Audit, Risk & Assurance Committee

Thu 07 April 2022, 09:30 - 12:30

Microsoft Teams

Agenda

1. Preliminary Matters

1.1. Apologies for Absence

Verbal *Chair*

1.2. Declarations of Interest

Verbal *Chair*

1.3. Draft Minutes of the Meeting held on 03 February 2022

Attachment *Chair*

1.3 AFR minutes 03.02.22.SB Approveddocx (002).pdf (13 pages)

1.4. Committee Action Log

Attachment *Chair*

1.4 Audit Committee Active Action Log.pdf (7 pages)

2. Counter Fraud

2.1. Counter Fraud Annual Report 2021/2022

Attachment *Head Of Counter Fraud*

2.1 ABUHB Annual Counter Fraud Report 2021-2022.pdf (43 pages)

2.2. Counter Fraud Annual Workplan for 2022/2023

Attachment *Head of Counter Fraud*

2.2 ABUHB Annual Counter Fraud Workplan 2022-2023.pdf (32 pages)

3. Efficient and Effective Use of Resources

3.1. Update on Outpatient Transformation

Attachment *Outpatient Transformation Lead*

3.1 Outpatient Transformation Cover Report.pdf (12 pages)
3.1a Appendix 1 - Director of Operations Risks.pdf (5 pages)
3.1b Appendix 2 - Outpatient Transformation Plan.pdf (3 pages)

3.2. Status Update: Estates Efficiency Framework

Attachment *Director of Planning, (interim Performance) Digital and IT /Interim Director of Finance, Procurement & Value*

3.2 ARAC report_Estates Efficiency Framework Update_April 2022.pdf (3 pages)

4. Financial Governance and Assurance

4.1. Update on Governance, Financial Control Procedures and Technical Accounting Issues

Attachment *Assistant Director of Finance (Financial Systems & Services)*

4.1 Financial Governance Report -07 April 2022 .pdf (6 pages)
4.1a Appendix_1 FCP_ Charitable Funds_Issue 6.pdf (50 pages)
4.1b Appendix 2 STA - Audit Committee Summary Jan to March 2022 REDACTED.pdf (1 pages)

4.2. Losses and Special Payments Report

Attachment *Assistant Director of Finance (Financial Systems & Services)*

Includes: WP10HP and the recommendation to settle losses

4.2 Losses & Special Payments Report .pdf (6 pages)

5. Financial Planning and Performance

5.1. Finance Update (Month 11 2021/2022)

Attachment *Interim Director of Finance, Procurement & Value*

5.1 Finance Report _m11_AFRC_April 2022.pdf (21 pages)

5.2. Comfort Break 11:10 - 11:20

6. Corporate Governance, Risk and Assurance

6.1. Internal and External Audit Recommendation Tracking

Attachment *Director of Corporate Governance*

6.1a Procedure for Approval
6.1b Tracking Report, March 2022

6.1 IA and EA Tracker_Cover Report_March22.pdf (9 pages)
6.1a Appendix A_Draft for Approval_IA and EA Audit Recommendation Tracking Procedure_March22.pdf (9 pages)
6.1b Appendix B_Audit Recc Tracker_IA_EA_March22_Internal Overdue.pdf (15 pages)
6.1c Appendix C_Audit Recc Tracker_IA_EA_March22_External Overdue.pdf (3 pages)
6.1d Appendix D_Audit Recc Tracker_IA_EA_March22_Internal and External Not Yet Due.pdf (5 pages)
6.1e Appendix E_Audit Recc Tracker_IA_EA_March22_MASTER.pdf (23 pages)

6.2. Risk Management

Attachment *Head of Risk & Assurance*

6.2.1. Risk Strategy Realisation Plan

Attachment

6.2 Committee Cover Risk Management Plan Mar2022.pdf (6 pages)
6.2a Appendix 1 Risk management realisation plan March2022.docxV2.pdf (5 pages)
6.2b Appendix 2 FINAL ABUHB Risk Management Strategy.pdf (10 pages)

6.2.2. Committee Risk Report March 2022

Attachment

6.2c AFR Committee Cover Risk Report Apr2022 V1.pdf (5 pages)
6.2d Appendix 1 - Corporate Risk Regsiter OverviewApr2022.pdf (7 pages)
6.2e Appendix 2 - Master Updates March2022.pdf (16 pages)
6.2f Appendix 3 Ukraine Crisis March 2022.pdf (2 pages)

6.3. Committee Priorities 2022/2023

Presentation *Director of Corporate Governance*

7. NWSSP Audit & Assurance - Internal Audit & Specialist

Attachment *Head of Internal Audit*

7.1. Internal Audit Plan Progress Update

Attachment

7.1 AB Internal Audit Assurance Progress Report April 2022 for ARA Committee.pdf (10 pages)

7.2. Internal Audit Reports

Attachments *Head of Internal Audit*

7.2.1. Limited Assurance Reports

Attachment

Director of Nursing and Interim Director of Community, Primary Care and Mental Health will be joining for this item

7.2 ABUHB 2021-22 MH LD CHC FINAL Internal Audit Report v2.pdf (32 pages)

7.2.2. Reasonable Assurance Reports

Attachment

7.2a ABUHB_2021-22_GUH Quality Assurance_Final Report.pdf (21 pages)
7.2b AB 2021-22 - Falls Management FINAL Internal Audit Report.pdf (15 pages)
7.2c ABUHB 2021-22 FINAL Flu Immunisation Audit Report.pdf (14 pages)
7.2d ABUHB 2021-22 FINAL Risk Management Report for client.pdf (18 pages)

7.3. Internal Audit Plan 2022/2023 for Approval

Attachment *Head of Internal Audit*

7.3 ABUHB_2022-23_Draft Internal Audit Plan_for April 2022 AFR Committee.pdf (30 pages)

8. External Audit

8.1. Performance Update Report

Attachment *Audit Wales*

8.1 Audit Finance Risk Committee Update_April 2022.pdf (10 pages)

8.2. External Audit Plan 2022/2023 for Approval

Attachment *Audit Wales*

8.2 ABUHB 2022 Audit Plan 2022-23.pdf (14 pages)

8.3. For Noting

Attachment *Director of Corporate Governance*

8.3.1. Recommendations: Audit Wales Report Welsh Health Specialised Services Committee Governance Arrangements Audit Tracker - Update January 2022

8.3 HB Board Secretaries - WHSSC AW tracker governance report 31 Jan 2022.pdf (5 pages)
8.3a Appendix 1 - Audit Wales WHSSC Governance Tracker.pdf (24 pages)

8.3.2. Committee Terms of Reference 2022/ 2023

8.3b Audit, Risk & Assurance Committee_March2022.pdf (13 pages)

9. Close of Meeting

Date of Next Meeting:
17 May 2022 09:00 - 10:30 MS Teams
Draft Accounts

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Finance, Audit & Risk Committee held on Thursday, 3rd February 2022 at 9.30 am via Teams

Present:

Shelley Bosson	Independent Member (Chair)
Richard Clarke	Independent Member (Vice-Chair)
Paul Deneen	Independent Member
Katija Dew	Independent Member

In attendance:

Rani Mallison	Board Secretary
Rob Holcombe	Interim Director of Finance
Gwen Kohler	Assistant Finance Director (Financial Systems & Services)
Danielle O'Leary	Head of Corporate Services, Risk and Assurance/Secretariat
Simon Cookson	Head of Internal Audit
Stephen Chaney	Deputy Head of Internal Audit
Darren Griffiths	Audit Manager (Performance), Audit Wales
Nathan Couch	Audit Wales
Andrew Strong	Audit Wales
Tracy Veale	Audit Manager (Finance), Audit Wales
Sarah Simmonds	Director of Workforce and OD
Adrian Neal	Consultant Clinical Psychologist
Peter Carr	Director of Therapies and Health Science
Collette Kiernan	Clinical Director of Therapy Services
Sam Haworth-Booth	
Nicola Prygodzicz	Director of Planning, Digital and ICT
Janice Jenkins	Interim Assistant Director of Digital Programmes

Apologies:

Glyn Jones	Interim Chief Executive

	Preliminary Matters
AC 0302/02	**Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted.
AC 0302/03	**Declarations of Interest** There were no Declarations of Interest to record.
AC 0302/04	**Draft Minutes of the Meeting held on 2nd December 2021**

	The minutes were agreed as a true and accurate record Subject to page 9; there was an action for the Board Secretary in relation to record keeping. The Board Secretary commented that in relation to this specific action, the Mental Health Act Monitoring Committee agenda setting meeting had happened and this action was therefore closed. However, a broader comment around all committee remits and work plans was made, and the Board Secretary suggested this was resolved as part of the Board's Effectiveness Review. **ACTION: Board Secretary**
AC 0302/05	**Action Sheet** The Board Secretary presented the Committee action sheet, and it was noted that the action sheet had been 'RAG' rated; a number of actions related to ongoing developments, and these would come through to this Committee at the following meeting in April 2022. The action "Audit of Accounts Addendum to be updated to reflect the updates and reissued" was noted as complete. An update against the ICT related actions included within the addendum would be covered under the Digital Systems, Efficiencies and Benefits Realisation Update Report. Katija Dew requested that the work plans be appended to the Committee papers to ensure the Committee is content that all relevant items are being addressed. It was agreed that this would form a standing item on all Committee agendas going forward. **ACTION: Board Secretary**
AC 0302/06	***"Taking Care of Carers How NHS bodies supported staff wellbeing during the COVID-19 Pandemic"*** – **ABUHB Management Response** Sarah Simmonds, Director of Workforce and Organisational Development, and Adrian Neal, Consultant Clinical Psychologist, presented the Committee with the Health Board's management response to the national audit. Broadly, the Health Board agreed with the recommendations. It was noted that the Health Board would continue to develop the staff and wellbeing strategy in conjunction with the continued use of the COVID risk assessment tool, further promotion of partnership working acknowledging the duty of care to the staff. Sarah Simmonds commented that staff wellbeing was difficult to measure, and the current measures were not necessarily an indication of wellbeing, and the Health Board should consider what the longer term response needed to consist of. Adrian Neal confirmed that there were a broad range of services available including a bespoke pathway for staff who have experienced psychological trauma during the pandemic. It was noted that to-date, there had been 60 members of staff who had been supported via this pathway and an evaluation was being undertaken to determine the outcomes. Access to the wellbeing service for staff was reported as positive, noting that 96% of referrals were seen within 6 months complimented by a 93% recovery rate of staff accessing and completing therapy. It was confirmed that ABUHB was the only Health Board in Wales to offer this service to staff and evaluation

	and monitoring would be undertaken to explore further ways of supporting staff. Paul Deneen, Independent Member, queried what the impact of long-COVID on the workforce was and if there would be support provided for staff called to provide evidence for the pending COVID Inquiry. Sarah Simmonds responded that there were currently 49 members of staff absent due to long-COVID and the Health Board continued to monitor this staff group, supported by the Director and Assistant Directors of Therapies. There were a small proportion of staff who had been absent for longer than 6 months and this was being managed through usual absence management arrangements. Diagnosis of and disabilities associated with long COVID had yet to tested through an employer tribunal and no formal advice had been provided as yet. However, the Health Board would be receptive to any precedents or any learning available. In respect of the pending COVID Inquiry, usual support arrangements for staff called to give evidence would be enabled. It was noted that Executive Team were currently looking at this and alongside Legal and Risk colleagues. It was also confirmed that Employee wellbeing remained a standing item on the People and Culture Committee agenda and the Board checklist within the report would be considered by the People and Culture Committee. It was agreed that this action would be communicated to the relevant Secretariat. **ACTION: Committee Secretariat/People and Culture Committee** Katija Dew, Independent Member, commented that it was positive to note that liaison with equality forums had been undertaken as not everyone would have responded the same to the staff survey. Sarah Simmonds updated the Committee that a 'People First' session was scheduled with Executive Team on 1st March 2022. Further development work to increase the capacity of the Health Board staff wellbeing service was underway with a previous capital bid to Welsh Government for an additional 8 WTEs being re-submitted in the near future. The Committee **NOTED** the management response and further planned actions.
	Counter Fraud
AC 0302/07	**Bi-Annual Counter Fraud Progress Report** Martyn Edwards, Head of Counter Fraud, presented the Committee with a half yearly progress update. The Committee was advised that awareness raising exercises and team promotion had been undertaken recently as a result in a deficit of investigations. This had been undertaken using the intranet and newsletters to staff. The Committee was reminded that the counter fraud team covered all primary care contractors and newsletters had been distributed to pharmacies, GP Practices and were going to all dental surgeries. This was also supplemented by presentations delivered by the counter fraud team. The Committee was made aware that the Crown Prosecution Service (CPS) had lessened the prosecution rates since before the pandemic. The

	Committee was assured that the way in which investigations were conducted had not changed, neither had the evidence provided to the CPS. It was explained that all cases presented to the CPS needed to pass a two-tier test, the first being an evidential test and the second being a public interest test. It was confirmed that the cases rejected by the CPS had not passed the second tier of the test. Paul Deneen raised concerns at this juncture and the Director of Finance and Procurement confirmed that he would explore this further to determine if this was also an emerging pattern across Wales. **ACTION: Director of Finance and Procurement** The Head of Counter Fraud indicated that he had liaised with his counterparts across Wales in relation to overpayment of salary issues. It was noted that this appeared to be a national challenge and the Director of Finance had indicated that he was keen for remedial action to be undertaken as soon as possible. Katija Dew commented that overpayments of salaries had been raised previously and there were system failures identified. She suggested that an approach to encourage managers to manage this appropriately should be established. It was queried if there were other deterrents in place other than disciplinary actions, for example, if departmental budgets could be impacted if persistent overpayments of salaries could be attributed to specific departments. It was confirmed that this was not something the Health Board would consider however, the issue around overpayments of salaries needed to be robustly addressed. Strengthened liaison with managers responsible for budgets and links with their respective financial reports, should provide some indication of where there may be overpayments of salaries. It was agreed that the Director of Finance and Procurement and the Head of Counter Fraud would liaise with ESR workforce colleagues and Shared Services to further streamline the termination/new starter process for managers. **ACTION: Director of Finance, Procurement & Value /Head of Counter Fraud** The Committee thanked the Head of Counter Fraud for the report and **NOTED** its contents for **ASSURANCE.**
	Efficient and Effective Use of Resources
AC 0302/08	**Muskulo Skeletal (MSK) Pathway Redesign** The Committee was advised that the previously circulated paper was a further development based on the proposal for MSK previously presented and endorsed at the Audit, Finance and Risk Committee at the April 2021 meeting. It was also noted that MSK would be listed as an organisational priority in IMTP and risks associated with this priority were being managed locally at this point. Peter Carr, Director of Therapies and Health Science, provided some context for the Committee and it was advised that the Executive Team had originally approved a £1.8million investment in to the MSK programme, the proposal outlined a request for the work that had already been undertaken to continue and The Director of Therapies and Health Science would remain as the Executive lead. The MSK transformation programme had developed an upstream, community, therapy led pathway which provided 'end to end' care and was

	described as 'phase 1' within the proposal. The Committee acknowledged that there was now a Programme Management Office (PMO) function in place that formed part of Corporate Planning and provided further resilience to the MSK programme. Peter Carr commented that the most significant area to now focus on was secondary care. It was confirmed that all Care Aims would be applied, and the programme leads were aware that in doing this work, unmet need would be identified. Peter Carr confirmed that the previous principles of the MSK programme would remain, these were: • Effective use of patient outcomes data (PROMS & PREMS) • Engagement with all key stakeholders including GPs • Engagement and liaison with Health Board related services • Continued monitoring of Key Performance Indicators. • Communicate any findings nationally for interest and ensure continued engagement for benchmarking and evidence of best practice. Collette Kiernan, Assistant Director of Therapies and Health Science, presented the Committee with a power-point highlighting the benefits realisation (including cost avoidance/efficiencies) and key risks to delivery. These were noted as the following: **Benefits:** • Improved patient experience • Improved patient outcomes • Reduced waiting times for MSK specialists • Equitable access to therapies across Gwent • Therapy management for urgent primary care/MIU attendances • Reduction in duplicated/inappropriate diagnostic requests from GPs • Reduction in referral redirection • Staff sustainability plan **Risks:** • Recruitment • Accommodation • Inefficient ICT systems • Untested model • Value assessment • Internal communications It was agreed that in order for the transformation programme to be successful, the Health Board would need to ensure that the stated benefits were realised, demonstrate successful influence on the national programme whilst continuing to delivery on key performance indicators. The Chair commented that this was an excellent piece of work with a significant amount of potential to be realised. Katija Dew was pleased to note the cohesion across finances, patient experience and positive impact on primary care colleagues. The Director of Finance and Procurement suggested that if this transformation programme could be realised, the story would be compelling

	and allow for further shared learning. It was agreed that MSK transformation programme would be added to a future Board Briefing Session. **ACTION: Board Secretary** Paul Deneen queried where patients could access this pathway. Peter Carr responded that the initial thoughts were that the clinical service would be provided through embedded, already established community service settings. There was an issue in relation to accommodation for the admin and clerical staff and initial discussions around linking to urgent primary care colleagues was being undertaken. The Committee **NOTED** and **AGREED** the update and proposal and agreed that MSK transformation would be added to the Committee work programme for an update on progress on the specific areas of interest to the Committee as outlined within its Terms of Reference, in 12 months-time. **ACTION: Secretariat**
AC 0302/09	**Digital Systems, Efficiencies and Benefits Realisation Update Report** Nicola Prygodzicz, Director of Planning, Digital and ICT, provided the Committee with an update on the previously highlighted action from the December 2021 Committee meeting. The Committee was advised that in light of the addendum to the Audit Wales Annual Accounts Audit, there had been an issue involving the number of servers the Health Board had been using. As a result, 5 ICT audit recommendations were made, and some queries were raised at the previous Audit, Finance and Risk Committee regarding the management response. Nicola Prygodzicz advised that in September 2018 the Health Board had 120 servers, this had been successfully reduced to 7, in line with the recommendation. Further work needed to be undertaken to continue to reduce the number of servers, and this was primarily due to local service areas using service specific systems. Decisions were required within the service areas on how they want to proceed with their respective applications; Cardiology, Glucose meters as examples, the third-party applications did not support later OS versions. The Committee was advised against the remaining recommendations: • Capital funding had been provided by the Health Board to support eradication of remaining devices over the last few weeks. The Health Board was currently awaiting delivery of the equipment to replace these. • Key Performance Indicators would be included in the monthly/quarterly reporting to the ICT management team and in the next digital delivery oversight board. In respect of the Digital Systems update and the Health Board's Digital Strategy, the Committee noted that an update on progress made had been shared with the Committee in April 2021. The following key points of further progress were noted: 1. A refresh of the infrastructure had been undertaken 2. Increased debate on Welsh Digital Portal and an enhanced national focus on this was anticipated for the next few years.

	3. The informatics directorate had conducted its own internal review and as a result the department had been restructured and was currently in the strategy, planning and design phase. 4. Further discussion on priority areas needed to be instigated as there was a recognition that the resource was not available to prioritise all areas. Paul Deneen queried the Health Board's position if a benchmarking exercise was conducted. It was confirmed that the levels of integration internally, were ahead on some aspects in comparison to other Health Board. The Committee specifically noted that in relation to WCCIS the Health Board was the furthest ahead; in respect of RPA, the Health Board was leading on this. Initiatives such as CareFlow and Attend Anywhere, were further examples of where the Health Board had taken a lead. The Committee was advised that progress in relation to Clinical Workstation (CWS) was where the Health Board was least developed. The Chair noted the progress, however indicated that further metrics would be welcomed to provide clarity on where the cash-releasing savings were being achieved. Nicola Prygodzicz confirmed that the Health Board was attempting to measure the outcomes and benefits although, some measures were more challenging to quantify. It was agreed that this item would be added to the Committee forward work programme for a further update. The Secretariat would liaise with Nicola Prygodzicz to determine an appropriate date. **ACTION: Secretariat/Director of Planning, Digital and ICT** The Committee thanked the Director of Planning, Digital and ICT for the updates and **NOTED** them for **ASSURANCE.**
	Corporate Governance, Risk and Assurance (part 1)
AC 0302/11	**Audit Recommendations Tracker** The Committee **RECEIVED** the proposal to monitor and track recommendations with clear principles around timeliness and content of management responses. The Committee was advised that the recommendations outlined in the report was also due to be presented to Executive Team later that day, for consideration and comment. It was proposed that a final version of the audit recommendations tracker proposal be presented to the Committee at the April 2022 meeting. The Committee **AGREED** with the principles outlined within the report subject to inclusion of the practice note developed by all Chairs of Audit Committees which had previously been adopted, being included in a future iteration. It was agreed that this would be captured along with specific processes for the role of Patient Quality, Safety and Outcomes Committee in receiving oversight of recommendations raise via inspections and unannounced visits in the revised version to the Committee in April 2022. **ACTION: Board Secretary**
AC 0302/12	**Update on Governance and Financial Control Procedures** The Committee was requested to **NOTE** the standard report and **APPROVE** the proposed changes to the Oversees Visitors Policy. Changes had been made due to some changes in legislation and associated resources.

The Committee was asked to note the key dates for consideration and submission of final annual accounts and end of year reporting:

Annual Reports 2021/22 - Key Dates		**2022**
First draft Performance Report and Accountability Report for consideration by Exec Team	Thurs	28-Apr
Unaudited accounts and associated returns to WG	Fri	29-Apr noon
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	Fri	06-May
Draft Reports to Audit Committee Members	Tue	10-May
Audit Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tue	**17-May**
Final Accounts & Accountability Report to Audit Committee Members	Mon	06-Jun
Audit Committee meeting to Consider Final Accounts, and Accountability Report	Mon	**13-Jun**
Board meeting to approve Final Accounts and Accountability Report	Tues	**14-Jun**
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Wed	**15-Jun noon**
Annual General Meeting – to receive the Annual Report and Accounts	Wed	**27-Jul**

The Committee was advised that the Health Board had continued to achieve the Public Sector Payments target of 95% and noted the Single Tender Actions taken since the last reporting period.

The Chair queried how the Committee could gain assurance that the Health Board had received value for money in respect of some Single Tender Actions and specifically in relation to the contract that was awarded extension to the car park as there would have been multiple contractors with the ability to undertake this work. The Committee requested clarity on why the contract was awarded in that way. It was agreed that this was something Finance colleagues should consider and report back to the next Committee.
ACTION: Director of Finance, Procurement & Value /Assistant Finance Director

The Committee **ENDORSED** the proposed changes to the Overseas Visitors Policy and **APPROVED** the report.

AC 0302/13	**Losses and Special Payments Report** The Committee received the standard report and noted financial position in respect of losses and special payments as at end of December 2021. The Committee **NOTED** the report for **ASSURANCE**.
	Financial Planning and Performance
AC 0302/12	**Finance Report** The Committee was presented with the Month 9 financial report. It was highlighted that the Health Board had reported a projection of financial balance by year end with a favourable underspend of £100,000 for the year to date. It was explained that financial balance is largely due to the COVID funding received from Welsh Government. Key points identified; - covid funding anticipated had now been confirmed and received from WG - variable pay spend had increased due to significant staff absences due to isolation resulting from increased staff COVID infection rates and continued urgent care pressures - savings achievement is in line with plan - uncertainty of future operational pressures due to Omicron response and impact on recovery delivery - the need to improve the underlying financial position to support future sustainability The Director of Finance, Procurement & VBHC (DoF) advised that a recent budget allocation letter had been received from Welsh Government which would afford the Health Board the opportunity to improve its underlying position. It was highlighted that the Health Board would not receive the same level of funding to be made available from Welsh Government next year and this will present a significant challenge. The DoF confirmed that there will be a significant challenge in relation to the emerging financial forecast predicted for 2022/23. There is Executive Team consensus to refresh the HB approach to operating efficiently and re-engage with staff in relation to the management of resources. A programme of work is being developed including OD, structural support, education and reporting mechanisms to progress improved resource utilisation and efficiency through the priority transformation programmes. It was agreed that an update on this would be presented to the Committee at its next meeting. **ACTION: Director of Finance, Procurement & Value** The Committee **NOTED** the Month 9 financial report.
	Corporate Governance, Risk and Assurance (part 2)
AC 0302/14	**Committee Risk Report** The Head of Risk and Assurance outlined the key points and updates of the report, including:

	• National Once for Wales (OfW) development of a risk management specific module; • Continued embedding of the Risk Management Strategy and associated delivery framework within operational and Divisional teams; • Current, high level, status of all strategic risks; and, • Update position of previous internal and external audit recommendations. Committee members noted the improvements made to date in regard to the previous internal and external audit recommendations. Members commented that the report was becoming more meaningful and useful in respect of providing assurance on how risks were managed within the Health Board. The Committee was advised that an additional paper outlining the key milestones for delivery and implementation of the risk management strategy, including the implementation of the Once for Wales (OfW) risk management module, would be provided to the Audit, Finance and Risk Committee at the April 2022 meeting. **ACTION: Head of Corporate Services, Risk and Assurance** The Committee **NOTED** the report for **ASSURANCE**.
	NWSSP Audit and Assurance – Internal Audit and Specialist Service Unit
AC 0302/15	**Internal Audit Plan Progress Update** The Committee was advised that there were 37 reviews planned for 2021/22 internal audit plan and the following table details the progress against each:

Number of audits in plan:	37
Number of audits reported as final	12
Number of audits reported in draft	2
Number of audits in progress	13
Number of audits at planning stage	3
Number of audits not started	6
Number of audits deferred	1

Within the report, Internal Audit had requested the deferral of the following audits:

1. Catering;
2. Agile Working;
3. Monitoring Action Plans;
4. Clinical Futures – Care Closer to Home; and
5. Quality Framework.

