
Affordable Housing	September 2024
Digital by Design?	August 2024
Community Pharmacy Data Matching Pilot	May 2024

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Annual Report and Accounts 2023/24	August 2024

Audit Wales

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Audit of Accounts Report Addendum – Aneurin Bevan University Health Board

Audit year: 2023-24

Date issued: October 2024

Document reference: 4508A2024

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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Audit of Accounts Report Addendum

Introduction

1 This report is an addendum to our Audit of Accounts Report that we presented to you on 11 July 2024. The report sets out the recommendations arising from our audit of the 2023-24 accounts and an update on the progress you have made against previous years' recommendations.

2 We should like to take this opportunity to once again thank all your staff who helped us throughout the audit.

Recommendations from this year's audit

3 We summarise in **Exhibits 1 to 4** our recommendations arising from our 2023-24 accounts audit.

Exhibit 1: matter arising 1

Matter arising 1 – Treatment of Pooled Budget transactions	
Findings	Following the use of the comparative Data Analytics tool, it was identified that the Health Board's "Local Authority" income in Note 4, was over double that of any other Health Board. A significant amount of this income related to Pooled Budget Income where the Health Board have included the transactions with the Pooled Budget, as well as the underlying expenditure incurred. Whilst our initial view is this treatment is incorrect, the guidance is not clear either way and so no amendment was sought.
Recommendation	Clarity sought from Welsh Government on the accounting treatment prior to 24-25 drafting.
Benefits of implementing the recommendation	Seeking clarity will ensure consistency across Health Board accounts and will ensure the financial statements accurately represent substance of the transactions.
Accepted in full by management	Accepted

Matter arising 1 – Treatment of Pooled Budget transactions	
Management response	Welsh Government were contacted prior to the submission of the 2023-24 Annual Accounts and confirmed that the pooled budget transactions should be shown gross in the accounts. This issue was raised at the Technical Accounting Group where further clarification regarding pooled budgets was requested to be include in the 2024/25 Manual for Accounts so that treatment across all Welsh NHS bodies is consistent
Implementation date	Draft Manual for Accounts – December 2024

Exhibit 2: matter arising 2

Matter arising 2 – Existence of Fixed Assets	
Findings	The Health Board is part way through an extensive process to tag their Vehicles, Plant and Equipment (VPE) Assets. During the audit we noted the following: • Many assets that had been tagged had not been scanned within last quarter of the financial year. This meant we were not able to take any assurance over the existence of the asset at year end. • The Fixed Asset Register did not include serial numbers for all assets so it is not possible to cross reference exact assets. • A number of VPE assets are grouped on the Fixed Asset Register. Whilst accounting standards allow grouping of assets for capitalisation purposes, it means administratively it can be difficult to track all of the assets, especially if one or more of the group are impaired or disposed of.
Recommendation	• Ensure there is a system in place to facilitate frequent and periodic scanning of assets.

Matter arising 2 – Existence of Fixed Assets	
	• Ensure all assets on the Fixed Asset Register have a serial number or equivalent unique identifier. • Ensure assets are listed on the Fixed Asset Register individually.
Benefits of implementing the recommendation	The process to tag assets will have maximum impact and the Health Board will have greater understanding on the location of their VPE assets.
Accepted in full by management	Partially Accepted
Management response	In line with the financial control procedure (approved in July 2024) periodic scanning will be carried out by Health Board staff to ensure that all main hospital and community sites are verified during the financial year. Current resources do not allow for all assets to be scanned within the last quarter of the financial year. The approved financial control procedure for capital assets requires assets that are unable to be verified or RFID tagged to be manually verified by departments in year. The work to update the asset register with unique identifiers and serial numbers for all assets has continued in 2024/25. The work to split grouped equipment assets into individual assets with unique identifiers has continued in 2024/25. IT assets are not currently within the scope of the RFID tagging project and are currently planned to remain as grouped assets within the asset register.
Implementation date	On-going

Exhibit 3: matter arising 3

Matter arising 3 – Senior Officer Remuneration	
Findings	During the audit we noted the following: • The Health Board did not have signed copies of the Senior Officer and Independent Member contracts readily available. • There were instances where pay issues had occurred during the year but there was limited supporting documentation when the details were requested.
Recommendation	• Signed versions of all contracts are retained and are available on request at the start of the audit • If any unusual instances occur during the year, information to be disclosed at the beginning of the audit alongside any relevant documentation.
Benefits of implementing the recommendation	Reduce the time taken to audit the Remuneration Report.
Accepted in full by management	Accepted
Management response	The points above were discussed at the 2023-24 Annual Accounts review meeting. Action will be taken in year to ensure that all contracts are retained and available to Audit Wales at the start of the audit Any unusual instances occurring in year will be highlighted to Audit Wales when the audit commences, with appropriate documentation provided.
Implementation date	September 2024

Exhibit 4: matter arising 4

Matter arising 4 – ProLease user reviews	
Findings	As part of the 2022-23 audit, we recommended that the NHS Wales should review the central access management and system administration process and put in place more formal 'business as usual' arrangements after the ProLease system was implemented Autumn 2023. This included controls over managing system access and password strength. During our audit for 2023-24 we identified that although there are now three people with system administration rights within NHS Wales, regular user access reviews do not take place. We have also identified some MRI users (the software provider) had been set up with ProLease access which the system administrators were not aware of. It is understandable that MRI staff have access to maintain the system, but the Health Board needs to ensure that all users are using the system appropriately. In addition, the Health Board should be monitoring the number of people with system access to confirm that only those that need access to the system actually have access.
Recommendation	The Health Board should undertake regular, for example, every six months, user access reviews of ProLease. The Health Board system admins (for Prolease) should also monitor the audit log for what actions any MRI users have taken and to regularly review users with MRI staff access.
Benefits of implementing the recommendation	Reduce the risks of inappropriate system access and use.
Accepted in full by management	Accepted

Management response	The Prolease User Group have agreed that the Audit Trail report, Last log in report and User Access Report will be reviewed quarterly. This will include monitoring of access by MRI users.
Implementation date	October 2024

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

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

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The People and Culture Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 to enable the Committee to:

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

Cefndir / Background

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

The Forward Work Programme Plan is designed to assist the Committee in the review of its programme of business. It captures the timing of report submissions, identifies items that have been deferred, and captures new requests for reports. The plan also allows the Committee to monitor and review its business at each meeting.

During the period of September to November the following requests and/or changes to the Forward Work Plan have been included:

Items deferred on the Forward Work Programme:

- Annual Review of Committee Effectiveness 2023/24 to include a review of the Terms of Reference.
- Review and report upon the adequacy of arrangements for declaring, registering, and handling interests.
- Receive full report of all offers of gifts and hospitality as declared.
- Receive the External Audit 2024 Structured Assessment.

Additions to the Forward Work Programme:

- No additions to note.

Asesiad / Assessment

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

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight.

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

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

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

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

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

ANNUAL PROGRAMME OF BUSINESS 2024/25

AUDIT, RISK & ASSURANCE COMMITTEE

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

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

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

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

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

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

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

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

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

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	12th Sept 2024	12th Nov 2024	18th Feb 2025
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			**10**	**15**	**15**	**12**	**16**	**24**
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	**BI**	Chair			√			√
Internal Audit Team	**BI**	Chair		√			√	
Local Counter Fraud Team	**BI**	Chair	√			√		

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

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

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

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