	In addition, an advisory report had been requested by the Director of Nursing over a current area of concern. If approved by the Audit, Finance and Risk Committee an assessment of Continuing Healthcare (CHC) for Children will commence during quarter four. The Head of Internal Audit advised that there were several audits which were due to be presented to the April Audit, Finance and Risk Committee. The Committee was advised that the Head of Internal Audit Opinion was hopeful to achieve a reasonable rating. Committee members queried how Internal Audit planned to prioritise the deferred audits and it was agreed that they would prioritised using the Board Assurance Framework and areas of most significant risk. The Committee **APPROVED** the deferral of the five audits and the commencement of Continuing Healthcare for Children.
AC 0302/17	**Internal Audit Review, reasonable Assurance: Welsh Radiology Information System** The Committee **NOTED** the reasonable assurance report.
	External Audit
AC 0302/18	**Performance Update Report** The Committee was presented with the Audit Wales Performance Update report and noted the work already completed, work which had commenced, and planned work not yet started. The Committee was advised that the efficiencies report would be reported to the April 2022 Committee meeting. The chair commented that she found the key messages from recent publications very helpful. The Committee **NOTED** the report for **ASSURANCE**.
AC 0302/19	**Structured Assessment** Nathan Couch, Audit Wales, presented the Committee with the findings from the 2021 Structured Assessment Report. The focus of the work was on 3 main areas: governance arrangements, financial management and planning arrangements. An update was also sought on progress in relation to previous Structured Assessment recommendations. Fieldwork was conducted between August 2021 and October 2021 and a final draft report for clearance was issued at the beginning of January 2022. The key messages from the report were recorded as: • The Health Board has adequate Board and Committee arrangements but should address issues around its website content and capacity and resilience in its Corporate Governance Support Team.

	• Embedding of the new governance structure continues and the Health Board intends to review its effectiveness by April 2022. • The Health Board has gone through a period of high turnover amongst its senior leaders at Board-level whilst also holding a number of Independent Member vacancies. The Health Board should manage the risks associated with this turnover; particularly given the significant operational challenges it is facing currently. • It has further revised its Board Assurance Framework, and risk management strategy and approach. However, embedding the new approach will take time. • The Health Board is strengthening its arrangements for employee wellbeing, however, there are opportunities to strengthen quality and patient safety reporting around services the Health Board commissions and arrangements for tracking internal and external audit recommendations. • The Health Board has successfully met its financial duties over the past three years and achieved its revised savings target despite the pandemic. It is also predicting to break-even during 2021-22. • The Health Board has effective financial planning arrangements and the 2021-22 plan reflects the exceptional nature of the pandemic and the uncertainties in response and recovery. • The continuing impact of the COVID-19 pandemic has led the Health Board to revise its initial savings target. As a result, the underlying financial deficit brought forward from 2020-21 of £20.8 million remains and will not improve during 2021-22 due to in-year cost pressures and continuing financial pressure. This represents a risk to the financial sustainability of the Health Board as savings will need to be achieved in future years to reduce the underlying deficit. • The Health Board has generally effective financial controls, monitoring and reporting arrangements. • The Health Board's arrangements for developing and submitting its annual plan are reasonable. The plan incorporates learning from the pandemic and outlines a strategic approach to providing healthcare in the region. • There are clear strategic objectives underpinned by a set of outcomes and measures to achieve them. However, the plan lacks target / dates and milestones to enable the Health Board to monitor and track progress against the various measures and ensure intended priorities and outcomes are achieved. • The Health Board is developing a monitoring and outcomes framework; however, this work has not been finalised, due to the impact of the pandemic, resulting in limited oversight and scrutiny on overall delivery against priorities outlined in its Annual Plan at Board-level. • However, the Annual Plan has been used to inform Board and Committee business, with assurance on individual strategic objectives provided at different points of the year. Five recommendations were concluded as a result of the Structured Assessment and the Health Board has agreed appropriate actions and implementation dates to progress these. Katija Dew recommended that the Strategy, Planning, Partnerships and Wellbeing Group of the Board become an assuring Committee of the Board

	with a particular focus on strategic partnerships. It was agreed that this would be considered via the Board and Committee effectiveness review in April 2022. **ACTION: Board Secretary** The Committee **RECIEVED** the Structured Assessment Report and Management Response for **ASSURANCE.**
AC 0302/20	**Annual Audit Report 2021** Audit Wales presented the Committee with the Annual Audit report and clarified that in respect of the financial statements, the Auditor General had signed this on 28th January 2022, which was before the deadline of 31st January 2022. The Board Secretary thanked the auditors for their work during a time of significant pressures. The Committee **RECEIVED** the report for **ASSURANCE**.
AC 0302/18	**Date of Next Meeting**
	The date of the next business meeting was noted as: - Thursday 7th April 2022 via Microsoft Teams.

Audit, Risk & Assurance Committee Action Sheet

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.

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

Outstanding	In Progress	Not Due	Completed	Referred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
August 2021	**AC 08/**	**Risk Management Strategy and Framework** The Committee welcomed the approach and for assurance requested staff feedback on the mechanisms being put in place. A review of how best to measure and capture staff feedback to be considered.	**Head of Risk and Assurance**	**March 2022**	**Completed.** **Taken to Board 23.03.22** Paper received for April meeting.
October 2021	**AC 0710/01 1.5**	**Committee Work Plan** Circulate to members the revised work plan with the inclusion of the following • Risk and BAF • Action log to be transposed into regular reporting • Provide clear visibility for the full year • Reporting of FOIs to be added	**Board Secretary**	**April 2022**	**Completed.** **Taken to Board 23.03.22**
		Review the work programme and indentify items that could be consolidated into single agenda items.			
		Share the Forward Work Programme with internal and external auditors			
		A standardised form capturing risks and assurances to be developed and shared with Committee Chairs for reporting to the AFR Committee.			

Outstanding	In Progress	Not Due	Completed	Referred to another Committee

October 2021	**AC 0710/02 2.1**	**Follow-up Outpatient Transformation** A progress report on the outpatient transformation (effective and efficient use of resources and risk) to be received April 2022	**Director of Operations, Outpatient Transformation Lead Outpatient Clinical Lead** **Secretariat**	**April 2022**	**Completed.** Paper received for April meeting
October 2021	**AC 0710/02 2.2**	**Agile Working:** The Committee requested an environmental impact assessment take place, linking with the Green Health Group	**Assistant Workforce Director**	**April 2022**	**Completed.** Included in the paper for April meeting.
		Agile Working A further update to come back to the Finance Audit and risk Committee, alongside the Estates Strategy.	**Assistant Workforce Director**	**April 2022**	**Completed.** Paper received for April Meeting linked with the Estates Strategy/Efficiency Framework
December 2021	**AC 0212/07**	**Estates Efficiency Framework** A progress report on implementation of the Framework, together with the governance arrangements to be received in February/April 2022 along with a progress report on implementation of the Agile Working Framework.	**Secretariat**	**April 2022**	**Completed.** Paper received for April meeting.
February 2022	**AC 0302/05**	**Action Sheet** Work plans to be a standing item on all Committee agendas	**Board Secretary**	**April 2022**	**Completed.** Added as a standard item.

Outstanding	In Progress	Not Due	Completed	Referred to another Committee

February 2022	**AC 0302/06**	**Taking Care of the Carers** Inform the secretariat that employee wellbeing is to remain a standing item on the People and Culture Committee agenda and the Board checklist within the report.	**Board Secretary**	**March 1st**	**Completed. Secretariat notified.**
February 2022	**AC 0302/07**	**Counter Fraud** Expolore the position of other Health Boards on cases not passing the public interest test to determine if there is an emerging pattern across Wales.	**Director of Finance, Procurement & Value**	**April 2022**	**Completed.** It has been confirmed that this is an emerging pattern across Wales and is not unique to ABUHB. Information on all rejected cases across Wales has been collated and the Manager of Counter Fraud Service (Wales) who is the liaison point with the CPS, proposes to meet with the Head of the CPS Specialist Fraud Division to discuss concerns. Contact to-date with the CPS has established that following the pandemic, the backlog of cases with the Department of Justice is extreme and the CPS are striving to reduce that backlog by reducing the number of new cases which are adding to that process.

Outstanding	In Progress	Not Due	Completed	Referred to another Committee

February 2022	**AC 0302/07**	Liaise with ESR workforce colleagues and Shared Services to further streamline the termination/new starter process for managers	**Director of Finance & Procurement Head of Counter Fraud**	**April 2022**	A local proactive exercise and risk assessment is currently being undertaken by Counter Fraud which involves Corporate Finance and Payroll Services. This LPE is still work in progress and is projected to be completed by month end March 2022 when outcomes will be actioned and reported back to Audit Committee.
February 2022	**AC 0302/08**	**MSK Pathway Redesign** MSK transformation programme to be added to a future Board Briefing Session	**Board Secretary**	**Before Feb 2023**	**Completed.** Scheduled for 24th August 2022.
February 2022	**AC 0302/08**	MSK transformation would be added to the Committee work programme for an update on progress in 12 months-time	**Secretariat**	**Feb 2023**	**Completed**. Added to forward work programme as agreed with Director of Therapis & Health Science.
February 2022	**AC 0302/09**	**Digital Systems** Add to the Committee forward work programme for a further update as advised by DoPD&ICT	**Secretariat Director of Planning, Digital and ICT**	**TBC**	Awaiting confirmation on date from Director of Planning, Digital and ICT. October and December 2022 offered.
February 2022	**AC 0302/11**	**Audit Recommendations Tracker** The practice note to be included in a future iteration along with specific processes for the role of Patient Quality, Safety and Outcomes Committee in receiving oversight of recommendations raise via inspections and unannounced visits in the revised version to the Committee.	**Board Secretary**	**April 2022**	**Completed.** Included in Audit Recommendations Tracker item on the agenda.

Outstanding	In Progress	Not Due	Completed	Referred to another Committee

February 2022	**AC 0302/12 6.1**	**Governance and Financial Control Procedures** Clarity on how the contract was awarded for the car park expansion at GUH	**Director of Finance, Procurement & Value** **Assistant Finance Director**	**April 2022**	**Completed.** Members emailed 18.03.2022 with following update. Laing O'Rourke preliminaries were not included in the order of cost provided for extending the temporary car park as Laing O'Rourke staff were already present on site completing other elements of work that were programmed to be carried out at the same time. This formed the basis of the original procurement and construction of the car park as preliminary costs were minimised, together with benefiting from Laing O'Rourke's knowledge and experience of the site. In the event that Laing O'Rourke were required to complete the car park as a standalone project the staff costs would be in the region of 9k a week, based on a Project Manager, Site Engineer, Quantity Surveyor and Electrical Engineer. As a result an estimated £9k per week would be avoided by using this contractor.
February 2022	**AC 0302/12 6.2**	**Finance Report** An update on the programme of work being developed including OD, structural support, education and reporting mechanisms to progress improved resource utilisation and efficiency through the priority transformation programmes.	**Director of Finance, Procurement & Value**	**April 2022**	**Completed.** Paper received for April meeting.

Outstanding	In Progress	Not Due	Completed	Referred to another Committee

February 2022	**AC 0302/14**	**Committee Risk Report** A paper outlining the key milestones for delivery and implementation of the risk management strategy, including the implementation of the Once for Wales (OfW) risk management module	**Head of Corporate Services, Risk and Assurance**	**April 2022**	**Completed.** Paper received for April meeting.
February 2022	**AC 0302/19**	**Structured Assessment** As part of the Board and Committee effectiveness review the Strategy, Planning, Partnerships and Wellbeing Group to become an assuring Committee of the Board with a particular focus on strategic partnerships.	**Board Secretary**	**April 2022**	**Completed.** Agreed by the Board.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Audit, Risk & Assurance Committee Thursday 7th April 2022 Agenda Item:2.1

Aneurin Bevan University Health Board
Annual Counter Fraud Bribery & Corruption Report 2021/22

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit, Risk and Assurance Committee. It highlights the Counter Fraud work which has been undertaken by the Local Counter Fraud Specialist (LCFS) for 2021/22.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	√		
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	√		
Executive Sponsor: Robert Holcombe, Interim Director of Finance and Procurement			
Report Author: Martyn Edwards, Head of Counter Fraud			
Report Received consideration and supported by : DoF			
Executive Team		**Committee of the Board [Committee Name]**	**Audit, Risk and Assurance Committee**
Date of the Report: 18th March 2022			
Supplementary Papers Attached: None			

Purpose of the Report

To comply with the below standards, which require the LCFS to provide a written report to the LHB (at least annually) on Counter Fraud work to illustrate compliance, outcomes and learning.

Background and Context

This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to comply with legal directions and the NHS requirements of Government Functional Standard 013: Counter Fraud.

Assessment and Conclusion

This report will form the basis of the annual Quality Assurance Self-Review as evidence that ABUHB has complied with the aforementioned Government Functional Standards.

Recommendation

This report is intended for Audit, Risk and Assurance Committee information and views.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	N/A
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	N/A
Link to Integrated Medium Term Plan/Corporate Objectives	N/A
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** N/A
	Integration – N/A
	Involvement – N/A
	Collaboration – N/A
	Prevention – N/A
Glossary of New Terms	N/A
Public Interest	N/A

ABUHB Audit Committee
Thursday 7th April 2022
Agenda item 2.1

On behalf of

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD BRIBERY & CORRUPTION REPORT

1st April 2021 to 31st March 2022

Martyn Edwards
Head of Counter Fraud
Aneurin Bevan University Health Board

CONTENTS

Page

1. Management Summary

1.1. The annual report for the period 1st April 2021 to 31st of March 2022 has been written in accordance with the provisions of the WG Directions on Counter Fraud Measures (WHC 095 of 2005) which require Local Counter Fraud Specialists (LCFS) to provide a written report, at least annually, to the LHB on Counter Fraud work. The report content and style used complies with the model prescribed by the NHS Counter Fraud Authority (NHSCFA) formerly NHS Protect and predecessor organisation NHS Counter Fraud Security Management Service (CFSMS).

1.2. Effective from April 2010, following the reorganisation of the NHS in Wales, Martyn Edwards was appointed as Head of Counter Fraud for Aneurin Bevan LHB and assumed the role of Lead LCFS assisted by support LCFS.

1.3. In relation to the support LCFS, Joanne Bodenham was appointed in 2011 which impacted upon year 2011 onwards, whereas Gareth LAVINGTON was appointed in 2019.

1.4. Martyn Edwards completed his Counter Fraud training in February 2009 and was accredited in March 2009. Joanne Bodenham completed her Counter Fraud training in 2011 and became accredited that same year. As a replacement team member, Gareth LAVINGTON was appointed on 4th November 2019, and successfully completed the National Counter Fraud Foundation Training. This resulted in University approval for accreditation as a Counter Fraud Specialist with the Professional Accreditation Board and subsequent nomination as a Counter Fraud Specialist with the NHSCFA on 6th January 2021.

1.5. In total, 595 Counter Fraud days were provided for Aneurin Bevan University Health Board during 2021/22. This breaks down across the standards key framework as follows: strategic = 121 days, proactive counter fraud practices = 221 days, reactive counter fraud practices = 253 days.

1.6. The aforementioned provision of Counter Fraud days was devoted to a workplan which contained 535 days spread across the key framework which was provided by 2.8 WTE LCFS's as defined in the corporate structure outline. Therefore the actual number of days provided by the LCFS for 2021/22 exceeded the expectation of the workplan by 60-days. The workplan itself was approved by the DoF in accordance with the legal directions and the NHS counter fraud manual and the workplan was ratified by Audit Committee.

1.7. During the period 1st April 2021 to 31st March 2022, Aneurin Bevan University Health Board Counter Fraud team handled **forty-six (46)** investigations into potential fraudulent or corrupt activity, which included cases brought forward from 2020/21. These cases are listed at **Appendix 2** (index of investigations).

1.8. **Thirty-three (33)** of those cases involved instances of staff related issues, which for the most part, the main categories were working whilst on sick leave, falsification of timesheets/expenses and dishonest retention of erroneous salary overpayments. The remainder of the cases involved alleged fraud on the part NHS primary care contractors and members of the public.

1.9. The aforementioned investigations have resulted in **six (6)** files of evidence being forwarded to the Crown Prosecution Service for charging decisions. The LCFS investigations have also resulted in **twenty (20)** disciplinary sanctions during 2021/22, predominately resulting in dismissal from employment with ABUHB for gross misconduct and/or sanctions by a professional body.

1.10. Furthermore, investigation number **(37)** is an impending criminal prosecution. Investigation number **(20)** resulted in a non-court based criminal sanction.

1.11. Financial recoveries stemming from LCFS investigations during 2021/22 stand at **£44,374.79** plus potential fraud prevention savings amounting to **£300,676.78.**

1.12. Appendix 2 (schedule of investigations) depicts that similar to year 2019, in comparison to previous years, overpayment of salaries for personnel who have terminated employment with the organisation (which have potential implications for criminal proceedings) remains at a low level. This report incorporates only two such investigations of that nature and this may possibly be viewed as assurance, insomuch as despite overpayments occurring in high volume for existing staff, salary overpayments for terminated staff remain low. As in previous years, the LCFS has continued to work in close liaison with NWSSP Payroll Services, NWSSP Accounts Payable staff and also ABUHB Accounts Receivable Staff from Corporate Finance. Intranet guidance has been reiterated to managers to remedy this, emphasising the crucial requirement for timely and accurate staff termination forms and staff changes forms to be disseminated to Payroll Services. One such example is a reminder to this effect on the ABUHB Intranet carousel in March 2021. To reinforce this principle, payslip messages have historically been disseminated to all staff advising of the potential criminal liability of the wilful retention of erroneous salary overpayments, and likewise on the intranet carousel. The implementation of the ABUHB Recovery of Overpayments Policy is promoted by Corporate Finance and the LCFS alike and is rigidly adhered to. All overpayments, regardless of origin, are notified to the LCFS by Corporate Finance/Payroll Services/Accounts Receivable staff. The ABUHB Recovery of Overpayments Policy is up-to-date and fit for purpose. This Policy, in conjunction with the Counter Fraud, Bribery & Corruption Policy, acts as a sanction and redress policy on behalf of the organisation. Counter Fraud guidance features throughout the Recovery of Overpayments Policy and in the action flowchart which is incorporated within the policy. Overpayments of salaries is addressed in greater detail later in this report.

1.13. In 2021, the LCFS requested the implementation of a speculative alert on ESR to electronically highlight staff payslips which go unopened on the system for a prolonged period of time. The purpose of this request is it could be an indicator that the staff member no longer works for the organisation yet is still being paid due to a failure in submission of a termination form to Payroll Services. This aspect is also covered in greater detail, later in this report.

1.14. The mix of cases investigated to date are summarised in **Appendix 1** and a full index of cases reported/referred to the LCFS' are listed in **Appendix 2**.

1.15. During year 2021/22, the ABUHB LCFS has conducted **two (2)** tape recorded interviews under caution with **two (2)** alleged offenders. This number of interviews is reduced from previous years as a consequence of Covid restrictions.

2. Strategic Governance

2.1 The NHS Counter Fraud Authority developed standards for NHS Bodies (Wales) for fraud, bribery and corruption which were implemented in 2013/14. This was created in accordance with Minister for Health and Social Service Directions and the service agreement between the Welsh Government (WG) and the NHS Counter Fraud Service under S.83 of the Government of Wales Act 2006.

During 2020, the ABUHB Counter Fraud provision was subject of an in-depth assessment by Audit Wales, as part of an all-Wales review. The AW report was positive and the ABUHB Team immerged well in comparison to counterparts in other Health Boards. This AW report was delivered to Audit Committee in October 2020.

As of April 2021, the Government Functional Standard for Counter Fraud (GovS 013) replaced the previous NHS specific Standards for Fraud, Bribery and Corruption. Together with stakeholders the NHSCFA have developed new NHS Requirements to meet the Government Functional Standards. These changes are reflected in the ABUHB Counter Fraud Bribery & Corruption Workplan for 2022/23.

The Government Functional standard essentially comprises of the following 12 components:

Component 1: Accountable individual
This component is split into two Requirements.

(NHS Requirement 1A) This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.

(NHS Requirement 1B) This relates to the work of the organisations board / governing body in gaining assurance and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.

Component 2: Counter fraud bribery and corruption strategy
This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is aligned to the objectives of the strategy and locally identified risks.

Component 3: Fraud bribery and corruption risk assessment
This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.

Component 4: Policy and response plan
This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.

Component 5: Annual Action Plan
This Component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.

Component 6: Outcome-based metrics
This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.

Component 7: Reporting routes for staff, contractors and members of the public
This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.

Component 8: Report identified loss
This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.

Component 9: Access to trained investigators
This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.

Component 10: Undertake detection activity
This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.

Component 11: Access to and completion of training
This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.

Component 12: Policies and registers for gifts and hospitality and Conflicts of Interest
This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.

The components/requirements of the Government Functional Standard for Counter Fraud (GovS 013) direct that a legal declaration must be included in the Counter Fraud annual report as to the outcomes of the Health Board counter fraud self-assessment process and compliance with the aforementioned functional standard. As the Health Boards first Audit Committee meeting for the financial year takes place prior to completion of the self-assessment return, it is not possible to include the declaration in this report. The LCFS has sought dispensation from the Senior Quality and Compliance Inspector with NHSCFA that the declaration and outcomes can be incorporated in the second Audit Committee report of the financial year and this will be considered as compliance with that specific aspect of the components/requirements.

The NHSCFA initiated changes to the investigation case management system called '*First'* (Fraud Information Reporting System Toolkit). This is a restricted and confidential system which has been used by the LCFS in the region of 15-years. *'First'* has been replaced by *'Clue-3'* which has the capacity for integration with the Police and other domains of law enforcement. The ABUHB LCFS's have undergone training on the replacement system which was rolled out on 1st April 2021. Due to technical complications, existing active investigations on '*First'* have not been migrated over to *'Clue-3'* but both systems are being used in tandem until the cases on *'First'* reach their

conclusion and are closed on that system. Legacy cases on *'First'* have been effectively managed and there are only 4 such cases remaining on the system which are awaiting the outcome of sanctions from the regulatory bodies for the professions in question.

2.2 The LCFS has maintained an ongoing review of the following policies/protocols initially incepted in 2011, which are pertinent to Counter Fraud to ensure that they remain current, effective, up to date and fit for purpose.

- Counter Fraud Bribery & Corruption Policy
- Counter Fraud Communication Strategy
- Local Counter Fraud Specialist & Workforce & OD Joint Working Protocol
- Policy entitled Appearing in Court
- Counter Fraud protocol with Internal Audit

2.3 The Communication Strategy was updated in March 2021. Whereas the Local Counter Fraud and Workforce & OD Protocol and the Internal Audit & Local Counter Fraud Services Joint Working Protocol were updated in October 2021. All policies received Executive approval and that of the Workforce & OD Policy Group.

2.4 Furthermore, the LCFS has engaged with the Board Secretary regarding the ABUHB *'declaration of interest policy'* and the *'Policy for Standards of Business Conduct for employees'* incorporating declarations of interest. The LCFS reviewed these policies for compliance with Government Functional Standard for Counter Fraud (GovS 013) in December 2021. The organisation will ensure that there is evidence of compliance through outcomes. The effectiveness of the work will be evaluated as will the reduction of the risk. The awareness of the policy amongst staff has also been tested.

2.5 Since April 2011, the LCFS has acted in a consultation role to the Workforce and OD Policy Group and has received notification of all policies, terms of reference guidance notes that are subject of review by the group. This ensures that the policies are robust and 'Fraud Proofed' at concept stage. Further information is provided on this topic at paragraph 4.24 regarding the **nineteen (19)** policies reviewed by the LCFS during 2021/22.

2.6 With reference to the aforementioned policy entitled 'Appearing in Court' the ABUHB LCFS continued to distribute a self-designed tri-fold leaflet on this theme, which can be provided to members of ABUHB staff in the event that they become a Crown witness in a prosecution case.

The information contained in the tri-fold leaflet has been promoted on Counter Fraud webpages.

A single point of contact within the organisation has been nominated to provide support and wellbeing service to such staff members, which could also include providing a chaperon to court.

Several of the LCFS investigations scheduled on **Appendix 2** involved instances whereby staff from both the Health Board itself and the Primary Care contractor domain demonstrated the resolve to stand up and be counted and do the right thing and become crown witnesses in those cases. This commendable conduct demonstrates support to protect the public purse and the economic interests of the NHS.

2.7 The Executives and Board of ABUHB has ensured that the resources invested into counter fraud work are appropriate to counter fraud, bribery and

corruption. The Counter Fraud staffing level has been maintained at 2.8 WTE which will have a marked impact on the Counter Fraud provision for 2022/23.

2.8 This is evidence that there is strong political and executive support for work to counter fraud, bribery and corruption and that the organisation is committed to making financial investment in work to tackle fraud, bribery and corruption which is proportionate to identified risks.

2.9 The budgetary provisions of ABUHB is contingent for the purchase of equipment necessary for the function of the Counter Fraud Team and for the purchase of promotional memorabilia. The team have recently been provided with widescreen monitors to support IT performance. The promotional products, which feature under the raising awareness strand of counter fraud work, include 'give away' products at presentations and events such as post-it pads, keyrings, pens etc, liveried with LCFS corporate identity and contact information. Distribution of such products serves to raise the awareness of the workforce, make them fraud savvy and encourage them to report suspicions of fraudulent activity.

2.10 To supplement previously purchased presentation display boards and the Fraud Criminal Law & Procedure Manual, these 'give away' products are duly replenished by ABUHB as required. This displays further evidence of financial investment on behalf of the ABUHB Board towards tackling fraud, bribery and corruption in the NHS. The LCFS has negotiated further replenishing of the products on a rolling basis.

2.11 This also demonstrates that the Board has a clear remit to reducing losses to fraud and corruption to an absolute minimum by the appropriate application of counter fraud resources. The Counter Fraud staffing level of 2.8 WTE LCFS' remains incorporated in the LHB formal organisational structure.

2.12 ABUHB has taken steps to ensure that the resources invested into Counter Fraud work are appropriate to counter fraud. The number of days invested to counter fraud work was based on the relevant NHSCFA template workplan but was also bespoke to the organisational needs. The LHB has taken steps to ensure there is a clear counter fraud strategy and remit present within the organisation.

A balanced and comprehensive workplan was agreed by the Director of Finance for the LHB. The plan was dynamic and reflective of the needs of the organisation.

The plan covered all the counter fraud bribery and corruption standards and relevant anti-fraud measures to ensure that a comprehensive service was provided. The plan also incorporated amendments made to the standards.

Tasks were allocated with consideration of local fraud risks and were flexible in order to accommodate changes.

The plan outlined a balance of both proactive and reactive work to address fraud issues. The workplan was approved by the Director of Finance and ratified by Audit Committee and progress against the plan is monitored accordingly.

2.13 On a reporting perspective, the LCFS customarily has quarterly meetings scheduled with the DoF to appraise and update on Counter Fraud work and identify and manage risk. The LCFS met with the DoF in this capacity on the following dates: 07/04/21, 03/06/21, 03/11/21, 02/02/22 & 15/02/22. These

meetings were supplemented by telephone and email contact maintained with the DoF, to whom, the LCFS has unrestricted access.

2.14 Furthermore, to consolidate the reporting process, the LCFS met with the Medical Director on 21/05/21 & 17/01/22.

2.15 Considerations have also been made as to how identified or perceived risks are covered off and alerted organisation-wide and how this information is disseminated down through the structures within various divisions to reach staff of all grades. The aim is to establish mechanisms to cascade the information to a wider managerial audience and encourage more managers to become proactive in relation to recognising counter fraud risks. This will mitigate the risks even further.

2.16 The LCFS has achieved a more effective communication flow process via the Assistant Director of Finance (Corporate) who, on behalf of the LCFS, highlights areas of concern at senior management financial team meetings, hosted by the DoF for cascade down through the organisations divisional financial structures. It was as a direct result of this process, that the LCFS commenced engagement with the organisations Business Partner Accountants, as outlined in paragraph 3.3.

2.17 Additionally, Counter Fraud reporting is a standing agenda item for the Audit Committee meetings. In compliance with legal requirements, the LCFS attended and delivered reports to 3 Audit Committees on 8th April 2021, 12th August 2021 & 3rd February 2022.

2.18 All aspects of Counter Fraud strategic governance is incorporated in the Audit Committee Self-Assessment Checklist. There is a requirement that as part of compliance and professional probity, the LCFS has a right of direct access to the Audit Committee Chair and its independent members. This entails private, pre-Audit Committee meetings with said members. The LCFS is scheduled to hold such a meeting on 7th April 2022.

2.19 With reference to further reporting, as part of quality assurance requirements, the LCFS submitted the self-review report based on the Government Functional Standard for Counter Fraud (GovS 013) to the NHSCFA by the deadline date of 31st May 2021. The submission was authorised by the DoF and ACC and a rating of green was recorded against all components/requirements.

2.20 In order to retain core skills and maintain best practice, the LCFS's have kept up to date on legislation and working practices through attendance at various training sessions. As part of continuing professional development, these inputs included training sessions from the NHSCFA. These sessions are more fully outlined in para 6.3 & 6.6 of this report.

2.21 Additionally, all three ABUHB LCFS's were virtual attendees of the National Public Sector Counter Fraud Summit on 23rd February 2021.

2.22 Furthermore, the LCFS attended the All-Wales LCFS Forums on 08/07/21, 13/07/21, 13/12/21 & 15/03/22 respectively.

3 Proactive Counter Fraud Bribery & Corruption Practices - Inform & Involve

3.1 The Health Board has worked with the LCFS and NHSCFA to promote an anti-fraud culture within the NHS. The LCFS's and Director of Finance (DoF),

identified target audiences for fraud awareness activities, with the following objectives:

- To highlight the role of LHB staff/contractors in the tackling of fraud, bribery and corruption within the LHB/NHS.
- To deliver a key message that fraud within the NHS is unacceptable, indefensible and will not be tolerated.
- To deter attendees from committing fraud against the NHS.
- To encourage individuals to report any concerns of fraud.

3.2 The fraud awareness programme undertaken by the LCFS is reaching its target audience and all mediums are being exploited in order to actively promote & encourage fraud referrals.

In ABUHB, for PADR purposes, Counter Fraud awareness input at Corporate Induction and the fraud awareness e-learning programmes remain mandatory requirements.

Quarter 3 Counter Fraud Service performance report statistics for 2021/22, indicate that ABUHB continues to have a high staff uptake figure for Counter Fraud e-Learning with a culminative figure of 3,016 staff having completed the e-learning programme.

The aforementioned Counter Fraud Service performance report further illustrates that ABUHB are the national leaders and has the highest number of fraud awareness presentation uptake figures to the Corporate Induction programme of all the Health Bodies in Wales with 948 members of staff completing the programme during 2021/22.

The face-to-face delivery of the Corporate Induction programme in ABUHB was suspended upon Covid lockdown in March 2020. There is currently no intention on behalf of the Health Board to resume face-to-face Corporate Induction sessions and virtual sessions will continue.

On the aspect of staff fraud awareness training, such training is a standing agenda item on every staff Corporate Induction in ABUHB. Whereas this training was normally delivered in person, to adapt during Covid restrictions, Counter Fraud have made a 45-minute video film of the training to provide virtual staff training until it is safe to resume conventional classroom training.

The video encompasses the film, 'taking the U out of fraud', it highlights NHS fraud risk areas, advises of the protection for staff under the Raising Concerns Policy with regard to whistleblowing and the video actively encourages the reporting of suspected fraud.

To comply with legal requirements, the video film is equipped with Welsh language sub-titles for viewers who wish to avail themselves of that facility. This fraud awareness video film went 'live' as part of the virtual Corporate Induction programme at the beginning of November 2020 and is still in place to-date. The staff uptake figures only identify staff numbers who complete the full Corporate Induction programme, not staff numbers who go through the programme over a period of time in a piecemeal fashion making multiple logon sessions. During the 2021/22 timeframe, the LCFS received 25-fraud referrals which is a further indication that the raising fraud awareness strand of LCFS work is reaching its target audience.

Furthermore, the LCFS has made a video film to Career Wales which is being used as a public awareness information film. This video film is unrelated and

distinct from the aforementioned fraud awareness video film currently utilised by ABUHB on the mandatory Corporate Induction programme.

3.3 To promote fraud awareness, in addition to attending every Corporate Induction session, the LCFS's would customarily attend major events such as the AGM, the annual HCA Conference and ABUHB careers fairs. In addition to this, Counter Fraud portable display stands would be sited at conspicuous locations in hospital environment's on a rotational basis. Covid lockdown curtailed these activities on the part of the LCFS, however; it is intended to resume these activities as soon as Covid restrictions permit.

Ancillary to the above, the LCFS delivers 'live' fraud awareness presentations via Microsoft Teams and this has become a standing agenda item on the 'Taking the Lead' programme which is a forum for staff members who are aspiring Senior Managers within the NHS.

Examples of LCFS work carried out to develop and promote an anti-fraud culture includes the delivery of 'live' fraud awareness presentations to the following audiences consisting of 387 attendees:

- Mangers Core Skills Module-7 Taking the Lead x 9
- Finance Team Lunch & Learn x 1
- All Wales Doctors x 1
- Finance Management x 1
- School Nurses x 1
- Hospital Division BPA's x1
- Corporate Finance Staff Team Day x 1

3.4 During 2021/22, a staff fraud awareness survey was published on the Health Board intranet via Smart Survey which was accessible to the entire workforce board-wide. The survey is still active and the responses available to-date are attached to this report as **Appendix 3**. Following commencement of the survey, to support and promote its uptake by staff, a reminder from the Communications Team was broadcast to all Managers on this topic. Early indications from the survey are that the pandemic has not impeded staff from making fraud referrals should they have occasion or are mindful of doing so.

These very positive responses indicate a strong anti-fraud, bribery and corruption culture where fraudulent and corrupt activity is not tolerated and all staff are aware of their responsibility to safeguard the NHS from economic crime, as well as recognizing the correct reporting procedures. A strong counter fraud, bribery and corruption culture provides the organisation with assurance that fraud will be recognized and reported.

3.5 Further assurance that the fraud awareness programme undertaken by the LCFS is reaching its target audience is typified in the schedule of investigations in **Appendix 2** and the 'whistleblowing' attributed to the majority of these investigations. This displays support for the work of the LCFS and support of the anti-fraud culture promoted by the ABUHB organisation.

Examples of this are investigations listed as **(11)(14)(23)(32)(42) & (42)** which stemmed from the 0800 National Fraud & Corruption Reporting Line. The remainder of the investigations on **Appendix 2,** were predominantly paper based anonymous fraud referrals using referral forms downloaded from the ABUHB Counter Fraud Team web-pages. This is a clear indication that all mediums are being used by 'whistleblowers' to report suspicions of fraud. The NHSCFA on-line reporting tool is also promoted by the LCFS but no referrals

have been received via this medium. Additionally, year beginning 2022, the Counter Fraud Service (Wales) received **(2)** fraud referrals via the 0800 National Fraud & Corruption Reporting Line which were attributable to the fraud awareness programme delivered by the ABUHB LCFS.

Additionally, under case reference WARO/18/00082 the Counter Fraud Service Wales were referred a General Ophthalmic Services investigation by the ABUHB LCFS. This case was closed in Q.2 of 2021/22 and yet again highlights the promotional work undertaken by the ABUHB LCFS.

3.6 In addition to paragraph 3.5 above, the sheer volume of referrals received by the ABUHB LCFS is testament that the anti-fraud message is getting across and hitting the intended target audience.

3.7 The LCFS has actively promoted CFS Wales, NHSCFA and the 0800 National Fraud & Corruption Reporting Line and online reporting tool and this is prominent in the Counter Fraud Bribery & Corruption Policy, the Standards of Business conduct for Employees, the Fraud e-learning application and Corporate Finance budget e-learning application, in addition to presentation material.

3.8 On an all-Wales basis, ABUHB personnel have consistently rated as amongst the top scoring of all NHS in Wales for having completed the fraud awareness e-learning application. This positive response has been enhanced by the fact that the fraud awareness e-learning application is a mandatory training dimension on ESR PADR for all ABUHB staff. The most recently available e-learning uptake figures for quarter 3 of year 2021/22, which indicates 3,016 members of staff have completed the application which equates to 22.4% of the workforce. The LCFS is now endeavouring to consolidate this figure following the placement of a reminder of this PADR mandatory learning requirement on both the carousel on the ABUHB intranet homepage and the ESR homepage carousel which occurred during February 2022.

3.9 Fraud Awareness month (FAM) which was a national NHS initiative was customarily orchestrated/managed by NHSCFA. This initiative has been reinitiated by the NHS Counter Fraud Service, following a number of year's absence due to funding restrictions. The initiative is now called fraud awareness week. This initiative not only serves to create an anti-fraud culture but heightens the awareness of a high footfall number of employees of all grades and the general public alike. The Health Board participated in FAW in November 2021 and it was promoted in the Health Boards Newsletter for that month.

3.10 Fraud information has been updated on the Aneurin Bevan University Health Board intranet website, which has advertised the outcomes of investigations and guidelines to staff for reporting fraud in addition to fraud notices. The ABUHB website was regularly updated and the LCFS web-pages and ancillary platforms received 497 'hits' during 2021/22. Articles placed on the organisation's intranet site front page comprised of national press releases, local sanctions and general fraud awareness messages from the LCFS. The LCFS has maintained the implementation on the ABUHB website the video entitled 'Taking the U out of Fraud' on the aforementioned web-pages. The format of the web-pages has been amended to meet corporate design.

3.11 In addition to the Counter Fraud's own section of the website, there are a number of link tabs available on the ABUHB intranet site which provides direct access to the Counter Fraud referral form. This is with a view to encouraging users of the intranet to make Counter Fraud referrals.

There is a further link on this site for the Counter Fraud Bribery & Corruption Policy to heighten the awareness of the workforce in this realm.

3.12 A Counter Fraud newsletter was distributed to Health Board Primary Care Contractors during 2021/22 with various counter fraud articles and successful NHS fraud cases. In total there are 383 Primary Care Contractors that provide NHS services to ABUHB which consist of GP's, Optometrists, Dentists and Pharmacists. The newsletter promotes the NHS Fraud and Corruption Reporting Line and LCFS contact details. The newsletter is bespoke and topical for primary care contractors.

3.13 A staff orientated Counter Fraud Newsletter was also publicized on the ABUHB intranet during 2021/22 and was accessible to the entire workforce.

3.14 The corporate identity and contact details of the LCFS is also incorporated in the Local Intelligence Network (LIN) newsletter which is accessible to the workforce of ABUHB and which is disseminated to all GP Practices and Community Pharmacies within the LHB.

3.15 The LCFS has set up a network of contacts throughout Aneurin Bevan University Health Board to enable an effective counter fraud programme. This includes Workforce & OD, Internal Audit, Procurement and Security and the PPV, Payroll and Primary Care Service Contracts Teams of NWSSP.

3.16 The LCFS has also established contacts and working relationships with the Department of Works and Pensions Regional Fraud Team, Council Fraud Team and the Police.

3.17 The LCFS has established a direct contact within the UK Borders Agency & H.M. Passport Office. This relationship has involved the sharing of information to progress investigations undertaken by both organisations.

Additionally, the LCFS has formulated links between UKBA and ABUHB Medical Recruitment to enhance the collaboration as to the employment and residency status of overseas visitors and identity checks.

3.18 Further evidence of partnership working are cases **(36)** & **(37)** on **Appendix 2** which resulted in gateway taxation requests being made by the LCFS to HMR&C and case **(46)** which involved passport data from HMPO.

3.19 The LCFS has initiated Counter Fraud awareness messages to be sent to every member of staff employed by the LHB by placing an entry on all employees' payslips highlighting the criminal liability of the willful retention of a salary overpayment.

3.20 In addition to the above, the LCFS has provided Payroll Services with a list of ten Counter Fraud awareness messages which are published on staff payslips on a rolling programme as and when free space allows.

For the most-part, such messages generally contain an encouragement theme to report fraud, for example 'Spot it – Stop it'. Two other recurring payslip messages warn against working elsewhere whilst on sick leave and the dishonest retention of erroneous salary overpayments.

4 Proactive Counter Fraud Bribery & Corruption Practices - Prevent & Deter

4.1 The LCFS is responsible for taking steps to prevent fraud against the LHB by eliminating system weaknesses to reduce the risk of fraud.

4.2 In order to ensure that they remain current, effective and up-to-date, the LCFS has a rolling-programme for reviewing the following polices/protocols which were initially created in 2011. These policies were extensively revamped again during 2014/15. This is necessary in order to reinforce the infrastructure of directives and the framework of organisation guidelines necessary to support the Counter Fraud provision. The Counter fraud Bribery & Corruption Policy is up-to-date and fit for purpose. Similarly, the Communication Strategy was updated in March 2021 and Counter Fraud and Workforce & OD Protocol and the Internal Audit & Local Counter Fraud Services Joint Working Protocol were updated in October 2021. All policies received Executive approval and Workforce & OD Policy Group input where necessary. These policies continue to be reviewed in compliance with target dates to ensure they are maintained up-to-date and fit for purpose. The Appearing in Court Policy, in respect of which, the Legal Services Directorate has ownership, is also current.

- Counter Fraud Bribery & Corruption Policy
- Counter Fraud Communication Strategy
- LCFS & Workforce & OD Joint Working Protocol
- Policy entitled Appearing in Court
- Counter Fraud Protocol with Internal Audit

4.3 The LCFS has worked proactively with the NHS Wales Shared Services Partnership-Primary Care Services GOS Payments Officers and the Ophthalmic Adviser. All General Ophthalmic Service payments made to Contractors are monitored and the LCFS is provided with quarterly GOS trend data for all ABUHB GOS contractors. This data is scrutinized for abnormalities in claiming patterns.

In addition to the above, on a contractor-by-contractor basis, the LCFS receives every GMS and GOS visit report which incorporates recoveries made.

4.4 The LCFS is linked to the Audit Committee via the DoF. The Audit Committee reviews the adequacy of the structures, processes and responsibilities for identifying and managing key financial risks facing the LHB.

The LCFS attends Audit Committees to highlight fraud risks and to appraise the Committee of current work undertaken by the Counter Fraud Team. The Counter Fraud update report and LCFS attendance at the Audit Committee is a standing agenda item on Audit Committee agendas.

4.5 The LCFS has developed relationships with individuals whose role within the LHB has an impact on counter fraud work to identify local areas of risk. The LCFS also meets regularly with External Organisations such as the Police, NWSSP-Primary Care Services, UK Borders Agency and the Department for Work and Pensions (DWP) to gather intelligence and identify Local and National risks. The LCFS also engages with HMR&C in this capacity and also engages with the Counter Fraud Operations Team of the H.M. Passport Office.

4.6 During 2021/22, as part of working in partnership with the Police, the ABUHB LCFS has provided criminal intelligence reports to the Gwent Police Force Intelligence Bureau and the South Wales Police Regional Asset Recovery Team on **two (2)** occasions, whereby the information would be deemed to be of value to law enforcement. In addition to this, the LCFS has also provided witness statements and documentary evidence to the Regional Asset Recovery Team for use in an impending criminal prosecution. Furthermore, the LCFS routinely provides NHS Drug Alerts to the Gwent Police Pharmacy Manager and works in

close collaboration with that Manager. Conversely, this information sharing practice has resulted in the LCFS being afforded access to Police held intelligence which was pertinent to the NHS.

Further evidence of partnership working with the Police are investigations **(42) & (46)** on **Appendix 2,** which are collaborative investigations.

4.7 The LCFS also liaises regularly with the PPV Team and all PPV reports which form part of the standing agenda item at Audit Committee are disseminated to the LCFS. Any concerns of fraud highlighted at a PPV visit are discussed immediately with the LCFS and the appropriate action is agreed. The PPV team reports their findings directly to the DoF. The LCFS has input to a current project conducted by NWSSP-PCS PPV in relation to data set trend analysis in the General Ophthalmic Services domain designed to identify inappropriate claiming in that primary care arena. The ABUHB LCFS attends quarterly all-Wales meetings with the PPV Senior Managers.

4.8 NWSSP-Primary Care Services is responsible for registering all new patients at GP Practices in Wales. Any patients that register with another practice will automatically be removed from the patient list of their previous practice. If a person fraudulently attempts to register at a practice temporarily to obtain prescription medication or controlled drugs an alert is sent out to all GP practices in the area. The LCFS receives every drug alert that is circulated and these alerts customarily highlight prescription fraud and cases of multiple fraudulent patient registration at GP Practices.

4.9 Routinely, the ABUHB LCFS has utilized the NWSSP-PCS Contracts Team drug alert system to generate the LCFS's own drug alerts which contain information and intelligence which has come to the attention of the LCFS via a variety of sources. These drug alerts can be circulated throughout an individual Health Board or clustered to a number of Health Boards or throughout all HB's in Wales if deemed necessary. The alerts are disseminated to prescribers, or dispensers or both if required.

On **four (4)** occasions during 2021/22 the LCFS has utilized ABUHB Primary Care Team resources to alert all Gwent GP Practices/pharmacies of immerging fraud threats which targeted the primary care GMS/pharmacy dispensing domains.

4.10 Fraud prevention notices can be issued by NHSCFA under the WG directions for Countering Fraud. Any such circulars include the request for specific action to highlight and minimize any known fraud risk. These fraud prevention instructions referred to as FPN's emanate from the Central Intelligence Unit (CIU) of NHSCFA. During 2021/22 the LCFS has actioned **two (2)** such circulars relating to banking mandate fraud – requests to change phone numbers and banking mandate fraud – email interception.

4.11 Additionally, the ABUHB LCFS generated a further **three (3)** self-generated alerts on banking mandate fraud throughout the Corporate Finance and Procurement communities.

4.12 In light of the COVID-19 crisis, all the indicators from the WG, the Government Counter Fraud Function and the NHS Counter Fraud Authority is that fraud risks are currently high and the economic attack against the NHS and other public sector bodies will increase.

The principal threat remains at Procurement level, i.e. banking mandate fraud, invoice fraud and the offer of goods or services which do not exist. Internal financial controls have been effective and have prevented these aspects to date.

Due to the threat level, the ABUHB LCFS has continued to focus on banking mandate and invoice fraud in the Procurement Services domain. During 2021/22, nationally within the NHS, banking mandate fraud has remained a high-risk fraud threat and ABUHB has been subject to attack from this type of high risk/high value fraud.

This fraud occurs when fraudsters implement changes to the banking mandate details of legitimate external suppliers/service providers, on Oracle via NHS Procurement Services (Accounts Payable) to that of the fraudsters own bank accounts. Outgoing payments are then hijacked into the fraudsters' bank accounts.

The ABUHB LCFS reviewed and risk assessed preventative measures which had been implemented a number of years previously to discover that due to a reconfiguration of duties within NWSSP, the measures may have become diminished and weakened.

The LCFS addressed the full ABUHB Procurement Team on 25th March 2021, when the following directives were reinforced to mitigate this area of fraud:

- No banking mandate changes will be implemented on the basis of an incoming telephone call or the receipt of an email or letter alone.

- To confirm the authenticity of the banking mandate request, the requesting supplier/service provider should be contacted (not on the contact reference on the letter but on the verified and established contact details NHS have held for them historically on file).

- A contact who is known to the NHS from within the company (with whom NHS have engaged previously) should be spoken with to and confirm the authenticity of the banking mandate request.

- To mitigate the insider threat, the NWSSP staff member who implements banking mandate changes should not be authorised to process payments on Oracle etc. This means that it would require two members of staff to collude or conspire together to transfer payments to a fraudulent bank account.

The threat to the NHS is ever present from this type of fraud and there is a real need for continued and heightened vigilance on the part of Procurement Services and Corporate Finance staff alike. The LCFS also emphasised with Senior Management of Procurement Services the need for continuous training and guidance for newly appointed members of staff on this topic, as inexperienced novice staff, agile working from home (due to pandemic) without supervision or support, can unwittingly present a risk in their own right. It was this combination that caused the loss of £80k to banking mandate fraud for a neighbouring Health Board during 2020/21.

4.13 Following consultation with the Head of Procurement Services for ABUHB, the LCFS has verified that best practice is being adopted in relation to single tender wavers and a one-page Declaration of Interest section forms part of the full form.

4.14 An area of managed risk within Procurement Services follows arrangements to support supplier businesses during Covid which was highlighted by the Cabinet

Office in March 2020. NHS Wales moved to support businesses during Covid with the aim of paying suppliers more speedily, improving their cash flow. This was the catalyst to a variation in the 3-tier procurement protocol for the payment of invoices under £500.00 in value. These type of invoices are of low individual value but extremely high in volume.

In its simplest form, the 3-tier system is:
1) ORDER.
2) INVOICE.
3) CONFIRM RECEIPT OF GOODS.
Then payment is made.

The change in protocol was that receipted verification would be undertaken retrospectively following payment.

Potential risks associated with the change of protocol are:
Being invoiced for goods/services not supplied.
The potential for invoice splitting by supplier on higher value transactions to keep invoice values below the £500.00 threshold.

The LCFS has confirmed with Procurement Services that retrospective receipted verification have been carried out and that spot checks have been done on samples of invoices which have been paid without being receipted and very few issues or areas of concern have been identified. This arrangement remains in place until the end of March 2022, on the basis that more testing will need to be undertaken prior to the arrangement being agreed beyond that date.

4.15 As with every NHS Healthcare organisation, ABUHB remains under sustained attack from cyber fraud. This predominately relates to attempts of banking mandate fraud, contractor invoice fraud and attempts to illicit same day electronic money transfers.

All preventative measures and internal financial controls have defeated these attempts at fraud and remain effective. The fraudsters have become increasingly accomplished at cloning e-mail addresses of ABUHB personnel which are regularly utilized in their fraudulent efforts.

The LCFS has continued working in conjunction with DHCW Digital Health & Care Wales – Cyber Security, who have applied system filters with a view to intercepting these cyber fraud attacks prior to them reaching their intended targets. This includes the blacklisting of identified I.P. addresses used by the fraudsters.

4.16 During the Covid pandemic, fraudsters have continued to target NHS staff on a variety of cybercrime fraud themes. In an effort to safeguard the workforce and raise their awareness on these aspects, the LCFS has actioned seven fraud notices to the workforce using permutations of intranet news items, staff newsletters and via the ABUHB intranet carousel.

4.17 The LCFS has worked in collaboration with Procurement Services as participation of a national exercise initiated by the NHSCFA:

Fraud Prevention Guidance Impact Assessment

This exercise related to Fraud Prevention Notices (FPN's) issued by NHSCFA which had been previously actioned by the LCFS. The assessment was submitted prior to its deadline date of 24th December 2021. The FPN's subject of the assessment were:

- Cyber enabled salary diversion fraud (issued 29/09/20)
- Timesheet overpayments (issued 30/11/20)
- Mandate fraud reminder (issued 14/12/20)
- Credit cards management (issued 15/12/20)
- The private purchase of Covid vaccines (issued 20/01/21)
- Mandate fraud – request to change phone numbers (issued 29/03/21)
- Mandate fraud – email interceptions (issued 09/06/21)
- NPE Continence services (issued 14/06/21)

The aforementioned FPN's have been actioned as Local Proactive Exercises on the *Clue-3* system.

4.18 The LCFS further worked in collaboration with Procurement Services undertaking a two-part national exercise initiated by the NHSCFA, as follows:

Part-1

PO V's non-PO spend exercise launched on Monday 21st June 2021.

Part-2

COVID-19 post-event assurance exercise launched on Monday 5th July 2021. This part-2 exercise will test the following three Procurement Policy Notes (PPNs) issued by the Cabinet Office during the pandemic as well as capture risk prevention activity undertaken at a local level:

- PPN 01/20: Direct award of contracts.
- PPN 02/20 and PPN 04/20: Supplier relief payments.
- Contract cancellations.

This exercise was completed and submitted prior to its deadline date of 23rd August 2021 and it required a significant data uplift by Procurement Services and the analysis report is awaited from the NHSCFA.

4.19 The Government Functional Standard for Counter Fraud (GovS 013) is heavily focussed on Local Proactive Exercises (LPE) and risk assessments. Consequently, in addition to the aforementioned exercise, the LCFS has conducted further risk assessments as follows:

1. Service specification review for Community Pharmacists - Common Ailment Scheme claims.
2. Additional productivity sessions - Consultant Doctors.
3. Overpayment of salaries – staff level.
4. Continence Service – supply of appliances to residential care/nursing homes.
5. Medical records – staff access level – G.P. Practices.

RISK ASSESSMENT 1 – COMMON AILMENT SCHEME CLAIMS

Remedial action service specification recommendations were made for implementation to the Primary Care Pharmacy Team on payments made to a community pharmacy under the common ailment scheme. This followed the identification of a system weakness during a proactive investigation exercise conducted by the LCFS which is detailed more fully at para 4.20 of this report. The recommendations were that Pharmacy Contractors should not be permitted to operate outside of service specifications by stockpiling claims and entering those claims onto the Choose Pharmacy system en masse.

RISK ASSESSMENT 2 – ADDITIONAL PRODUCTIVITY SESSIONS

Additional productivity sessions performed by Consultant Doctors – WLI & backfill sessions. A risk assessment was conducted on selected scheduled/unscheduled care directorates for the potential of overlapping or doubling up of additional productivity sessions against contracted NHS job plan sessions. System weaknesses were identified in relation to the informal (non-

automated) based allocation of this work (where no evidence of any checks/balances were found). This is in contrast to the automated based allocation of these duties (which provided for greater risk mitigation and greater assurance). A total of 7 remedial recommendations were incorporated in the assessment, the 3 principal recommendations being the move to Health Board wide use of the automated system for allocation of extra duties, the necessity for Consultants to sign Job Plans and the need to update out-of-date policies. The assessment outcomes and recommendations were reported back to the Medical Director for allocation to a risk owner/risk manager. The report has also been shared with Internal Audit.

RISK ASSESSMENT 3 – OVERPAYMENT OF SALARIES

The risk assessment was initiated as a consequence of a recent increase in such events as depicted in the following illustration:

Invoiced Salary Overpayments	P01-P10	Full year	Average month
2020-21 (£)	551,056	760,991	63,416
2021-22 (£)	918,445	tbc	91,844

Currently, overpayments arguably accounts for the highest percentage of invoices raised by the Corporate Finance team and the staff headcount for overpayments to P10 is circa 800.

The conclusion of the assessment indicates the primary contributing factor for such overpayments is an ongoing failure on the part of NHS Managers to action staff termination and staff change forms in a prompt and expeditious manner. This has resulted in events such as salary overpayments on inaccurate pay banding supplements and overpayments to former employees who were no longer employed by ABUHB.

It also appears there is a reluctance on behalf of Payroll Services to action employment termination of staff other than those received via the ESR Manager Self Service System. This; however, would not cater for bank staff or staff with more than one employment assignment (as many ABUHB staff have).

As pre-emptive action to the risk assessment, the LCFS has published bulletins to Managers to remind them of the need for prompt and expeditious submission of staff termination and staff change forms.

These bulletins have been reinforced with information from the ABUHB Recovery of Overpayments to Employees Policy, which in a directive to Managers at Section 6.2 cites:
'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'.

The LCFS commissioned a 'deep dive' into ESR data with a view to identifying null system logon by staff and instances whereby there was null access of payslips. The rationale behind this review is it could potentially be an outlier for staff who no longer work for ABUHB, yet are still in receipt of salary. Follow up enquiries with specific managers could then indicate whether individuals were still actively employed by the Health Board. The findings of this review was it identified significant numbers of staff who never accessed ESR or their payslips despite the fact they remained gainfully employed by the Health Board.

Additionally, the LCFS recommended format changes to the generic letters which are disseminated to the recipients of salary overpayments. These letters are apologetic by nature and essentially concede responsibility at the outset, on the part of the Health Board. It was considered that this may prejudice subsequent legal action and financial recovery. The recommendations met with disapproval.

Monthly, expenditure reports are provided at Senior Management level in Divisions/Directorates, which contain such data as staff names, assignment numbers, pay bands and salaries paid. The LCFS suggests that these expenditure reports are also disseminated to Junior Managers and Supervisors who would be better placed to identify any names which feature thereon, of staff who no longer work for the organisation. This could allow for remedial action to be implemented at an earlier stage, potentially reducing losses.

A system weakness which has been identified to date, is the current working practice with regard to internal staff moves is fundamentally flawed in the event that the employee fails to take up the new post. This is as a direct result of the onus being on the new manager to request the changes on ESR without any corroboration from the previous manager. Therefore, if a member of staff fails to take up their new post, they can inadvertently continue to be paid salary, and this has in fact occurred.

It is the intention of the LCFS to convene a multi-departmental input and agreement for a unified and standardised response towards tackling this issue, which would include Payroll Services, Corporate Finance, Counter Fraud, Workforce & OD and Education & Development Teams. The principal recommendation is the need for a cultural change within the organisation and training, education and development of Managers within this realm. The report has been shared with Internal Audit.

The LCFS works in close liaison with the Accounts Receivable Team of Corporate Finance who informs the LCFS of each and every such overpayment. The LCFS is selective and identifies any suspected criminal conduct attached to the overpayments. If criminal conduct is suspected then a criminal investigation is incepted by the LCFS. If not, and the overpayment bears all the hallmarks of a civil debt, then the Accounts Receivable Team seek to recover the debt by an alternative civil legal process.

The ABUHB LCFS also notifies their NWSSP counterpart of overpayments of salary, particularly when Payroll Services have failed to action notifications of staff changes/termination. The NWSSP LCFS reports these incidents to the DoF and Audit Committee of NWSSP with a view to improving operating systems and strengthening internal financial controls within Payroll Services.

This overpayment problem is not unique to ABUHB. From collaboration with counterparts in other Welsh Health Boards, it is evident to the LCFS that this is an all-Wales issue.

RISK ASSESSMENT 4 – CONTINENCE SERVICE – APPLIANCE SUPPLY

It was identified that in one instance, appliances were supplied to a particular care home for over 4-years in duration for a significant number of residents, who had in fact been deceased for that length of time. System weaknesses were identified and were reported back to Continence Service heads as the risk owners/risk managers. Remedial measures were implemented and speculative checks are now conducted on residential care service providers in ABUHB to

ensure service users are still actually alive. Financial recovery has been made and the report has been shared with Internal Audit.

RISK ASSESSMENT 5 – G.P. PRACTICE – MEDICAL RECORDS ACCESS

The LCFS identified at a G.P. Practice that a staff member was able to access medical records of close family member which afforded the opportunity to delete past prescribing history in an effort to obtain further medications for the family member in a fraudulent manner. Recommendations were:

1. To develop a more robust system of managing access to Patient Management Systems. This would require liaison with the developer of the relevant data system.
2. To ensure all staff members are obligated to make a declaration upon appointment and annually/ad-hoc to identify friends and family registered at the practice in order that access be restricted - coupled with consequences of failing to do so.
3. To eliminate the practice of allowing third party members of staff to request medications for family members.
4. To incorporate into staff training, a package provided by Counter Fraud Team to GMS primary care providers
5. Random audit of staff members history trail for medical record access will assist as a deterrent or detection tool.

4.20 **PROACTIVE INVESTIGATION EXERCISE – COMMON AILMENT SCHEME**

This exercise commenced with a proactive review of outliers in claiming activity on behalf of the 131 community pharmacies within the Health Board under the Common Ailment Scheme.

The scheme exists to relieve pressure upon primary care G.P. Practices when dealing with common ailments. Pharmacists are now able to provide a service of direct consultation with patients who are suffering from specific listed ailments. Patients are required to register at the pharmacy and are only allowed to register at one. The scheme allows for a Pharmacist to dispense medication/treatment for a condition, free of charge to the patient, without the need for a G.P. medical prescription.

The cost of the service is then recharged to the NHS via the Choose Pharmacy system which is operated by Digital Health & Care Wales (DHCW). The payment is based on the medication dispensed plus a set fee according to the number of patients the pharmacy has registered under the scheme.

Outliers in claiming patterns indicated abnormal, high volume claiming activity on the part of one independent pharmacy contractor. This raised concerns that claims may have been processed when the patient service had not actually been provided.

This individual claiming activity accounted for the majority of claims of this nature in the Health Board and also identified that claims were being mass entered on the Choose Pharmacy system, by the contractor, in single sessions.

These outliers warranted scrutiny by the LCFS and demanded mass canvassing of patients in order to confirm that the service claimed for had in fact been provided to the patients. The conclusion of the exercise was that no areas of concern were identified and that the service had actually been provided.

Service specification breaches were identified; however, which have been addressed with the Health Board Primary Care Pharmacy Team.

4.21 The LCFS is in engagement with the office of Medical Director with a view to establishing directives regarding displacement of job plan contracted SPA sessions by Consultant Doctors in order to uptake additional productivity sessions elsewhere. Further directives are also under consideration regarding the appropriateness of self-pay private patients receiving a private consultation in the first instance then receiving diagnostic scans as an NHS patient, following which, the patient reverts back to private patient status for follow up consultations.

4.22 The LCFS is a permanent attendee of the Gwent Local Intelligence Network (LIN). The Medical Director is the Accountable Officer for the LIN which has Police representation, representation from neighboring county LIN's and also representation from HoPMM, Pharmacy, GPhC, Health Inspectorate Wales, Care & Social Services Inspectorate Wales and this allows for exchanges of information. A primary function of the LIN relates to the security of and addressing risk factors attributed to controlled drugs (CD's).

The LIN meetings were scaled down due to the pandemic, however; the LCFS attend all LIN meetings during year 2021/22, which took place on 07/09/20 & 25.01.22 respectively.

As a by-product of the LIN, the LCFS is named (with contact details) on the LIN Newsletters and this serves to promote the identity of the LCFS and highlight their presence to the workforce and all GP's and Community Pharmacists within the LHB.

4.23 Additionally, the LCFS was a fully appointed member of the NHS Prescription and Forms Group (Wales). This group had the capacity to implement changes to prescription forms and NHS forms in Wales. Security issues relating to NHS forms and prescription form handling were addressed by the Group which also has Welsh Government (WG) representation. The group has been dissolved however, the LCFS still continues to be consulted prior to any major changes in prescription and NHS forms in Wales.

4.24 The LCFS monitors the pharmacy reward scheme within the LHB and is the sole countersignatory to authorise payments under the scheme. The LCFS liaises with Pharmacist and G.P. primary care contractors to ensure the guidelines are adhered to and that prescription fraud is reported appropriately.

The LCFS has also provided these contractors with written literature relating to the pharmacy reward rules to heighten their awareness to prescription fraud.

These rules have been distributed to all 130 Pharmacies in the LHB. During year 2021/22 ABUHB have made payment on **one (1)** Pharmacy Reward Scheme claim.

The previously mentioned, the Counter Fraud Newsletter disseminated by the LCFS to all 130 Community Pharmacies within ABUHB reinforced the Pharmacy Reward Scheme.

4.25 Since April 2011, the LCFS has acted in a consultancy role to the Workforce & OD Policy Group and has received notification of all polices, terms of reference guidance notes that are subject of review by the group. This ensures that all policies are robust and 'Fraud Proofed' at concept stage.

The LCFS has reviewed and has initiated inclusions on **nineteen (19)** documents which have been implemented by ABUHB during 2021/22. These policies are:-

- Internal Audit Protocols.
- Local Counter Fraud and Workforce & OD Protocol.
- Roster Policy (exc Medical)
- Mobile Device Insurance Policy.
- Risk Management Strategy.
- Information Systems Access Policy.
- Workstation Display Screen Equipment.
- Management of Violence and Aggression.
- Guidance on use of Bedrails and Bedrail Covers.
- Telephone Use Policy.
- Equality Impact Assessment VA Policy.
- Respect & Resolution Policy.
- Password Management.
- Corporate Telephony Policy.
- Raising Concerns (all Wales policy).
- Counter Fraud Communication Strategy.
- Internal Audit & Local Counter Fraud Services Joint Working Protocol.
- Policy for Standards of Business Conduct for employees.
- Declaration of interest policy.

4.26 A frequent concern raised by NHSCFA is potential relaxation of pre-employment checks in this time of Covid crisis and failure to comply with the NHS employment standards insomuch as the NHS may be employing staff as a consequence who have dubious or spurious credentials, or whose identity may not be verified as rigorously as usual. Pre-employment checks need to remain robust in this domain and the LCFS is monitoring this area both within Health Board processes and on the National Fraud Initiative. An example of this is case **(46)** on **Appendix 2** which pertains to a person who gained employment as a HCSW and who had been previously imprisoned for drug trafficking offences.

4.27 As required, the ABUHB LCFS engages with the Head of Engagement and Support for NWSSP on the aspect of monitoring and sharing of PPV audit data pertaining to claims by General Ophthalmic Service contractors.

Consequently, the LCFS has access to GOS trend data which allows for proactive monitoring of claiming patterns and for any abnormal claiming activity on the part of Health Board GOS contractors.

4.28 The LCFS frequently reports system weaknesses on the investigation management system *Clue-3* to allow for remedial national NHS system strengthening measures to be applied if considered necessary. This was the case in respect of the aforementioned risk assessments/LPE's.

4.29 The ABUHB LCFS remains committed to implementing changes to the return-to-work interview form in so much as it is strongly recommended that a question is included in the document which asks the member of staff if they have worked elsewhere during a period of paid sickness absence. This is to supplement information in the NHS Wales Managing Attendance at Work Policy which advises workforce of the potential disciplinary and criminal liability of this conduct. This request is currently being actioned.

4.30 In order to maximise the deterrence of fraud, the LCFS has promoted successful Local and National cases to LHB staff and Contractors at every given opportunity.

4.31 A range of communication tools have been utilised to deter staff and contractors from committing fraud, including: fraud awareness presentations, newsletters, leaflets/posters, payslip messages and Counter Fraud web pages and ABUHB intranet site & ESR homepage.

4.32 During year 2021/22, where legally permissible, the LCFS has continued with the practice of publicizing national media reports of individuals who have been convicted at Court of defrauding the NHS. This positive counter fraud reporting is with a view to maximizing the deterrent impact of such cases.

4.33 The Counter Fraud Communication Strategy Policy developed for Aneurin Bevan University Health Board, outlines the communication methods that are utilized to promote fraud awareness.

4.34 The LCFS has continued to provide guidance to ABUHB Head of Communications which includes the work of the NHS Counter Fraud Service (NHSCFA) Deterrence and Engagement Unit Media Team and the Advance Warning System adopted by that organisation. The DEU is able to support the LHB with media handling of cases that attract the attention of the press. The Head of Communications is customarily given advance notification of cases prior to their arraignment at court.

4.35 The Counter Fraud newsletters that were circulated during 2021/22, highlighted local and national cases of fraud against the NHS that have been successful in court. The newsletter also provided information on the correct way to report fraud and all the relevant contact details. The Newsletters sent out a clear deterrent message to readers that fraud in the NHS is unacceptable, indefensible and will not tolerated and that action will be taken against any known perpetrators.

4.36 The LCFS promotes the ABUHB Whistleblowing Policy in every instance at fraud awareness presentations and roadshows.

Feedback questionnaires are distributed at every presentation and the results of these questionnaires are retained and analysed by the LCFS. Any areas of perceived deficiency are addressed.

4.37 The proactive fraud detection exercise which was incepted by the LCFS in 2011 which centered on the audit of expenditure reports at ABUHB hospital Prescription Handling Directorates is still an ongoing rolling programme. This continuing audit of hospital prescription forms not only acts as a preventative measure but also acts as a deterrent because the LCFS publicizes the fact to prescribers that this scrutiny is taking place.

4.38 NHSCFA fraud prevention media titled, *'Who pays for fraud in the NHS – we all do'*, features on the ABUHB intranet site. This media encompasses current NHSCFA fraud prevention leaflets.

4.39 In order to ensure the effectiveness and staff awareness of the Standards of Business Conduct for Employees Policy, the Board Secretary continues to pursue the submission of declaration of interest forms or a nil return, whichever applies.

In order to reinforce the obligation for staff to submit declarations of interest, the aspect is included on ESR as part of PADR core documents in order to reach the largest audience of staff members.

5 Reactive Counter Fraud Bribery & Corruption Practices - Hold to Account

5.1 The LCFS has highlighted that a proactive review programme helps to develop the cultural change necessary to allow the Counter Fraud Strategy to be effective.

5.2 The Audit Commission is responsible for running the National Fraud Initiative (NFI). This commenced in 1996 and runs every two years. The NFI is an exercise that matches electronic data both within and between some 1,200 public sector bodies and participating private sector bodies to prevent and detect fraud. This includes the NHS, DWP, HMR&C, Police Authorities, Local Probation Boards, Fire and Rescue Authorities as well as Local Councils and number of private sector bodies. Since the NFI commenced, the initiative has helped to identify £1.93 billion of fraud, overpayment and error across UK public bodies. The NFI data collection operated in 2020/21. By the deadline date of October 2020, the LCFS facilitated the downloading of the Trade Creditors payment history and Trade Creditors standing data to the Wales Audit Office in compliance with the NFI mandate.

NHS Pension and Staff Payroll Data was also downloaded by the deadline date. This included the incorporation of fair processing notices to staff on the ESR homepage carousel.

The data matches were received by ABUHB on 29th January 2021. The matches total 6,616 in number, of which, 6,121 relate to trade creditors standing data.

The ABUHB LCFS continues work on these NFI data matches. The work into trade creditors standing data matches, however; has been hindered by unavoidable staffing deficiency within NWSSP Procurement Services Account Payable Section and this aspect has been reported back to the Cabinet Office by the LCFS.

5.3 The LCFS has maintained the following proactive investigation exercises, albeit impeded by Covid restrictions:

- Monitoring of GOS trend data pertaining to claims by GOS Contractors.
- Data mining for outliers and abnormal claiming patterns for common ailment scheme claims by Community Pharmacies.
- Rolling programme of monitoring the medication prescribed on Hospital Directorate medical prescription forms.

5.4 The Counter Fraud team investigates all referrals of alleged fraud, bribery and/or corruption in accordance with Welsh Government Directions and the counter fraud bribery & corruption manual. The LCFS provides the DoF and the NHS Counter Fraud Service (Wales) with a concluding report on each investigation.

5.5 Investigations are anonymised in reports to the Audit Committee. Internal Audit and External Audit receive copies of the LCFS report to the Audit Committee and vice versa. Incorporated in **Appendix 2** are details of the LCFS counter fraud investigations conducted between 1st April 2021 and 31st of March 2022.

5.6 CFS Wales carry out high value complex investigations. If an investigation is linked with the area in which the LCFS operates they may be required to assist

the CFS Wales by taking witness statements, assisting in the search of a premises or carrying out interview of witnesses and suspects.

5.7 The LCFS has liaised with the Information Governance Manager who is aware of the work of the LCFS. The LCFS has confirmed that ABUHB is compliant with registration on the ICO Data Protection Register. The LHB has an extensive and up-to-date information asset register.

5.8 The LCFS actively promotes working in partnership through collaboration and interaction with other agencies. A demonstration of this are cases listed as **(20)(42) & (46)** on **Appendix 2,** which in this instance pertains to Police collaborative investigations.

5.9 On the aforementioned cases, information sharing occurred between the LCFS and Police. The LCFS provided a witness statement and documentary evidence to support a joint LCFS/Police prosecution in case **(46)**. Additionally, the LCFS provided a statement of evidence to HR to support the disciplinary process in relation to investigation **(7)** on **Appendix 2**.

5.10 Additionally, on investigations **(3)(4) & (8)** on **Appendix 2** the LCFS provided evidential support to the professional bodies and actually provided witness statements to the NMC & GMC in these instances.

5.11 The LCFS is committed to pursuing every line of enquiry during an investigation and this includes employing every available investigative technique and resource. A further demonstration that the LCFS utilizes the full range of investigative resources, applies to investigation **(37)** on **Appendix 2**. This case demanded a financial investigation under the Proceeds of Crime Act 2002, which was undertaken by an Accredited Financial Investigator attached to Counter Fraud Service (Wales). Additionally, as part of the investigation, a production order was obtained from a Crown Court Circuit Judge in order to access bank records for evidential purposes.

5.12 On four occasions historically, ABUHB has provided expenditure for handwriting forensic analysis, to progress LCFS investigations and this is yet further evidence that there is strong political and executive support for work to counter fraud, bribery and corruption. It is apparent that the ABUHB organisation is committed to making financial investments in work to tackle fraud, bribery and corruption which is proportionate to identified risks.

5.13 During 2021/22 the ABUHB LCFS disseminated **eighteen (18)** Data Protection requests to external bodies i.e. Police, DWP & UKBA etc, whereby information was sought by the LCFS to progress investigations.

Similarly, **twenty-five (25)** Data Protection requests were received by the LCFS from the Police and other agencies, whereby information was sought by law enforcement. This resulted in the release of information by the LCFS and from probity and information governance best practice, the Head of Information Governance was party to all the disclosure.

5.14 Liaison was effected with HMR&C on investigations (36) & (37) on Appendix 2 and gateway authorities were utilised to obtain taxation records as part of these LCFS investigations.

5.15 Automated number plate recognition evidence (ANPR) was obtained from Heddlu Gwent Police on **two (2)** occasions in relation to investigations **(7) & (13)** on **Appendix 2**.

In addition to this, the LCFS has collaborated with Gwent Police to facilitate PNC checks as a consequence of NHSCFA inability to do so following initial Covid lockdown.

5.16 During 2021/22, the LCFS conducted **two (2)** interviews under caution with **two (2)** alleged offenders. The ability of the LCFS to conduct such interviews has been impeded due to Covid restrictions.

5.17 In the event that the LHB has a case of proven fraud, the next step will be to seek to apply an appropriate sanction. There are three different types of sanctions which can be followed parallel to each other. The sanctions are as follows:

- LHB Disciplinary Procedure: Applicable to NHS staff only. Contractors can be referred to the relevant professional body.
- Civil law Procedures: Applicable where the LHB needs to recover monies lost to fraud that cannot be sought through voluntary payments or the Criminal Courts.
- Criminal law Procedures: to apply an appropriate criminal penalty.

5.18 **Six (6)** investigations on **Appendix 2** have resulted in prosecution files of evidence being submitted to the Crown Prosecution Service (Paragraph 1.9 above refers).

5.19 **Three (3)** of those cases **(3)(4) & (20)** on **Appendix 2** have resulted in criminal convictions/sanctions.

5.20 **Twenty (20)** cases **(6)(17)(18)(20)(21)(26)(27)(28) & (31)** on **Appendix 2** have resulted in disciplinary action. These generally pertain to dismissal from employment for gross misconduct but include formal written warnings or where staff members have resigned prior to the conclusion of the disciplinary process.

5.21 Investigations **(9) & (20)** on **Appendix 2** are ongoing matters with the NMC which have impending sanctions from the professional body.

5.22 **Four (4)** cases **(3)(4)(8)** & **(10)** on **Appendix 2** have received professional sanctions from the professional bodies the GMC & NMC.

5.23 The LCFS has sought to maximise the deterrent value of criminal sanctions by publicising them and exploiting media coverage of cases. Two cases which feature as **(3) & (4)** on **Appendix 2** received extensive regional media reporting following convictions at Court. Additionally, case **(4)** received national media attention during its hearing at the NMC. This media coverage amplified the deterrent message to any would-be NHS fraudsters.

5.24 It is important that sanctions are applied in a consistent manner according to the seriousness of the fraud, which is believed to be present. All sanctions are carried out in accordance with the NHS policy publication entitled 'Applying Appropriate Sanctions Consistently'. Full compliance is also made to Legal Directions and the NHS counter fraud manual.

5.25 The protocol between the Counter Fraud Specialist and Workforce & OD (referred to previously at paragraph 2.2 above) outlines the procedure that should be followed if a staff member is being investigated for fraud. The protocol ensures that both parties work together to ensure that any disciplinary action does not affect any criminal investigation. The implementation of the protocol by the LHB ensures consistency in working practices and will be

supportive of the Counter Fraud provision and the LCFS. Consideration in this domain is also given to the NHSCFA policies on Parallel Criminal and Disciplinary Investigations.

5.26 The Covid lockdown essentially brought the Criminal Justice court process to a standstill and impending prosecutions were severely delayed with the closure of law courts. Additionally, under the Crown Prosecutors Code, it is evident that the emphasis in relation to public interest considerations were affected in the decision-making process applied by the CPS.

Under the Crown Prosecutors Code, each case under consideration must pass two individual tests before it can proceed to court, firstly the evidential test and secondly the public interest test. If a case fails the evidential test, then no consideration should be given to public interest factors irrespective of how serious a case may be.

Investigations listed as case numbers **(7) (8)** & **(13)** on **Appendix (1)** received declined charging decisions by the CPS. Pre-Covid, such cases would have undoubtedly resulted in criminal court proceedings. This currently appears to be an immerging theme in respect of contested cases.

At the request of Audit Committee, the LCFS was tasked to establish if this was exclusive to ABUHB cases. It has been confirmed that this is an emerging pattern across Wales and is not unique to ABUHB. Information on all rejected cases across Wales has been collated and the Manager of Counter Fraud Service (Wales) who is the liaison point with the CPS, proposes to meet with the Head of the CPS Specialist Fraud Division to discuss concerns.

Contact to-date with the CPS has established that following the pandemic, the backlog of impending prosecution cases with the Department of Justice is extreme and the CPS are striving to reduce that backlog by reducing the number of new cases which are adding to that process.

5.27 The criminal investigations conducted by the LCFS during Covid lockdowns continued virtually unhindered throughout their evidential gathering phases. Towards the conclusion of any such investigation, following the evidence gathering stage, if areas of concern are found to be prevalent, there is the requirement to conduct an audio recorded interview under caution, with the defendant, in the presence of their Solicitor. Due to Covid restrictions, interviews under caution reduced in number, however; it is anticipated that such interviews will now progress as normal.

5.28 Fraud whistleblowing referrals have continued to be received by the LCFS but the dynamic for raising fraud concerns has changed during the Covid crisis. Pre-Covid, the most common method of this type of referral was by means of the fraud referral form downloaded from the Counter Fraud web-pages on the ABUHB intranet site. Since Covid lockdown, these type of fraud referrals have reduced in number whereas there has been an increase in referrals via the NHS 0800 national fraud & corruption reporting line which is linked to crime-stoppers.

5.29 In all cases, the LCFS, in agreement with the DoF, seeks to recover monies lost to the LHB as a result of fraud and corruption. Recoveries totalling **£44,374.79** were made against investigations listed as numbers **(22) (36)** & **(37)** on **Appendix 2** of this report. Additionally, the NHSCFA are currently driven to fraud prevention savings as a result of counter fraud intervention and such savings of **£300,676.78** are recorded against investigations **(1)** & **(22)** on Appendix 2. The LCFS also seeks to maximise possible sanctions against the

perpetrator. Effective recovery can benefit from other work performed by the LCFS to professionally investigate, to seek to apply sanctions and develop an anti-fraud culture.

5.30 The LCFS keeps a record of the outcome of all investigations including details of recoveries being sought. The LHB has procedures in place for recovering money lost to fraud and the recoveries policy is enforced and adhered to rigidly.

6 Counter Fraud Arrangements

6.1 CFS (Wales) the regional arm of NHSCFA, hold All-Wales bi-annual summits at which all LCFS's who work within the NHS in Wales are required to attend.

6.2 The meetings give the LCFS an opportunity to share best practice with other Counter Fraud Specialists and to receive training and updates on legislation relating to criminal investigations.

6.3 During 2021/22, such meetings were held on 8th July 2021, 13th July 2021, 19th October 2021, 13th December 2021 & 15th March 2022. Additionally, the meetings on 8th July 2021, 19th October 2021 & 15th March 2022, were also attended by NHSCFA Q.A. Managers and involved training in relation to quality and assurance and local proactive exercises. The ABUHB LCFS attended these meetings.

6.4 The Lead LCFS has regularly met/liaised with the DoF during 2021/22 to monitor the progress against the Counter Fraud workplan. The LCFS has regular interaction with the DoF relating to fraud investigations, to highlight potential fraud risks and to circulate fraud notices. These meetings are customarily scheduled on a bi-monthly basis.

On behalf of ABUHB, the DoF is also the authority for prosecution. These meetings are scheduled at paragraph 2.13 of this report.

6.5 The Counter Fraud team consistently takes action to develop new skills for Counter Fraud, and where necessary attends the relevant training courses and workshops. NHSCFA Q.A. Managers provided training inputs at the all-Wales forums referred to at paragraph 6.3 above. This training pertained to Quality Assurance & Local Proactive Exercises.

6.6 Further to the above, the ABUHB LCFS undertook the following training sessions during 2021/22:

- NHSCFA Clue-3 Training
- RL Datix Cloud training
- Datix incident reporting
- Datix Risk Module
- Pulse intranet training
- NHSCFA Risk Assessment Training
- Fraud risk knowledge hub training
- Dashboard training
- Local proactive exercise training
- Patient administration system training
- Microsoft Office 365 training
- Migration to Share Point
- Trac Training
- Mandatory PADR online modules

6.7 The Lead LCFS has ongoing liaison throughout the financial year with CFS (Wales) with regards to ongoing measures that the Counter Fraud Team has to adhere to. During 2021/22 the Counter Fraud Team has submitted quarterly statistics to CFS (Wales) which included Counter Fraud work and risks identified.

6.8 The Lead LCFS presented the Counter Fraud workplan for 2021/22 which was duly agreed by the DoF. The LCFS identified areas of greatest risk that needed addressing. The workplan is a dynamic document and is regularly updated to ensure that it is reflective of the LHB's needs.

6.9 By the submission deadline date of 30th April 2022, ABUHB Counter Fraud will submit a standards self-assessment review to NHSCFS, Quality Assurance. This review is based on Government Functional Standard for Counter Fraud (GovS 013) and will reflect the ABUHB Counter Fraud provision for 2021/22. The NHSCFA Quality Assurance Team scrutinise the counter fraud provision and assess for embedded counter fraud arrangements and evidence of qualitative outcomes. The resulting report will be presented to Audit Committee for its recommendations to be implemented accordingly.

6.10 Counter Fraud work is a standing item on the Aneurin Bevan University Health Board's Audit Committee meeting agenda. During 2021/22, the LHB Lead LCFS was required to attend and report at **three (3)** such Audit Committee meetings for the LHB i.e. 8th April 2021, 12th August 2021 & 3rd February 2022.

6.11 During 2018/19 the LCFS referred one case to Counter Fraud Service (Wales) for investigation relating to a primary care ophthalmic contractor for potential GOS fraud. This investigation was closed in Q.2 2021/22.

Appendix 1

1. Reporting lines

Chief Executive	Mr. Glyn JONES Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: glyn.jones7@wales.nhs.uk
Director of Finance	Mr. Robert HOLCOMBE Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: robert.holcombe@wales.nhs.uk
Head of Counter Fraud	Martyn EDWARDS Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: martyn.edwards3@wales.nhs.uk
Local Counter Fraud Specialist	Gareth LAVINGTON Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: gareth.lavington@wales.nhs.uk
Local Counter Fraud Specialist	Joanne BODENHAM Counter Fraud Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: joanne.bodenham@wales.nhs.uk

2. Further Information\Mix of cases

Number of cases as at 31st of March 2022, including those brought forward from previous year:

Area (based on Initial reported category)	Number of Cases	Closed	Ongoing
Contractor – Pharmacy (Falsify dispensing charges)	1	1	0
Contractor – Social Care (Continence product fraud)	1	1	0
Contractor – Dental (Prescription misuse)	1	1	0
Contractor – GP Staff (Fraudulent prescribing)	2	2	0
Contractor – GP Staff (Theft of monies)	1	1	0
Contractor – GP (Falsify application for performers list)	1	0	1
Patient – (Compensation fraud)	1	0	1
Patient – (Prescription fraud)	5	5	0
Staff – (Falsely obtain paid leave)	2	2	0
Staff – Doctors (Private work in NHS time)	1	0	1
Staff – Doctor (Working whilst on sick-leave)	1	1	0
Staff – (Falsify CV to obtain post)	3	2	1
Staff – (Contract fraud)	1	1	0
Staff - (Working on sick leave)	8	7	1
Staff – (Dishonest retention of salary overpayments)	2	0	2
Staff - (Falsified expenses/timesheets)	10	9	1
Staff – (Theft/fraud)	3	1	2
Staff – (Failing to complete contracted hours)	2	2	0
Totals	**46**	**36**	**10**

3. NHS Counter Fraud Authority Website

Information about NHS Counter Fraud Authority and the NHS Counter Fraud Strategy can be found at https://cfa.nhs.uk/

Appendix 2

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2022

Case	FIRST Ref	Health Body	Area	Subject	Status
1.	WARO/18/00048	ABUHB	Community Pharmacist	Falsely claiming pharmacy fees.	NFA on criminal aspect. Fraud prevention saving of £300K. Case closed 24/09/2021.
2.	WARO/18/00084	ABUHB	NHS Staff	Failure to complete contracted hospital sessions.	NFA on criminal aspect. No disciplinary issue identified. Case closed 24/09/2021.
3.	WARO/18/00106	ABUHB	NHS Staff	Working elsewhere whilst on sick leave and falsification of NMC revalidation paperwork.	At Merthyr Crown Court on 29/11/2019, defendant was convicted of fraud and sentenced to 8-month imprisonment. Defendant resigned from employment with ABUHB prior to disciplinary outcome. NMC sanction on 06/06/2021, striking off nursing register. Case closed 11/06/2021.
4.	WARO/18/00122	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Recovery of £3,996.43. At Newport Magistrates Court on 26/04/2019, defendant was convicted of fraud. Sentenced to Community Order for 12-months, 100 hours unpaid work. Pay £85.00 costs and £85.00 victim surcharge. Disciplinary and professional action has also been implemented by ABUHB and GMC. Striking off order implemented by GMC 01/09/2021. Case closed 24/09/2021.
5.	WARO/18/00136	ABUHB	NHS Staff	Timesheet fraud.	NFA on criminal aspect. No disciplinary issue identified. Case closed 01/12/2021.
6.	WARO/19/00034	ABUHB	NHS Staff	Irregularities with job application form as well as professional issues.	Employee dismissed from employment for gross misconduct following disciplinary action. NFA on criminal aspect. Case closed 18/10/2021.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2022					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
7.	WARO/19/00145	ABUHB	NHS Staff	Falsify WLI claims.	CPS declined charging decision.
8.	WARO/19/00122	ABUHB	General Practitioner	Falsify information on application for Welsh G.P. performers list.	Subject has been interviewed under caution. CPS declined to charge. Subject has been suspended from practising by GMC pending fitness to practice hearing.
9.	WARO/20/00020	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Dismissed from employment on 21/10/2020 following disciplinary action. NMC sanction impending.
10.	WARO/20/00046	ABUHB	Agency Nurse	Timesheet fraud.	NFA on criminal aspect. NMC issued a suspension order July 2021. Case closed 04/11/2021.
11.	WARO/20/00051	ABUHB	NHS Staff	Contract fraud.	NFA on criminal aspect. No disciplinary issue identified. Case closed 24/11/2021.
12.	WARO/20/00066	ABUHB	G P Practice Staff	Prescription fraud.	NFA on criminal aspect. Case closed 29/10/2021.
13.	WAR0/20/00070	ABUHB	G P Practice Manager	Theft of income at G.P. Practice.	CPS declined to charge. Subject resigned ahead of disciplinary hearing July 2020. Case closed 18/01/2022.
14.	WARO/20/00099	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed 15/07/2021.
15.	WARO/20/00101	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed 15/07/2021.
16.	WARO/20/00108	ABUHB	Dental Contractor	Prescription misuse.	NFA on criminal aspect. Case closed 24/09/2021.
17.	WARO/20/00110	ABUHB	NHS Staff	Theft of NHS equipment.	NFA on criminal aspect. Written warning issued. Case closed 23/12/2021.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2022					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
18.	WARO/20/00111	ABUHB	NHS Staff	Falsely obtain compassionate leave.	NFA on criminal aspect. Dismissed for gross misconduct Aug 2021. following disciplinary action. Case closed 21/08/2021.
19.	WARO/21/00001	ABUHB	NHS Staff	Timesheet fraud.	NFA on criminal aspect. Case closed 1/3/2022
20.	WARO/21/00003	ABUHB	NHS Staff	Theft of medication.	Dismissed for gross misconduct on 10/08/2021 following disciplinary action. Police sanction Women's pathway. NMC sanction impending.
21.	WARO/21/00039	ABUHB	NHS Staff	Timesheet fraud.	NFA on criminal aspect. Written warning given as disciplinary sanction. Case closed 05/07/2021.
22.	INV/21/00021	ABUHB	NHS contractor	Continence products fraud.	NFA on criminal aspect. Recovery of £1,827.31 made plus further loss of £676.78 prevented during 2021. Case closed 01/06/2021.
23.	INV/21/00030	ABUHB	NHS Staff	Timesheet fraud.	NFA on criminal aspect. No disciplinary issue identified. Case closed 19/08/2021.
24.	INV/21/00050	ABUHB	Community Pharmacist	CAS claim irregularities.	NFA on criminal aspect. Case closed 26/07/2021.
25.	INV/21/00052	ABUHB	Member of public	Prescription fraud.	NFA on criminal aspect. Case closed 10/01/2022.
26.	INV/21/00053	ABUHB	NHS Staff	Conduct private work in NHS time.	NFA on criminal aspect. Words of advice given as disciplinary sanction. Case closed 01/06/2021.
27.	INV/21/00089	ABUHB	NHS Staff	Timesheet Fraud.	NFA on criminal aspect. Dismissed from employment for gross misconduct following disciplinary action. Case closed 08/12/2021.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2022					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
28.	INV/21/00102	ABUHB	G.P. Staff	Prescription fraud.	Resigned following suspension. NFA criminal aspect. Case closed 09/09/2021.
29.	INV/21/00109	ABUHB	NHS Staff	Irregularities with job application form.	NFA on criminal aspect. No disciplinary issue identified. Case closed 26/07/2021.
30.	INV/21/00130	ABUHB	NHS Staff	Falsify Covid result to obtain sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed 23/08/2021.
31.	INV/21/00066	ABUHB	NHS Staff	Timesheet fraud.	NFA criminal aspect. 12 members of staff received disciplinary sanctions. Case closed 01/08/2021.
32.	INV/21/00161	ABUHB	GP Surgery	Prescribing concerns.	NFA on criminal aspect. Case closed 23/08/2021.
33.	INV/21/00194	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed 24/09/2021.
34.	INV/21/00228	ABUHB	Nursing Agency Staff	False declarations on agency timesheets.	NFA on criminal aspect. Robust HB systems in place prevented loss. Case closed 01/10/2021.
35.	INV/21/00229	ABUHB	Patient	Prescribing concerns.	Strategy meeting to progress. NFA on criminal aspect. Case closed 15/10/2021.
36.	INV/21/00267	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Investigation ongoing. Civil recovery of £28,000 implemented.
37.	INV/21/00276	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Subject interviewed under caution & prosecution file of evidence forwarded to CPS for charging decision. Civil recovery of £14,218.80 implemented.
38.	INV/21/00286	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed 20/10/2021.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2022					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
39.	INV/21/00294	ABUHB	NHS Staff	Falsification of hospital appointments.	Investigation ongoing.
40.	INV/21/00346	ABUHB	Patient	Prescribing concerns.	NFA on criminal aspect. Case closed 10/01/2021.
41.	INV/21/00348	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. No disciplinary issue identified. Case closed 19/11/2021.
42.	INV/21/00367	ABUHB	Patient	Prescribing concerns.	Case passed to Gwent Police. Case closed 09/12/2021.
43.	INV/21/00372	ABUHB	NHS staff	Timesheet fraud.	NFA on criminal aspect. Case closed 1/02/2022
44.	INV/22/00060	ABUHB	Member of public	NHS compensation claim.	Investigation ongoing.
45.	INV/22/00110	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.
46.	INV/22/00123	ABUHB	NHS staff	False declaration on job application form.	Investigation ongoing in joint venture with Gwent Police.

Appendix 3

COUNTER FRAUD STAFF SURVEY

1. In order to ensure we provide the appropriate training to the right people we would really appreciate it if you would tell us your name and place of work

		Response Percent	Response Total
1	Full Name	99.11%	111
2	Department or Place of Work	100.00%	112
		answered	112
		skipped	7

2. Have you ever attended a fraud awareness session?

		Response Percent	Response Total
1	Yes	47.06%	56
2	No	52.94%	63
		answered	119
		skipped	0

Statistics								
	Minimum	1	Mean	1.53	Std. Deviation	0.5	Satisfaction Rate	52.94
	Maximum	2	Variance	0.25	Std. Error	0.05		

3. Would you be interested in a further fraud awareness session?

		Response Percent	Response Total
1	Yes	78.15%	93
2	No	21.85%	26
		answered	119
		skipped	0

Statistics								
	Minimum	1	Mean	1.22	Std. Deviation	0.41	Satisfaction Rate	21.85
	Maximum	2	Variance	0.17	Std. Error	0.04		

4. Have you completed the 'On-line' Fraud Awareness Training Module linked to your PADR compliance?

		Response Percent	Response Total
1	Yes	54.62%	65
2	No	45.38%	54
		answered	119
		skipped	0

Statistics								
	Minimum	1	Mean	1.45	Std. Deviation	0.5	Satisfaction Rate	45.38
	Maximum	2	Variance	0.25	Std. Error	0.05		

5. When did you complete this on-line module?

		Response Percent	Response Total
1	In the last 6 months	13.92%	11
2	In the last 12 months	26.58%	21
3	Longer than 12 months ago	59.49%	47

Statistics									
	Minimum	1	Mean	2.46	Std. Deviation	0.73	Satisfaction Rate	72.78	answered 79
	Maximum	3	Variance	0.53	Std. Error	0.08			skipped 40

6. Are you aware that there is a Fraud, Bribery and Corruption Policy?

		Response Percent	Response Total
1	Yes	70.59%	84
2	No	29.41%	35

Statistics									
	Minimum	1	Mean	1.29	Std. Deviation	0.46	Satisfaction Rate	29.41	answered 119
	Maximum	2	Variance	0.21	Std. Error	0.04			skipped 0

7. Have you read the policy?

		Response Percent	Response Total
1	Yes	30.51%	36
2	No	69.49%	82

Statistics									
	Minimum	1	Mean	1.69	Std. Deviation	0.46	Satisfaction Rate	69.49	answered 118
	Maximum	2	Variance	0.21	Std. Error	0.04			skipped 1

8. What Fraud Awareness publicity material have you seen? (PLEASE TICK ALL THAT ARE APPLICABLE)

		Response Percent	Response Total
1	Posters	16.84%	16
2	Leaflets	2.11%	2
3	Article in newsletter	7.37%	7
4	Information/videos on Intranet	43.16%	41
5	Other (please specify):	30.53%	29

Statistic									
	Minimum	1	Mean	3.68	Std. Deviation	1.37	Satisfaction Rate	67.11	answered 95
									skipped 24

8. What Fraud Awareness publicity material have you seen? (PLEASE TICK ALL THAT ARE APPLICABLE)

							Response Percent	Response Total
s	Maximum	5	Variance	1.88	Std. Error	0.14		

9. What, in your opinion/role is the easiest method of getting fraud awareness messages to you?

		Response Percent	Response Total
1	email	72.03%	85
2	intranet	45.76%	54
3	newsletter	20.34%	24
4	in person presentation	29.66%	35
5	Other (please specify):	9.32%	11

Statistics								
	Minimum	1	Mean	2.2	Std. Deviation	1.27	answered	118
	Maximum	5	Variance	1.62	Std. Error	0.09	skipped	1

10. Are you aware there are nominated Local Counter Fraud Specialists (LCFS) who deal with fraud, bribery and corruption within ABUHB?

		Response Percent	Response Total
1	Yes	55.56%	65
2	No	44.44%	52

Statistics										
	Minimum	1	Mean	1.44	Std. Deviation	0.5	Satisfaction Rate	44.44	answered	117
	Maximum	2	Variance	0.25	Std. Error	0.05			skipped	2

11. Do you know how to report a suspicion of fraud?

		Response Percent	Response Total
1	Yes	53.78%	64
2	No	46.22%	55

Statistics										
	Minimum	1	Mean	1.46	Std. Deviation	0.5	Satisfaction Rate	46.22	answered	119
	Maximum	2	Variance	0.25	Std. Error	0.05			skipped	0

12. Has the Covid 19 pandemic had any effect on your ability to identify fraud, bribery or corruption?

		Response Percent	Response Total
1	Yes	16.95%	20
2	No	83.05%	98
	answered		118
	skipped		1

Statistics								
	Minimum	1	Mean	1.83	Std. Deviation	0.38	Satisfaction Rate	83.05
	Maximum	2	Variance	0.14	Std. Error	0.03		

13. Has the Covid 19 pandemic had any effect in you reporting your concerns to the ABUHB Counter Fraud Department/anyone else?

		Response Percent	Response Total
1	Yes	2.54%	3
2	No	97.46%	115
	answered		118
	skipped		1

Statistics								
	Minimum	1	Mean	1.97	Std. Deviation	0.16	Satisfaction Rate	97.46
	Maximum	2	Variance	0.02	Std. Error	0.01		

14. Please provide any additional comments or suggestions you have that may assist us in improving this service.

		Response Percent	Response Total
1	Open-Ended Question	100.00%	10
		answered	10
		skipped	109

Aneurin Bevan University Health Board

Annual Counter Fraud Workplan - 1st April 2022 to 31st March 2023

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit, Risk and Assurance Committee. It highlights the Counter Fraud work which is proposed to be undertaken by the Local Counter Fraud Specialist (LCFS) for 2022/23. This workplan encompasses all the components of Government Functional Standard GovS 013: Counter Fraud, which took effect over the NHS Counter Fraud provisions on 1st April 2021.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	√		
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	√		
Executive Sponsor: Robert Holcombe – Interim Director of Finance, Procurement & Value			
Report Author: Martyn Edwards – Head of Counter Fraud			
Report Received consideration and supported by : Robert Holcombe – Interim Director of Finance, Procurement & Value			
Executive Team		**Committee of the Board [Committee Name]**	**Audit Committee**
Date of the Report: 19th March 2022			
Supplementary Papers Attached: No			

Purpose of the Report

The Workplan requires to be approved by the Director of Finance and ratified by Audit, Risk and Assurance Committee.

Background and Context

This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to facilitate mapping the provisions of the Government Functional Standard GovS 013: Counter Fraud and the recommendations of the NHS Counter Fraud Authority.

Assessment and Conclusion

This report will contribute towards the Quality Assurance Self-Review as evidence that the LHB has complied with Government Functional Standard GovS 013: Counter Fraud. The report content and style complies with the model prescribed by the NHS Counter Fraud Authority (NHSCFA) for Quality Assurance Assessment.

Recommendation
This report is intended for Audit Committee information and views.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	N/A
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	N/A
Link to Integrated Medium Term Plan/Corporate Objectives	N/A
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** N/A
	Integration – N/A
	Involvement – N/A
	Collaboration – N/A
	Prevention – N/A
Glossary of New Terms	N/A
Public Interest	N/A

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD, BRIBERY & CORRUPTION WORK-PLAN 1st APRIL 2022 to 31st MARCH 2023

This document is prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Director of Finance.

WORKPLAN 2022-2023

1 Background

1 On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding).

The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and will be responsible for ensuring the effective implementation of the NHS Counter Fraud Requirements. The requirements have superseded our own fraud, bribery and corruption standards for providers, commissioners and NHS bodies in England and Wales.

The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. The Quality Assurance Programme will enable the analysis of trends and patterns in performance in relation to each requirement.

.

1.1 This Workplan provides a basis to formulate Local Counter Fraud arrangements for Aneurin Bevan University Health Board. The tasks outlined should be considered and reviewed on an annual basis. This guidance recommends the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures. These recommendations are based on the Government Functional Standard 013: which replaces the previous NHS specific Standards for Fraud, Bribery and Corruption (Standards). Together with stakeholders the NHSCFA have developed new NHS Requirements to meet the Functional Standard.

1.2 The Health Board follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and employs a dedicated, professionally accredited team of NHS Local Counter Fraud Specialists (LCFS), to undertake the role of countering fraud within the Health Board.

1.3 To ensure that the Health Board's resources remain resilient to the risk of fraud, bribery and corruption, an Annual Work-Plan is compiled by the LCFS and submitted to the Audit Committee for approval at the commencement of each financial year.

1.4 The LCFS' are aware of the importance of liaison with External Auditors when planning Local Counter Fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g., Whistle-Blowing arrangements, Declaration of Interests, Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter Fraud arrangements are robust.

1.5 **NHS Counter Fraud Authority Fraud, Bribery and Corruption Strategy**

NHS Counter Fraud Authority has published new counter fraud requirements to ensure compliance with **Government Functional Standard GovS 013: Counter Fraud.** Together with stakeholders the NHSCFA have developed new NHS Requirements to meet the Functional Standard. The Work-Plan below provides detail of where Standards have been aligned to the new NHS Requirements, under 4 key principle headings:

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

- **Inform and Involve –** This sets out the requirements into raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

- **Prevent and Deter –** This sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

- **Hold to Account –** This sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes and seeking redress.

1.6 NHS Counter Fraud Authority (NHSCFA) has also published detailed information on how the new Government Functional Standard 013 will be applied across the NHS and wider Health Group. The Health Board's 2022-23Work-Plan for Local Counter Fraud work will therefore closely mirror this Standard and Provider's Guidance, which in turn supports the objectives set by the Welsh Government.

1.7 The total number of suggested **Pro-Active days** to be allocated in 2022-23 is **312** (out of a total of resource of 535 workdays) this *excludes* the resource required for undertaking 'Reactive' Local Counter Fraud work (Hold to

Account). This reactive resource is required to conduct detailed investigations into allegations received by the Health Board in relation to NHS Fraud, Bribery and Corruption. The total number of **Reactive days** to be allocated in the 2022-23 Work-Plan is **223** (inc proactive investigations).

1.8 Pro-Active work (i.e. *Key Principles: Strategic Governance, Inform & Involve and Prevent & Deter*) should not be absorbed by reactive activity or *vice versa* and to this end NHSCFA strongly encourages Pro-Active work to be 'ring-fenced'. Effective Pro-Active work needs to be undertaken otherwise the Health Board may be at risk from Fraud, Bribery and/or Corruption.

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

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

1.10 Organisations that fall below this guidance should be able to provide evidence as to why decisions on work planning have been taken and these should be provided to NHSCFA upon request.

2 Taking a risk-based approach to planning local counter fraud work

2.1 During 2013-14 NHSCFA issued a 'Standards Self Review Tool' template to support NHS organisations in assessing if they are meeting the recommended 'Standards for Providers for Fraud Bribery and Corruption'.

2.2 The Work-Plan is a framework on which to build robust Counter Fraud arrangements and is therefore analogous with the 'Standards Self Review Tool' that Health Boards are requested to submit to NHSCFA at the end of the financial year.

2.3 Those who are locally based are best placed to identify and understand the Counter Fraud requirements for their organisation. The successful implementation of NHS Policy for Countering Fraud, Bribery and Corruption relies greatly on the success of the Local Counter Fraud Specialist (LCFS) role.

2.4 Meeting with key personnel within the Health Board is crucial to information gathering and, along with staff survey results, can assist in the formulation of planning and provide information on the most effective methods of communication. Responses may also indicate areas of perceived risk and this may also be supported by previous experiences which could highlight a need for Pro-Active preventative or detection work.

2.5 The LCFS should have effective liaison with the Local Risk Manager and Risk Group. It is recommended that frauds that have occurred within the organisation and beyond be brought before this group to ascertain the risk to the Health Board from the same type of fraud. Once identified, the fraud can be proactively addressed.

2.6 Risks identified by the LCFS need to be placed onto the appropriate Risk Register to provide another level of assurance that the risk will be managed appropriately.

2.7 Whilst every effort should be made to identify local risks, it is also important that consideration is given to information provided from outside the organisation (for example, from NHSCFA fraud alerts) and this too must be incorporated into risk-based planning in the same way that local information is.

2.8 Keeping accurate records of Counter Fraud work is crucial for successful work-planning as is utilising previous LCFS outcomes, Risk Register entries and Internal Audit Reports. The end of year assessment also encourages accurate record keeping and accountability and the end of year declaration should also be used to identify strengths and weaknesses.

3 Focusing on outcomes and not merely activity

3.1 The Counter Fraud work that is completed at the organisation should have outcomes that are demonstrable, they might relate to successful investigations or progress being made in the proactive areas. For example, the staff survey supports progress being made in developing an Anti-Fraud Culture or that Fraud Proofing Policies has seen a cessation of referrals from that particular area. Clearly the NHS must get value for the money it spends on Counter Fraud work and in planning for the year ahead consideration needs to be given to obtaining evidence to demonstrate this is happening.

Risk Assessment of Counter Fraud Arrangements

Approach

1.1 The Standards for NHS bodies Wales necessitated the need to review the use of the previous Risk Assessment Tool (RAT) issued by NHSCFA and adopt the revised Qualitative Assurance Process to assess the Local Counter Fraud provision within the Health Board. This revised process is based on a traffic light rating system (**Green**, **Amber** and **Red**).

1.2 Adopting a risk-based approach to counter fraud work is important on many levels and helps to ensure that bespoke arrangements are put in place for the health care organisation being served. A risk-based approach demonstrates the rationale for planning to undertake counter fraud work together with importance of conducting that work. This is a significant factor when demonstrating value for money, efficiency and service improvement; allowing ABUHB to achieve its strategic themes and priorities.

1.3 The revised Qualitative Assurance Process has allowed a thorough self-assessment of the counter fraud arrangements which are in place across Gwent to be undertaken. This enables the strengths and weaknesses throughout ABUHB to be identified. By managing identified weaknesses, the organisation will be able to demonstrate that it has implemented robust counter fraud measures across the range of tasks.

1.4 This twelve-month Counter Fraud Work-Plan has been prepared by the ABUHB LCFS Team in consultation with the Director of Finance and is designed to manage the perceived counter fraud risks within ABUHB.

1.5 The overall risk assessment of organisational Counter Fraud Arrangements on 31st March 2022 was rated **Green** (Score- 100%) in all areas.

1.6 Summary of Risk Level Assessment contained in the Standards Self Review Tool is as follows:

Suggested Response to Summary Outcomes

It is anticipated that the outcomes in each of the area of action support the following response:

Green	Meets the standard
Amber	Partially meets the standard
Red	Does not meet the standard

Summary of risk assessment outcome

1.7 The summary assessment by the ABUHB Counter Fraud Team of each Key Section at 31st March 2022 is shown in the table below:-

Key Section	Strategic Governance	Inform & Involve	Prevent & Deter	Hold to Account	Overall 'Green' risk assessment rating of Counter Fraud Arrangements (100%)
Overall risk assessment rating by generic area	**Green**	**Green**	**Green**	**Green**	**Total score across all Key Sections**
Number of red ratings by key sections	**0**	**0**	**0**	**0**	**0**
Number of amber ratings by key sections	**0**	**0**	**0**	**0**	**0**
Number of green ratings by key sections	**20**	**6**	**12**	**13**	**51**
TOTALS	**20**	**6**	**12**	**13**	**51 (100%)**

1.8 The policies considered to be immediately critical to the Counter Fraud Agenda, are as follows:-

- Declaration of Interest Protocol/Form
- Standing Financial Instructions
- Counter Fraud, Bribery & Corruption Policy
- Disciplinary Policy
- Staff Code of Conduct Policy
- Raising Concerns Policy
- Counter Fraud Communication Strategy
- Counter Fraud and HR Protocol
- Counter Fraud Standard Operating Procedure
- Counter Fraud Protocol with Internal Audit

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
1.1	***(Component 1 NHS Req.1A)*** **A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud, bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations for the accountable board member, audit committee chair and counter fraud champion are accurate and any changes are notified to the NHSCFS Wales at the earliest opportunity, in accordance with the nominations process.**	Lead LCFS (Counter Fraud Champion) to hold regular scheduled meetings with DoF, objectives to be reviewed and work to date evaluated. During these meetings target audiences will be identified for presentations in line with promoting counter fraud work within the organisation. The DoF to act as the link between the Audit Committee and Risk Management Group to allow key risks to be identified, managed and mitigated. The LCFS to produce the ABUHB Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee.			2 18
1.2	***(Component 1 NHS Req.1B)*** **The organisation's non-executive directors, counter fraud champion or lay members and board/governing level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are**	The LCFS will hold regular one to one meetings with the Audit Committee Chairperson. In addition to this LCFS to attend pre-audit committee meetings with non-executive Audit Committee and Board Members Preparation and attendance at audit committee meetings. (Including progress reports). Counter Fraud is a standing agenda item at Audit Committee. The LCFS to provide written and oral reports to this forum.			8 6

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
	present within the organisation. **The CF champion understands the threat posed and promotes awareness accordingly.** **Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken should be documented. Where recommendations have been made by NHSCFA following an assessment, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation.** **The organisation reports annually on how it has met the requirements set by NHSCFA in relation to counter fraud, bribery and corruption work, detailing corrective action where requirements have not been met.**	The LCFS to facilitate the organisation's ongoing commitment to continue to fund promotional 'giveaway' material promoting and identifying the counter fraud department to both internal and external customers and stakeholders. The LCFS to undertake staff surveys to evaluate the level of staff awareness of fraud, bribery and corruption across the health board, to include primary care contractors as well as staff employed directly by the health board. As a result of evaluation implement corrective/preventative measures to ensure counter fraud, bribery and corruption work continues to identify and address areas of organisational risk.			2 12
1.3	**(*Component 9 NHS Req.9)*** **The organisation employs one or more accredited nominated LCFSs to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who**	ABUHB Counter Fraud Team currently consists of 3 team members (equates to 2.8 WTE), all are fully accredited LCFS personnel. The LCFS undertakes the full range of duties associated with the role on behalf of ABUHB. All investigations will comply with all relevant legislation.			10

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
	commit fraud, bribery and corruption to account. The organisation will ensure that any changes to nominations are notified to NHSCFA.	All staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. LCFS will undertake continuing professional development opportunities associated with role. All training and development to be recorded on ESR and referenced during annual staff appraisals.			2
1.4	***(Component 3 NHS Req.3)*** **The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has a counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Govt. CF Profession (GCFP) fraud risk assessment methodology and included on the appropriate risk registers. And the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the Audit Committee.**	The organisation undertakes an honest appraisal of risk across all domains on a rolling programme, focussing on existing arrangements, using appropriate risk assessment techniques/procedures to identify fraud, bribery and corruption risks, with findings reported to the Audit Committee to be recorded on the Audit Committee Risk Register and the overall Corporate Risk Register accordingly. The Audit Committee and DoF to monitor progress to mitigate risks and ensure resources remain suitable for this purpose. LCFS to manage existing arrangements with NWSSP and local Accounts Departments in a bid to prevent payroll and mandate fraud. Local risk assessment exercises recorded on CLUE/Datix if appropriate.			5 2
1.5	***(Component 1 NHS Req.1B)*** **The organisation reports annually on how it has met the standards set by**	LCFS to provide interim reports to Audit Committee at each meeting attended. These reports to include the outcomes of actions against minutes from			3

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
	NHSCFA and NHS CFS Wales in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.	previous meetings. Preparation for and attendance at audit committee meetings. (including progress reports) LCFS to compile the annual report at the end of the financial year for presentation at the Audit Committee alongside the counter fraud workplan for the coming year. These are to be agreed with the Director of Finance. LCFS to complete annually the NHSCFA Counter Fraud Functional Standard Return and present to audit committee.			4 2
1.6	***(Referenced in NHS Regs. 3&5)*** **The organisation ensures that those carrying out counter fraud, bribery and corruption work have all the necessary tools and resources to enable them to carry out their role efficiently, effectively and promptly. This includes (but is not limited to) access to appropriate IT systems as well as access to secure storage.**	The LCFS maintains the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role and comply with legal requirements. LCFS to continue to have access to secure office accommodation accessible only by them. Secure storage facilities both in the office and on site to be utilised effectively for the necessary retention and storage of evidential data in line with legal requirements. Secure access to relevant IT systems and programmes is maintained including use of NHS Wales email addresses. Maintain and supply data and statistical information to NHS CFS Wales on a quarterly basis using the designated templates supplied. Also provide ad hoc data as and when requested.			6 6 3

Key Principle 1: STRATEGIC GOVERNANCE					
	Standard & NHS Requirement	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Implement fraud, bribery and corruption prevention guidance as and when provided by NHS CFS Wales.			
1.7	***(Referenced in NHS Regs. 3,5&7)*** **The organisation ensures that there are effective lines of communication between those responsible for counter fraud, bribery and corruption work and other key staff groups including (but not limited to) audit, risk, finance, communications and human resources also contractors and mangers within the organisation. Also members of the public should have access to reporting routes.** **These routes should be publicised, reviewed, evaluated and updated as required with levels of staff awareness being measured.** **There is evidence of positive outcomes as a result of this liaison.**	Liaison with person responsible for HB security arrangements keeping each other informed of local concerns and issues. Maintain unrestricted access to key staff groups e.g. Audit Committee, chairperson and non-executive members. Continue to interact with key managers and stakeholder groups such as NWSSP Payroll Services, Corporate Finance, Information Governance, Internal Audit and HR exchanging relevant information and providing necessary support and guidance. LCFS to maintain and update existing policies and protocols with key stakeholder groups such as payroll services, PPV, HR, Corporate Finance, Internal Audit and Contractor Services. Where fraud, bribery or corruption is identified, the LCFS will consider the full range of available sanctions – criminal, civil, disciplinary and/or regulatory in line with “Parallel Criminal and Disciplinary Investigations Policy” guidelines. When requested LCFS to assist with joint operations involving internal and external departments and organisations (HR, Internal Audit, police forces, DWP, UKBA, HMRC).			2 5 4 3 4

Key Principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
2.1	***(Component 11 NHS Req.11)*** **The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff across the HB. This should cover NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard** **Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.**	Review local fraud material generated to promote the counter fraud work being undertaken by the LCFS within HB. Ensure it remains fit for purpose where necessary remove/update information accordingly. Ensure that literature developed by ABUHB contains details of the NHSCFA's Fraud and Corruption Reporting Line and online fraud reporting tool. Where appropriate utilise electronic and written information/ newspaper articles from other HBs to demonstrate the commitment to countering fraud across the Welsh Region. Include details of prosecutions etc. in both staff and contractor newsletters. The LCFS to attend all HB corporate induction training events (where practicable) to provide an input to new staff on the role of the Counter Fraud Department. Material to be regularly reviewed and updated to reflect any changes in legislation, policy or working practices. Evaluate feedback from all presentations, collate results, and where appropriate amend presentations as a result of feedback. Write up a report on the outcomes for the Director of Finance.			5 5 8

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		A programme of counter fraud awareness training to be delivered to staff at all levels within the HB (board-level, managerial staff, clinical staff and junior staff). An LCFS should aim to complete at least 15 presentations to staff groups. The aim of this is to ensure the HB is proactive in raising fraud awareness and able to build a genuine anti-fraud, bribery and corruption culture. These should include presentations: • to the Audit and Governance committee • at Staff Forums • to the Professional Executive Committee • to Practice Managers • at Staff Team Briefings • at Management Forums • at General Practitioner Forums • at Pharmacy Forums • to Authorised Signatories • to NHS Contractors (e.g., Dentists, Pharmacists etc) and their staff Review and update the induction material distributed during the HB's induction process, including slides, handouts, leaflets and CFS forms, ensuring it remains current and in line with any changes to legislation/policy/working practices.			14 3

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Develop and maintain counter fraud information on the HB intranet also use extranet and public website materials where appropriate. Having a counter fraud site provides staff easy access to counter fraud, bribery and corruption information. Items to include on the site are: • overview of the counter fraud initiative locally and nationally • role of LCFS • Fraud, Bribery and Corruption Policy • proven NHS fraud cases • presentation slides • link to NHSCFA's website • link to appropriate HR policies (including Whistleblowing policy) • contact details of LCFS • feedback form • referral form			8
		The LCFS should be able to ascertain the number of staff visiting the counter fraud intranet site.			2
		LCFS to E-mail an introduction or reminder to senior staff with their contact details, outlining the role they fulfil in the HB. Field the resulting responses and encourage informal communication to build up rapport. Use this opportunity to organise bespoke fraud awareness presentations to specific staff groups.			1

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		The LCFS to meet with the practice managers to highlight the role of the LCFS and the obligations of the practice to report suspicions of fraud, bribery and corruption according to HB Policy. Ensure contact details of LCFS are available in all hospitals/offices.			3
		The LCFS to promote fraud awareness by offering to deliver presentations to staff groups on an ongoing basis.			2
		LCFS to meet with key personnel around the HB to discuss fraud matters. To include: • Head of Pharmacy & Prescribing • Contractor Payments Manager • Director of HR • Director of Service Development • Medical Director • Director of Nursing • Agency/Bank Co-ordinator • NWSSP Payroll Manager • Complaints Manager			5
		LCFS to arrange for a pay-slip message promoting counter fraud to be published on a quarterly basis via interaction with NWSSP payroll services.			2

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Undertake Local Fraud Awareness events and other initiatives across the HB. Provide a rolling program of displaying counter fraud material on a site by site basis. Promote contact details and visits by counter fraud enabling staff to discuss any concerns or issues relating to counter fraud.			60
2.2	***(Component 4 NHS Req.4)*** **The organisation has a counter fraud, bribery and corruption policy that follows NHSCFA's strategic guidance, publicises the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool, and has been approved by the executive body or senior management team. The policy is reviewed, evaluated and updated as required, and levels of staff awareness are measured**	Establish/review existing counter fraud bribery and corruption policy, update and amend as appropriate. **Refer to Counter Fraud, Bribery and Corruption Policy for further guidance.** LCFS to ensure effective links between the **Counter Fraud, Bribery and Corruption Policy** including 'online fraud reporting tool' and counter fraud work. Policy/reporting tool to be published on HB intranet site. Utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.			1 1 1
2.3	**(MOG advises on info. requirements) The organisation liaises proactively with other organisations and agencies (including local police, local authorities, regulatory and professional bodies) to assist in countering fraud, bribery and corruption.**	Work closely with the Regional and the Pharmaceutical Fraud Teams in respect of Patient GP registration fraud and communicate ***'best practice'*** and situation updates to GP surgeries including guidance to minimise the impact of GP multiple registration fraud.			2

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
	All liaison complies with relevant legislation, such as the Data Protection Act 1998 – General Data Protection Regulation (GDPR), and with relevant organisational policies. The organisation can demonstrate improved investigative and operational effectiveness as a result of the liaison.	The LCFS will engage with investigators from other organisations and agencies (including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies, complying with relevant legislation and organisational policies when countering fraud bribery and corruption. Continue to build upon existing relationships already established with other departments, organisations and agencies (including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies.			5
		Maintain and review a joint working protocol with Contractor Payments Department to define liaison roles and interaction. This should include the fact that all post payment verification (PPV) reports are forwarded to the LCFS and action is taken as appropriate.			2
		Intelligence from PPV, dental and optical teams is available to identify areas of weakness and to reflect concerns in planning the proactive reviews and to assist any investigations where requested. Review quarterly GOS trend data identifying anomalies in contractor claiming activity and taking necessary action here appropriate.			4
		Utilise NFI database to assist in countering fraud, bribery and corruption within NHS and other organisations.			13

Key principle 2: INFORM & INVOLVE					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
2.4	***Component 12 NHS Req.12)*** **The organisation has a fully implemented code of conduct that includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the code of conduct is regularly tested.**	The LCFS to actively promote to staff the organisations policy on 'Standards of Business Conduct for Employees'. A link to 'The Bribery Act 2010' to remain as a permanent feature on the HB intranet site's home page.			2

Key principle 3: PREVENT AND DETER					
	Functional Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
3.1	***Review of Polices*** **(The Manual of guidance refers)** **The organisation reviews new and existing relevant policies and procedures, using audit reports, closure reports and guidance from NHSCFA and NHS CFS Wales, to ensure that appropriate counter fraud, bribery and corruption measures are included. This includes (but is not limited to) policies and procedures in human resources, standing orders, standing financial instructions and other finance and operational policies. The organisation evaluates the success of the measures in reducing fraud, bribery and corruption, where risks have been identified.**	The LCFS will ensure that the whistle blowing, disciplinary, standards of business conduct, declaration of interests, gifts and hospitality policies and other relevant HR policies are adequately robust to counter the risk of fraud, bribery and corruption. The LCFS will review existing and new local policies ensuring that they are fraud proofed and fit for purpose. Maintain records of these reviews for reporting purposes.			2 12

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
3.2	***(Component 10 NHS Req.10)*** **The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action to address them. Results are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption.** **Relevant information and intelligence may include (but is not limited to) internal and external audit reports, evidence of primary care work, information on outliers, recommendations in investigation reports and information from payroll. The findings are acted upon promptly.**	Where investigations identify system weaknesses the LCFS to suggest policy development or amendments to processes making them more robust against the risk of fraud, bribery and corruption. LCFS where practicable will evaluate effectiveness of recommendations. The LCFS will monitor Drug Alerts and Pharmacy Reward Scheme Processes. Meet regularly with internal audit to discuss potential system weaknesses identified during audits or investigations, highlight work being undertaken by the LCFS, e.g. national or local proactive work. The LCFS to maintain existing relationship with finance and payroll encouraging data sharing in relation to salary and contractor overpayments. Check year to year income and expenditure variances to ascertain unaccounted for fluctuations that could indicate expenditure or income concerns. Suggested areas would include: ➢ *Overtime payments* ➢ *On call payments* ➢ *Travel expenditure* ➢ *Bank and agency usage* ➢ *IT equipment* ➢ *Use of selected external contractors, suppliers, taxi companies etc*			4 2 1 2 5

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
3.3	***(Amalgamated into NHS Req.10)*** **The organisation issues, implements and complies with all appropriate fraud, bribery and corruption intelligence bulletins, prevention guidance and alerts issued by NHSCFA or NHS CFS Wales. In addition, the organisation issues local counter fraud, bribery and corruption warnings and alerts to all relevant staff following guidance in NHSCFA's Intelligence Alerts, Bulletins and Local Warnings Guidance.** **The organisation has an established system of follow up reviews to ensure that it remains vigilant and that all appropriate action has been taken.**	Ensure that any fraud prevention instructions issued by the NHSCFA are actioned and completed. Return relevant compliance statements. Pass appropriate risk information to the risk manager for possible consultation. Maintain an audit trail of fraud alerts disseminated to both internal and external staff. Use the Systems Weakness Reporting (SWR) form to inform the NHS CFS Wales at the earliest opportunity of any system weaknesses identified during the course of investigations which potentially have national implications. The LCFS will respond promptly to queries from NHS CFS Wales. Ensure that any Intelligence Bulletins and Local Warning Guidance, issued by NHSCFA are appropriately disseminated to key personnel to avoid HB from falling victim to similar activities. Maintain records of distribution for audit purposes.			4 4 1 2

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Where appropriate utilise the intranet site as a medium to raise vigilance for fraud, bribery and corruption activities that could be used to target the HB.			3
		Provide NHSCFA Central Intelligence Unit with information to support the intelligence function using the facilities provided. Information submitted may be about a person, organisation or methodology and should relate to fraud or corruption within the NHS.			2
3.4	***(Amalgamated into NHS Req.10)*** **The organisation ensures that all new staff are subject to the appropriate level of pre-employment checks, as recommended by NHS Employers, before commencing employment within the organisation. Assurance is sought from any employment agencies used that the staff they provide have been subject to adequate vetting checks, in line with guidance from NHS CFS Wales, NHS Employers and Home Office.**	Full employment checks to be conducted in line with NHS Employer's Guidance. These checks to include photographic ID checks, employer's reference checks, Disclosure & Barring checks, right to work in UK (checks to be made with UKBA if necessary), professional registration checks and academic qualification checks. Any anomalies which arise from pre-employment checks to be referred to LCFS for consideration.			1
		The All Wales Employment Policy stipulates that all employees of the HB must inform their manager at the commencement (time of charge) of any criminal proceedings being brought against them and of any criminal conviction(s) or criminal caution received.			1

Key principle 3: PREVENT AND DETER					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		The HB to ensure that it receives assurances from employment agencies that appropriate vetting checks have been carried out on agency staff being supplied to work for the HB			1
3.5	***(Amalgamated into NHS Req.10)*** **The organisation has proportionate processes in place for preventing, deterring and detecting invoice fraud, bribery and corruption in procurement.**	The LCFS to review and test existing procurement controls ensuring they remain proportionate and fit for purpose. To include tendering processes, procurement processes. Conflict of interest declarations etc. for all staff and in particular procurement staff. Processes to be reviewed by internal and external audit to ensure adherence to financial control procedures are being adhered to and maintained and that staff have received appropriate training to raise awareness.			2 2
3.6	***(Amalgamated into NHS Req.10)*** **The organisation has proportionate processes in place for preventing, deterring and detecting invoice fraud, bribery and corruption, including reconciliation, segregation of duties, processes for changing supplier bank details and checking of deliveries.**	The LCFS disseminates information to finance staff to prevent potential fraudulent activity from internal and external sources. Staff to be briefed in relation to current trends and criminal activities. Maintain clear segregation of duties to prevent potential diversion of NHS funds by finance staff.			3

Key principle 4: HOLD TO ACCOUNT					
Standard		**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
4.1	***(Component 8 NHS Req.8)*** **The organisation uses the approved NHS fraud case management system to record all incidents used to record all reports of suspected fraud, bribery and corruption, to inform intelligence held nationally by NHSCFA and NHS CFS Wales. The case management system is also used to record all system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.**	The LCFS to utilise case management system to promptly record all allegations where fraud, bribery and corruption are suspected. Undertake mandatory **proactive** exercises as instructed by NHSCFA/NHS CFS Wales. Undertake local **proactive** exercises at the HB as agreed with the Director of Finance. These exercises to be undertaken when information suggests there are reasonable grounds to justify focussing on a particular area. *Exercises that should be considered for local initiatives include:* • *mobile phone use* • *potential for ghost suppliers* • *pre- and post-appointment checks* • *expense claims* • *payroll/timesheet claims/salary overpayments* • *audit concerns of financial abuse occurring due to poor system controls.* These exercises are guided by local proactive work in gathering useful intelligence. All exercises must only be undertaken where there is good reason to do so and only as directed by the Director of Finance.			(Days inc 195) 4 10

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Detailed comprehensive reports to be completed on all **proactive** exercises undertaken by the LCFS. Where recommendations have been made the LCFS should, where appropriate, review findings. Where identified, system weaknesses should be noted on case management system and promptly addressed to prevent further potential incidents occurring. The LCFS to ensure that case progress/closure reports to contain detailed recommendations based on investigation findings.			2
4.2	***(Component 8 NHS Req.8)*** **The organisation uses the case management system to support and progress the investigation of fraud, bribery and corruption allegations, in line with NHSCFA's guidance.**	The LCFS to be mindful of NHS CFS Wales's current case acceptance criteria when progressing referrals relating to allegations of fraud, bribery and corruption. The LCFS will ensure that all allegations of fraud, bribery and corruption are recorded on FIRST, maintain detailed records of all referrals that have been received. Regular case progress reports are completed which will reflect an accurate up to date account of all work undertaken in relation to an investigation. To include any interactions with CPS, Police, NHS CFS Wales etc.) LCFS to upload all appropriate evidential MG forms onto FIRST, including witness statements and IUC's.			195

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		LCFS to conduct investigations as required in line with Appendix 5 of the *NHS Counter Fraud and Corruption Manual*, which outlines relevant procedural investigative legislation. The LCFS must ensure that arrangements are in place so that all work is undertaken in an environment conducive to criminal investigation work. This includes the maintenance and appropriate storage of records.			Days inc (195)
4.3	***(MOG and further evidenced by use of Case Management System)*** **The organisation shows a commitment to pursuing, and/or supporting NHSCFA and NHS CFS Wales in pursuing, the full range of available sanctions (criminal, civil, disciplinary and regulatory) against those found to have committed fraud, bribery or corruption in primary and secondary care sectors, as detailed in NHSCFA guidance and following the advice of the Operational Fraud Manager in NHS CFS Wales.**	Assist the NHS CFS Wales with information as required for any regional or national fraud cases. Ensure comprehensive information is provided to enable risk exercises to be carried out effectively and submitted in a timely manner. Undertake effective liaison with other HB members of staff including HR and where necessary other relevant Health organisations for example NMC,GDC and GMC, to ensure that sanctions, such as internal disciplinary action is not applied in isolation where there are indications of potential wider fraudulent activity.			1 4

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
		Where cases have been successfully prosecuted the LCFS will communicate the facts of the case to staff and relevant stake holders by publishing information on the HB intranet site, placing newspaper articles on the counter fraud notice boards, notifying NHS CFS Wales of successful outcomes via the use of the advanced warning process.			2
4.4	***(NHS Requirement 9)*** **The organisation employs an accredited person(s) nominated to the NHSCFAt o undertake the full range of duties associated with counter fraud, bribery and corruption work, including proactive work. The LCFS completes witness statements that follow best practice and comply with national guidelines.**	The LCFS will complete all witness statements and evidential case files in line with NHSCFA best practice model and NHS National File Standards ensuring compliance with legal requirements.			Days inc (195)
4.5	***(NHS Requirement 9)*** **Interviews under caution conducted in line with the National Occupational Standards (CJ201.2) and the Police and Criminal Evidence Act 1984.**	The LCFS will plan and prepare for all interviews under caution, developing an interview plan, assessing the suspect's fitness for interview, and setting up an appropriate location. All interviews will be conducted in accordance with legislation (PACE), policy and other guidelines using appropriate interviewing techniques and communication skills. The LCFS will evaluate the interview (including own performance) in line with NOS (CJ201.2) and PACE 1984.			Days inc (195)

Key principle 4: HOLD TO ACCOUNT					
	Standard	**Task**	**Response**	**Expected Outcome/date**	**Planned Resource**
4.6	***(MOG and further evidenced by use of Case Management System)*** **The organisation seeks to recover, and/or supports NHSCFA and NHS CFS Wales in seeking to recover, NHS funds that have been lost or diverted through fraud, bribery and corruption, following an assessment of the likelihood and financial viability of recovery. The organisation publicises cases that have led to successful recovery of NHS funds.**	Maintain comprehensive records of LCFS time spent on each individual investigation so that this can be included in any compensation claim made by the HB. Identify and maintain a record of the actual proven amount of loss to the HB, in order that appropriate recovery procedures can be initiated and progressed where viable. Ensure the HB has a procedure in place to recover funds that have been lost or diverted as a result of fraud, bribery and corruption in line with the HB Counter Fraud, Bribery and Corruption Policy guidelines and as outlined in Sections 10 and 11 of the NHS Counter Fraud, Bribery and Corruption Manual.			2 2 1

Appendix 1

Number of Days agreed for 2022/23 ***535 Days***

Agreed/signed by

Signature: **Date:**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Audit, Risk and Assurance Committee 7th April 2022 Agenda Item: 3.1

Aneurin Bevan University Health Board

Outpatient Transformation

1. Summary

A paper providing an update on the Outpatient Transformation Programme was presented to the Audit, Risk and Assurance Committee on 7th October, 2021. Following the meeting, the team were asked to provide a further update in April 2022.

This paper provides an update on progress of the Outpatient Transformation Programme, providing detail on the broader impact of the work, as well as any associated risks, mitigations and action plans to address these. The paper also demonstrates how the ABUHB programme aligns to the Welsh Government Planned Care Recovery, Reset and Transformation objectives and the 7 key priorities for delivery.

Each speciality has an Outpatient Transformation Plan. Gynaecology has been used to understand and model the impact of their transformation plans, in terms of patient outcomes and also how any financial benefits can be quantified. The learning from this work will be used to model other specialities.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	x
Receive the Report for Assurance/Compliance	x
Note the Report for Information Only	
Executive Sponsor: Leanne Watkins, Director of Operations	
Report Author: Julie Poole, Outpatient Transformation Lead	
Report Received consideration and supported by :	
Audit, Risk and Assurance Committee	
Date of the Report: 25th March 2022	

Supplementary Papers Attached:

- Appendix 1 – Risk Assurance
- Appendix 2 – Transformation Plan

2. Purpose of the Report

The purpose of the report is to update the Committee about the work ongoing in the Outpatient Transformation Programme following a presentation in October 2021. A progress report on outpatient transformation, particularly effective and efficient use of resources and risk was requested for the Committee in April 2022.

3. Background and Context

The ABUHB Outpatient Transformation plan aligns to the Welsh Government (WG) Planned Care Recovery, Reset and Transformation Objectives and the 7 key priorities for delivery.

Objectives

Focus on those with greatest clinical need	Increasing health service capacity	Transform the way we provide planned care

Outcomes

Equitable access to a quality service	Modernised planned care service	Quality driven clinical pathways	Sustainable workforce

Key priorities for Delivery

Transform Outpatients	Prioritise diagnostics	Suspected Cancer Pathway	Patient Prioritisation	Eliminating long waits at all stages	Increased elective capacity	Better Information and support for patients

Underpinned by:

- Infrastructure and estates
- Workforce
- Clinical and Pathway Redesign
- Data and digital
- Communication and engagement

Immediate plans within the National Programme:

- Immediate rollout of national pathways (See on Symptom (SOS)/Patient Initiated Follow Up (PIFU)/Self-management) – 10 specialities
- Increased virtual activity – use of video group consultations
- Effective referral –implement enhanced pathways, focus on 10 most common referrals, Do Not Dos (DNDs), Interventions Not Normally Undertaken (INNUs)
- Waiting list prioritisation – admin and clerical validation, re-categorise outpatient referrals, focus on urgent and long waiters
- Prudent follow-up – discharge as default, eliminated patients who are over 100% delayed
- Advice and Guidance – implement e-advice, rollout and standardise specialist advice and guidance

Risk Assurance

One of the key principles aligned to the Outpatient Transformation Programme is in terms of reducing the risk of harm to patients and improving the patient experience. Outpatient capacity and speciality outpatient transformation plans are prioritised to enable the risks to be decreased. Priorities being:

- Cancer, suspected cancer, and urgent, for new outpatients (R1 for ophthalmology) for all surgical and non-surgical specialities including therapies
- Suspected cancer, urgent and routine for diagnostics (due to the number of cancer cases that arise from routine tests)
- New urgent and routine outpatients over 52 weeks

- Patients waiting for a new outpatient appointment over 104 weeks to be reviewed
- 100% delayed Follow-up outpatients

However due to the substantial backlog of patients waiting to be seen and the ongoing demand into the services, specialities will be unable to eliminate all risks to patients.

In terms of Risk Assurance, the Outpatient Transformation Programme provides regular updates for the 'Mapping against 4 Harms of Covid'. Two areas reported against are 'Harm for overwhelmed NHS and Social Care System' and 'Harm from reduction in non-covid activity'. Please see **Appendix 1** for further detail.

The Outpatient Transformation Programme holds its own Risk Log as below:

ID	Date Raised	Raised by	Risk Category	Risk Event / Cause	Risk Effect	Impact	Likelihood	Score	Status	Response	Response / Mitigation
R01	26 Oct 21	JP	Operational	Urgent care system pressures	Impacting on stakeholders' capacity to engage in the programme. Also causing loss of outpatient activity which will impact on WG target delivery	4	5	20	Open	Accept	Whilst pressures are high, the programme can focus on activities that do not require stakeholders' enagagement/work to progress.
R02	26 Oct 21	JP	Operational/ IPC/Safety	Social distancing rules	Decreased activity, increased waiting times, causing potential harm to patients	3	5	15	Open	Reduce	Reviewed social distancing in some areas (from 2m down to 1m). Further review underway.
R03	26 Oct 21	JP	Operational	Conflicting demands on managerial and clinical time	Slow pace to transformation or no work done	3	4	12	Open	Reduce	Providing project/programme management support. Identifying additional resource to help. Developing IT solutions that decrease manual processes. Steering Group to aid with unblocking issues. Identifying priorities for IMTP.
R04	26 Oct 21	JP	Operational	Informatics requirements competing with other priorities in the HB.	Non delivery of some workstreams with informatics requirements. If not accommodated , risk to programme delivery and operational delivery of outpatient model	4	3	12	Open	Reduce	Engaging with John Frankish/Informatics to identify priorities. Requirements will be fed into IMTP.
R05	26 Oct 21	JP	Financial	Non-recurring monies	Not able to deliver the same kind of transformation. Inability to attract staff.	4	4	16	Open	Reduce	Use shorter-term plans to evidence outcomes for a more sustainable solution.

The Clinical Futures Programme Management Office (PMO) is developing a standardised Risk Log for use across all programmes.

Outpatient Transformation Plan and Progress

Most patient interactions with secondary care are through outpatient clinics. Patients are referred predominantly by their General Practice for examinations, diagnostic tests, to undergo treatment or reviews. Pre-pandemic a National 3-year strategy and local action plan was in place focused on reducing attendances, with emphasis on a self-directed model of care (patient initiated, see-on-symptoms), adoption of digital technologies and ensuring the correct patients access secondary care services. Covid-19 was a trigger for a more rapid adoption of change including the use of digital solutions such as virtual outpatients and widespread use of electronic communications. We learned the importance of liaising with patients referred to and/or waiting to safely access diagnostic and treatment in what was a very uncertain and frightening time for everyone. Embedding and expanding these new ways of working is key to delivering a sustainable service. We know that the status quo is not an option and that we must transform outpatient services at scale and pace.

Our immediate plans to transform outpatient services will focus our efforts on those specialties that represent the greatest concern, specifically Endocrine/ Diabetes, Ophthalmology, ENT, Orthopaedics, Gastroenterology, and Maxillofacial in the first instance.

Our overall transformation plan **(see Appendix 2)** aligns to the National Planned Care Board Recovery Plan, as well as the National Outpatient Transformation Strategy.

Below is a summary of our programme priorities and a high level Red/Amber/Green (RAG) rating indicating progress:

Workstream	Projects	RAG
Optimising Capacity	• Optimising use of capacity (decreasing hospital cancellations, Did Not Attend (DNA) rates, monitoring utilisation, increasing non face to face activity)	
	• Automated booking system (decreasing fallow space, re-allocating space, ability to flex nursing staff)	
New ways of working	• Increase SOS and PIFU, discharge at first appropriate opportunity	
	• Increase advice only/specialist advice service (currently consultant connect), existing speciality processes, including triage of referrals	
	• One Stop Treatment Centre at RGH	
	• Scope One Stop Treatment Centre at NHH	
	• Patient Platform	
Outpatients Clinical Leadership/Ownership/Risk	• Directorate Outpatient Clinical leads supporting development and delivery of Directorate/specialty Outpatient Delivery Plans (factoring in Cancer work, transformation, new pathways, modes of consultation)	
	• Programme of validation of waiting lists - clerical and clinical (optimise automation and job plan clinical validation)	
	• Risk stratification of new patients (re-evaluate those on waiting list for some time to ensure resources as aligned to most at risk cohorts)	Ophthalmology Other specialties
Dynamic Planning	• Consolidate specialty outpatient delivery plans with Outpatient Strategy and demand/capacity plans to inform a 3-year transformation plan with clear milestones and deliverables	
	• Delivering Specialty Outpatient plans	
Single Point of Contact, Communication and Co-ordination	• Central Outpatient Team to be single point of contact for patients (queries, supporting SOS, PIFU, updating/informing) and ongoing validation). • This team will be responsible for maintaining ongoing communication, liaison and engagement with people while they remain on waiting lists to access services.	

RAG Rating Key	
	Project not yet started.
	Project started but experiencing delays. Plans in place to mitigate.
	Project started and on track.

Examples of Transformation within Outpatients

Specialist Advice and Guidance - Consultant Connect	The Consultant Connect telephone advice and guidance service routes GPs though to specialist consultants within the Health Board. The contract with Consultant Connect has been extended whilst an All Wales procurement exercise is finalised. Areas where Consultant Connect is being used: • Adult Community Mental Health Team (from all locations across AB) • Burns: Referrals & Advice (Swansea) • Care of the Elderly (Royal Gwent Hospital) • Crisis Assessment Support Unit (CASU) • Crisis Home Treatment Team (across multiple locations in AB) • Eating Disorders Service • Referrals Flow Centre (Aneurin Bevan UHB) • Gastroenterology – Hepatology (Grange University Hospital) • Lymphoedema (National – Wales) • Medicines Advice (Royal Gwent Hospital) • North Gwent GSSMS • Older Adult Community Mental Heal (multiple locations across AB) • Paediatrics – Outpatient Clinical Advice (Grange University Hospital) • Paediatrics – Urgent Referrals Advice (Grange University Hospital) • Palliative care – Gwent (St David's Foundation Hospice Care) • Palliative Care – Blaenau Gwent • Perinatal Mental Health Service • Plastic Surgery: Trauma Referrals & Advice (Swansea) • Respiratory – Ambulatory Care Unit (RACU) (Royal Gwent Hospital) • Safeguarding Adults • Safeguarding Children • South Gwent GSSMS • Urology (Royal Gwent Hospital) • SE Wales Vascular Surgery • Veterans Mental Health service Next steps: • Meeting being organised with Cardiology • Meetings held with Diabetes and Endocrinology
Gastroenterology – Calprotectin Test for IBD	Process in place to offer a straight to test colonoscopy for patients at high risk of Inflammatory bowel disease (IBD). Utilising Nurse-led care rather than consultant-led care, by triaging patients on the waiting list with symptoms suspicious for IBD using a calprotectin test. Approximately 50% would meet the criteria. Of those patients that meet criteria approximately 20% would meet criteria for IBS/FODMAP pathway in Dietetics. This has improved waiting times to meet the IBD standards.
Audiology – BeMore App	Covid 19 had a significant impact on audiology face to face clinics. Large percentage of the patients are over 70 and were reluctant to attend face to face clinics. Changes were made to hold some virtual clinics an issue

	remotely programmable hearing aids. Previously patients would have three booked face to face appointments – initial assessment, hearing aid fitting and follow-up appointment and ongoing reassessment, follow-up and repairs. The new process has changed to one booked appointment for hearing test and fitting. There are virtual appointments pre and post clinic and ongoing support via phone triage. This has increased the focus in terms of patient education and self-help. The use of Attend Anywhere helped with lip reading – particularly as no PPE was required. An App - 'BeMore' – designed by a hearing aid manufacture allowed aid users to be able to adapt some settings on their hearing aids, and this App has transformed patients' ability to self-help. Patient satisfaction was high, face to face and remote consultations showed very little difference from all perspectives. If patients could not engage due to lack of technology or preferred face to face this was accommodated. 51% of consultations were undertaken remotely and age was not a barrier with a number of patients 76+ happy to consult via this method. An evaluation was undertaken in terms savings relating to reduction in time with the patients (not having to clean down area between patient), patients undertaking their own adaptions. Patient outcomes showed a very positive response to both the quality of sound on the remotely programmable hearing aids and the ability to adapt the hearing aids to improve their listening experience using the BeMore app. The BeMore app enabled patients to make small adjustments to the setting on their aids, use GPS to set up favourite programmes in certain locations, adjust the volume, reduce wind noise and background noise as well as adjust the bass and treble. For tinnitus patients they could adjust the tinnitus calming sounds or switch them off. The use of this app significantly reduced the need for face to face follow ups as patients were able to make small changes to settings and from patients feedback increased/enhanced their hearing aid use.

The impact of Outpatient Transformation on Financial performance

Gynaecology has been used as the pilot area to understand and model how the impact of outpatient plans can be quantified in terms of financial benefits. We have worked with Gynaecology to understand the baseline of outpatient clinics. This has been done down to clinic level showing the capacity in terms of number of patients, the workforce required for each clinic and therefore the associated cost along with the clinic and location. This has enabled Gynaecology to be costed at both a clinic and patient level. On completion of the baseline, Gynaecology plans have then been reviewed in detail to measure the impact of the changes being implemented and to evaluate the financial impact, which are demonstrated below. Although there are financial benefits in terms of efficiencies, it is important to point out that with waiting lists due to the pandemic the efficiency savings are currently more likely to generate cost avoidance and also allow improved outpatient capacity to meet the backlog of patients.

Gynaecology currently run by mixing clinics with both face to face (F2F) and virtual appointments. Therefore costing for these type of appointments are the same and we are unable to differentiate between the cost of a virtual and F2F appointment for this speciality. However, as we roll out other specialties and capture the baseline information where clinics are set up as either F2F or virtual we

will be able to measure any efficiency of offering virtual appointments. The reason for integrating the two elements is due to the social distancing requirements currently within OPD that restricts the number of F2F attendees, therefore this methodology helps to maximise activity. The benefit of virtual appointments has now been seen in the work started within Neurology where clinics are either F2F or Virtual and a virtual clinic can see more patients than a F2F, this will then allow measurement of impact on the move to more virtual appointments.

Findings Gynaecology

Advice Only

Gynaecology has delivered an increase in advice only patients averaging 101 per month in 21-22 compared to 51 per month in 20-21 as demonstrated in the table below.

Advice Only	**Patients**		
Period	**Actual**	**Av Per Month**	**Increase**
Aug 20 - Mar 21	409	51	
Apr 21 - Feb 22	1,114	101	98%
Total	**1,523**	**152**	

This results in patient benefits, saving travelling unnecessarily to appointments, decreases time for the patient, arranging leave and or cover for dependents, preventing footfall into the hospitals along with environmental benefits of less traffic and pollution.

This also then quantifies into financial benefits, demonstrated in the table below, as a Consultant providing advice only is quicker and more cost effective than seeing a patient in clinic. The below table demonstrates the cost avoidance of the 1,523 advice only Gynaecology patients since August 2020 with a cost avoidance of £41.46 per patient and an overall cost avoidance of £63,144. This also translates into 355 Consultant hours saved and an estimated 230 – 609 nursing hours saved.

Amount of Advice Only Attendances	1,523	
Type of Attendance	**Cost Per Patient**	**Total**
Advice Only	£16.84	£25,647
Outpatient Appointment	£58.30	£88,791
Cost Avoidance (£)	**£41.46**	**£63,144**

Further to this work analysis has also been completed to understand of the patients receiving advice only, how many came back into the system within 6 months. Results show 21% of these patients presented back within Gynaecology either via an admission or a subsequent outpatient appointment. Resulting in a true avoidance of 79% of these patients. This is an excellent indicator that advice only is working within Gynaecology. Based on the pathway costs 22% of patients need to be completely diverted for advice only to be cost effective, at 79% patients diverted this is being more than achieved.

Nurse Led Endometriosis Clinics

There has been an introduction of a nurse led Endometriosis clinic in order to divert appropriate patients away from Consultant Clinics. This has created annual capacity for 572 additional patients to be seen at a lower cost generating an efficiency saving of £15,010 per annum shown in the table below. The Consultant clinic capacity is 18 patients per month with the nurse led offering 44 patients

per month meaning it would take 127 weeks for a Consultant to see the patients diverted at the current clinic set up.

Patient Capacity Nurse Led Clinics	**572**	
	£	
Endo Clinics	**Per Patient**	**Per Annum**
Nurse Led	32.54	18,612
Consultant	58.78	33,622
Cost avoidance (£)	**26.24**	**15,010**

Video Life Style Clinic

The service has introduced a new video life style clinic for patients that fit a set criteria. This involves a 50 minute video consultation with a Consultant, a follow up appointment with a nurse after 6 weeks and another follow up clinic with the Consultant after 3 months. The focus is on prudent healthcare and an improved life style plan for the patient to implement to improve patient outcomes. The scheme will be evaluated along with PROMS and PREMS captured. In terms of financial evaluation the benefits could be as a result of an avoided treatment. Comparing the cost of a day case pathway versus the new life style clinic pathway could result in a saving of £625 per patient. Based on capacity of 42 patients per annum could generate savings of £26k per annum.

Life style clinic	**£**
New Pathway Cost Per Patient	£219
Day Case Pathway Cot Per Patient	£844
Potential saving per patient	**£625**
No. patients per annum	42
Potential cost avoidance per annum	**£26,252**

SOS

The table below demonstrates the number of patients who have been diverted to SOS pathway within Gynaecology. Based on these patient numbers this has resulted in a saved outpatient appointment due to the patients being put onto SOS instead of having another FU appointment. The overall impact is 858 patients and a total cost avoidance of £50,622.

SOS	**No. Patients**	**%**	**FU Clinic Cost**	**Cost Avoidance**
2019-20	222		£59	**£13,098**
2020-21	392		£59	**£23,128**
2021-22*	244	6.1%	£59	**£14,396**
Total	**858**		**£59**	**£50,622**

*Apr21 - Feb22

Follow Up Reduction

In the 4 months since the last Audit, Finance and Risk Committee, Gynaecology have managed to reduce their FU waiting list by a further 317 patients which would have been as a result of the

various initiates being completed above along with validation exercises. This reduction demonstrates a potential avoidance of 32 Consultant sessions which would translate into a cost avoidance of £23k based on a WLI session.

Gynaecology	Reduction in FU Waiting list	No. sessions saved	£ cost avoidance based on WLI
Follow Up Reduction	317	32	23,454

Summary Gynaecology

As demonstrated above there have been a number of plans to increase capacity by diverting patients within Gynaecology to the most appropriate pathways. There is further work to understand the impact of a functional mailbox created for patients to have direct access to a nurse with the aim of avoiding the need for a Consultant appointment. Data is being captured on patient contacts which needs to be worked through. The final part of the pilot will be to model all these schemes to show the overall impact linked back to the waiting list and demand. This will allow analysis to understand the true overall impact of these schemes.

Other areas in ABUHB being modelled

Alongside the work on Gynaecology and Neurology other areas are being progressed which are mentioned below:

DNAs – Health Board overall

One of WG targets for the Health Board is to reach a DNA rate of 5%. The current figure stands at 6.9%. DNA cost avoidance opportunity of achieving a 5% target could potentially avoid £1.074m based on the cost of having to pay a Waiting List Initiative (WLI) session as demonstrated in the table below. Saving 14,526 appointments across the HB and 1,453 Consultant sessions. The rate in October 2021 was 6.7% so a slight worsening, however, it is felt that Omicron has contributed to this. Further work will be done to determine reasons for DNA's and how we influence patient behaviour understanding patterns of behaviour.

Year	**OP Attendances**	**OP DNAs**	**DNA %**	**Potential DNA reduction 5% target (Patients)**	**Potential DNA WLI reduction (sessions)**	**Potential Cost Avoidance WLI £**
2021-22*	700,807	48,356	**6.90%**	14,526	1,453	£1,074,707

*data taken Apr 21 - Feb 22 extrapolated for 12 months for potential DNA reduction to 5%

T&O Multi-Disciplinary Team (MDT) Triage

Within T&O work has begun piloting an MDT triage. This began back on 13th September which involves a Consultant along with a therapist triaging referrals. With the exception of Foot & Ankle, who completed their triage in Supporting Professional Activities (SPA) time, all other sub specialities completed the triage in normal clinic sessions. This is being phased out with the aim of only spines using clinic time.

Early pilot data is shown in the table below:

No. MDT Sessions	**Referrals**	**Av. Referrals per session**
74	4,110	56
Outcomes	**Referrals**	**%**
Redirected Therapies	699	17%
Rejected	164	4%
Redirected non Consultant Led Pathways (T&O)	288	7%
Total Avoided	**1,151**	**28%**

From 74 sessions 4110 referrals have been reviewed averaging 56 per session. 17% of referrals are being redirected to therapies (includes podiatry). 4% are being rejected and 7% are being directed to non-consultant led pathways. So a total of 28% which are being triaged away from traditional consultant led pathways and 21% being removed from the Directorate's waiting lists.

Based on running a session per week for all sub-specialties except shoulder, which will run fortnightly, capacity to review 10,497 patients should be achieved. Based on the pilot data this could potentially redirect 2,939 patients freeing up 294 Consultant sessions and potential WLI cost avoidance of £218k.

Estimate Referrals reviewed per annum	
T&O MDT	**Patients**
Total Referrals	**10,497**
Anticipated Outcomes per Annum	**Patients**
Redirected Therapies	1,785
Rejected	420
Redirected Non-Consultant Led	735
Total avoided Consultant Appointment	**2,939**
Avoided Consultant Outpatient Sessions	**294**
Cost avoidance WLI session	**£218,223**

One Stop Treatment Clinic at RGH

Another area is the work on a Business Case to develop a one stop clinic in RGH for outpatients. Below shows the planned number of surgical procedures anticipated to be carried out within the unit. The focus of this unit is the patient benefits of avoided unnecessary appointments and delays in waiting times but there is also likely to be a financial benefit of cost avoidance due the mitigation of the need of a day surgery appointment.

The cost per procedure based on the increased investment needed for the unit stands at £122 per procedure. Comparing this to the day case cost based on costing information (removing medical and overhead costs) of £431 this could generate a cost avoidance of £309 per procedure. This would also free up day theatre capacity to treat more patients.

Procedure/Speciality	Numbers per annum
General Surgery lumps and bumps	50
Dermatology	2,268
Maxillofacial	300
Breast cysts	15
TOTAL	**2,633**

One stop Clinic	One stop clinic	Day Case	Cost Avoidance
Cost Per Procedure	**£122**	**£431**	**£309**

4. Assessment and Conclusion

Summary

The work in Gynaecology will be finalised in the coming weeks and we will continue the work on Neurology. This will allow us to quantify changes now the baseline is near completion. It will provide a consistent methodology for ensuring we are assessing the value of outpatient transformation and then to look to roll out to other specialities at pace.

It is essential that we are able to do this robustly. The financial risk associated with non-delivery of outpatient transformation is estimated at £2.3m savings included in the IMTP.

Recommendation

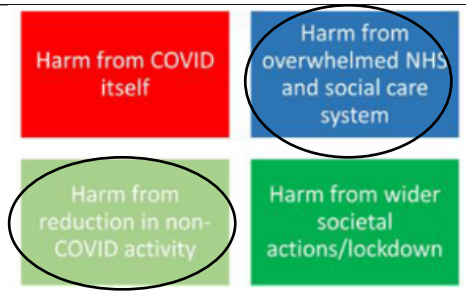
The Audit, Risk and Assurance Committee are asked to:

- Note the progress on developing a financial model to assess the efficacy of outpatient transformation
- Note the progress being made on outpatient transformation delivery

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*Failure to address the elements outlined within the plans will result in potential harm to patients, increased waiting times, patients complaints, inability of the HB to manage waiting times and difficulties in providing sustainable options*
Financial Assessment, including Value for Money	*An initial costing exercise has been undertaken to estimate potential savings. These figures will change as the specialities start to form plans at a lower level. The opportunity to quantify savings as a result of move to PIFU/SOS and virtual will need to be worked through as plans emerge. Although this is flagging potential savings/cost avoidance then due to the level of the number currently on the waiting list as a result of COVID it is likely any efficiencies initially in outpatient transformation will enable the backlog to be addressed quicker and just mean an*

	increase in outpatient appointments rather than a reduction in costs.
Quality, Safety and Patient Experience Assessment	*The proposals outlined in this report will improve access for patients thus improving patient quality, safety and experience through improved access.*
Equality and Diversity Impact Assessment (including child impact assessment)	*This proposal will not have an adverse equality or diversity impact but will improve access to outpatients/consultations for all patients.*
Health and Care Standards	*Timely access to services.*
Link to Integrated Medium Term Plan/Corporate Objectives	*This proposal links to the HB IMTP Plans*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	***Long Term –*** *This proposal fits into the longer term strategy for opd and is key to delivering the Health Boards key priorities.*
	Integration *– This proposal ensures that there is a focus on the whole system approach in terms of patients pathways*
	Involvement *– This proposal will support a range of services across primary and secondary care.*
	Collaboration *–A number of the schemes have linked with patients to assist with delivery and evaluation. It is imperative that his is extended and patients are part of the transformation programme*
	Prevention – *Improved access to diagnostics will improve population health*
	N/A
Glossary of New Terms	*N/A*
Public Interest	

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision				
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		***CRR023 – (May 2020)*** ***Threat Cause: Priority being given to management of the COVID pandemic*** ***Threat Event: Risk to population health in relation to non - COVID harm*** **TREAT**				
High Level Themes	• Population health • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Finance	**Risk Appetite**	Zero or low level of risk in terms of protecting patient safety and the quality of services however, innovative means of tackling backlogs of waiting lists and working SMARTER in the future needs to be considered and in this case, a higher risk appetite will be applied.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**				
Patient, Quality, Safety and Outcomes Committee	• Departmental repurposing and redesign to accommodate non-COVID activity has occurred. New ways of working adopted e.g. virtual reviews. Nosocomial Group operating, providing advice and support. • Adapt and sustain progress being monitored through Exec Team meetings via Director of Operations. • Plan in place for for green recovery (treatments) RGH – all specialities excluding orthopaedics • Orthopaedic operating at OSU and NHH (P2) • Outpatient Steering Group • Robust escalation reporting and escalation arrangements within primary and community services division.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	4	5
Trend		**Executive Owner: Director of Operations and Director of Primary Care, Community and Mental Health**					
Mapping Against 4 Harms of COVID		**Update**					



Jan 2022

Prioritisation for use of capacity is as follows:

- Cancer, suspected cancer, and urgent, for new outpatients (R1 for ophthalmology) for all surgical and non-surgical specialities including therapies
- Suspected cancer, urgent and routine for diagnostics (due to the number of cancer cases that arise from routine tests)
- New urgent and routine outpatients over 52 weeks
- Patients waiting for a new outpatient appointment over 104 weeks to be reviewed
- 100% delayed Follow-up outpatients
- Adhering to the surgical prioritisation during the coronavirus pandemic (Version 2 – June 2020 – P1a, 1b, 2, 3 and 4), as well as the separate guidance in terms of obstetrics and gynaecology (RCOG) and ophthalmology (RCOphth):

Continued use of Consultant Connect – Specialist Advice Service. The aim of which is to enable a GP to gain immediate advice on a patient, with the aim of avoiding either an emergency admission or urgent outpatient referral. Current specialities are:

- Burns: Referrals & Advice (Swansea)
- Care of the Elderly (Royal Gwent Hospital)
- Referrals Flow Centre (Aneurin Bevan UHB)
- Gastroenterology – Hepatology (Grange University Hospital)
- Lymphoedema (National – Wales)
- Medicines Advice (Royal Gwent Hospital)
- Paediatrics – Outpatient Clinical Advice (Grange University Hospital)
- Paediatrics – Urgent Referrals Advice (Grange University Hospital)
- Palliative care – Gwent (St David's Foundation Hospice Care)
- Plastic Surgery: Trauma Referrals & Advice (Swansea)
- Respiratory – Ambulatory Care Unit (RACU) (Royal Gwent Hospital)
- Stroke Medicine (Grange University Hospital)
- Urology (Royal Gwent Hospital)
- (looking to implement next for vascular)

Support for Patients

Divisions have in place various examples of offering support to patients' who are waiting, some of the examples are:

- Tinnitus patients have the availability of help groups with the Clinical Nurse Specialists provide support and advice for patients and their families.
- In 2021, the Family & Therapies Division launched a new online platform dedicated to supporting families through the stages of maternity and child health development, in partnership with local health professionals in the Health Board area.
- ABUHB Paediatric Service is the first in Wales to respond to the needs of Children and Young People coping with the impact of Post-Covid. A Recovering from Illness Pathway (multi-disciplinary approach) has been

established to support these CYP. The pathway is designed to also deliver some support to CYP who have Chronic Fatigue, Chronic Pain and Fibromyalgia within the HB

- The Orthopaedic Directorate is in the process of commissioning an App which will facilitate two way communication with patients and providing access to information and exercises etc.
- Within Orthopaedics, Physiotherapy 'Escape Pain' sessions are running virtually. The team are also in the process of planning group exercise sessions for long waiting spinal patients

The outpatient transformation lead is in the process of forming a core team to provide support for patients on waiting lists. A number of staff have recently been appointed, and a communication plan is being drafted. This will enable patients to have one point of access, making communications simpler for patients. The team will be able to advise on issues such as waiting times, or assist with obtaining the information about treatments or prehabilitation actions.

The OPD Lead is in the process of finalising correspondence to send out to all the patients waiting on the new outpatient waiting lists. The letter covers a number of areas in terms of waiting times, providing links to 'restart services' and also 'staying well. Staying safe' websites.

External Validation of Waiting Lists

A number of HBs are using an external provider to validate waiting lists, Meetings are being organised in Jan/early Feb to explore this option further with the HBs involved and a number of key personnel from the HB.

Outpatients

The OPD team have contacted patients who are waiting over 52 weeks for a new outpatient appointment to establish whether they still require the appointment, for example patients' condition has resolved or they have been seen elsewhere. Patients who wish to remain on the list also complete questions in relation to their condition, and clinical reviews are being planned to review their outcomes (this latter part of the process will be an ongoing plan). This will help determine if they still need to be seen, or can go straight for tests, non-face to face or face to face consultation etc. These letters have been sent to patients where specialities do not have the capacity to see them in clinic. Those patients booked into clinic are undertaken via the partial booing exercise which then removes any patients who does not require the appointment.

The process above will continue for new patients who are waiting 36-52 weeks, commencing at the beginning of March 2022 (ENT commenced January 2022). Roll out programme to be finalised.

A process is commencing with patients on the follow-up outpatient waiting lists, with the aim of determining if the appointment is still required. Orthopaedics commences in February with a rolling programme to be developed. All specialities are currently being contacted to establish which patient cohorts are to be included.

Ongoing clerical validation of both outpatient and treatment waiting lists, which enables the HB to cleanse its waiting lists and use its capacity for patients who need the appointment. Focus on duplicate entries and pathway errors.

An extensive exercise was undertaken to re-start clinics across the HB with the specialities/conditions prioritised when allocating clinic space. Social distancing was decreased from 2 metres to 1 metre with guidance from Infection Control and approval via the Nosocomial Group, this increased capacity from approximately 40% to around 75%.

	In terms of prioritising patients, some specialities are risk stratifying, for example: ➢ PROMS in Neurology, COTE, Respiratory ➢ Gastroenterology – PROMS for Hepatology and Alcohol Liaison. Plus STT Endoscopy using RCS/NG12 NICE guidance ➢ Triage of patients within Paediatrics (patients reclassified where appropriate), Dietetics, Physiotherapy and some orthopaedics. ➢ Reviewing paediatric orthopaedic patients A scoping exercise has just been completed to determine what Directorates are doing to risk stratify patients and this will be discussed at the next Outpatient Steering Group meeting in January to agree next steps. Introduction of an Advice Only process, which enables referrals sent by GPs to be reviewed by a clinician and both the GP and patient given advice without having to have either a face to face or non-face to face appointment. Approximately 10,000 patients to date (2020/Dec 2021). Each speciality has developed their Outpatient Transformation Plans with actions in terms of increasing the use of SOS/PIFU, non- face to face consultations, etc but with a focus on developing new pathways. Some examples: Audiology – remote monitoring of hearing aids Ophthalmology – optometrists involved in reviewing patients on waiting lists for paediatrics, glaucoma and paediatrics Direct Access to Audiology ENT Unilateral tinnitus pathway Gastroenterology - Alcohol team intervention (excellent patient engagement) – luminal and hepatology pathways GPwSI clinics – Cardiology CAMHS – Eating Disorder sessions for children and young people HyCoSy (Ultrasound) Diagnostics and clinics for Fertility Patients Lifestyle clinics utilising attend anywhere, for endometriosis patients The Outpatient Transformation team have been successful in obtaining capital monies to convert the 'old cath lab' at RGH to a one stop OPD Treatment Centre (completion date 21st February). It will consist of two theatres, post minor A Business case is being finalised identifying the recurring monies required to support the unit. The procedures currently looking to be undertaken are: ➢ Iron Infusions - colorectal, rheumatology, neurology, nephrology ➢ Neurology – one stop lumbar punctures ➢ Minor ops – Max Fax, training lists ➢ General Surgery minor ops –lumps and bumps, cysts, lipomas ➢ Minor breast lists – cysts ➢ Dermatology Approximately 6,982 patients per annum to be undertaken within the unit (social distancing requirements still apply).

Programme	Outpatient Transformation			
Workstreams	**Self Management & Advice**	**Referral Management**	**First Outpatient Appointment**	**Follow Up/Long Term Condition Management**
Aims & Objectives	To empower patients to manage their own conditions and recognise when they may need the advice of a specialist	To ensure that referral guidance and thresholds are in place to ensure that those most in clinical need are referred to appropriate care	To provide patients with access to appropriate care at the right time at the right place	To reduce unwarranted follow ups and improve use of available capacity
	To support primary care clinicians to support patients who don't need to see a specialist	To support primary care clinicians in the referral process and ensure the right information is provided as part of the referral, thus improving referral quality	To provide care closer to home	To give individuals more choice and control over their care
	To provide access to high quality advice and guidance to enable informed decision making for individuals as well as primary and secondary care clinicians	To ensure patients are risk stratified, triaged and appropriately streamed at point of entry	To transform care to better meet the need of the patient (and the needs of the service)	To provide patients with access to appropriate care at the right time at the right place
		To ensure that referrals are triaged and advice and guidance provided if referral not necessary		To provide care closer to home

Primary Drivers	Managing Demand	Managing Capacity	
	Patient-led Care		

National Planned Care Programme Goals	Effective Referral	Treat Accordingly	Follow Up Prudently
	Advice & Guidance		
	Measure What's Important		

NPCB Transforming Outpatients Priorities	**Effective Referral** Implement National Enhanced Pathways Focus on Top 10 most common referrals DNDs, INNUs and threshold management		**Increased Virtual Activity** Video Group Clinics
	Self Management	**Waiting List Prioritisation** Admin and clerical validation Re-categorise outpatient referrals Focus on urgents and long waiters	**Prudent Follow Up** Discharge as default Eliminate patients who are over 100% delayed
	Immediate roll out of National Pathways See on Symptom/PIFU Pathways		
	Advice & Guidance Implement e-advice Roll out and standardise specialist advice and guidance		

PROJECTS/Task & Finish (needs prioritisation)			
Patient information & self management advice			
Central Patient Support Team			
Accommodation Booking System			
Advice & Guidance		Delivery/monitoring/reporting of Welsh Government Targets	
Health Pathways	Job Planning		
		Reduction of DNAs & HICs	
		Virtual Group Consultations	
Expectation management	Clear referral criteria, red flags & pathways	Pre-consultation communication	Clear criteria & schedule for follow up
Signposting	Single point of referral	Patient information & decision aids	Default telephone/virtual
Social prescribing	Electronic referral	Access to patient record, including test results & referral info	PIFU/SOS
Patient-facing portals	Triage, risk stratification & appropriate streaming at point of referral	Clinician - who sees the patient?	Supported self management
Pre-hab	Referrals are directed to the appropriate service, prioritised and added to the correct waiting list	Mode - F2F/Tel/Virtual/Group	LTC management
A service directory for GPs & PC for specialist advice	Straight to Test	Location - Estates plan to support delivery	Virtual/face to face group consultations
	Communication back to primary care	Complex/one stop/hot clinics	Follow up waiting list management
Consultant connect	Management of referrals	Post-consultation communication back to referrer & copied to patient (standardised format/principles)	Appropriate discharge process

Enablers		Estates
	Informatics/Digital	
		Workforce
	Communications	
	Finance	
	Dashboard/Data	
	Value-Based Healthcare	

Aneurin Bevan University Health Board
Audit Risk & Assurance Committee

Capital/Revenue Estates Efficiency Framework

Executive Summary

The Audit, Risk and Assurance Committee requested an update on the progress to date of utilising the Capital/Revenue Estates Efficiency Framework ('the framework').

This paper describes the limited application to date and outlines the proposed programme of work proposed to be delivered during the first quarter of 2022/23.

The proposed programme includes:

Establishing a multi-disciplinary team, who will assess:

- Utilisation of the premises
- Condition Analysis
- Agile working potential
- Revised use or refurbishment for better HB use and to support rationalisation of other leased or unwanted premises.
- Be cognisant of service plans and requirements & opportunities for partnership working.

Recommendation:
The Committee is requested to note the proposed programme of work.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	x

Executive Sponsor: Rob Holcombe, Interim Director of Finance and Procurement			
Report Author: Suzanne Jones, Assistant Director of Finance			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: March 2022			
Supplementary Papers Attached: None			

Purpose of the Report

To provide the Committee with an update on the application of the framework and the proposed programme of work for 2022/23.

Background and Context

The Strategic Capital and Estates Group requested a framework for capital efficiency to be developed. The final version of the proposed approach describing a capital/revenue efficiency framework with potential scoring and implementation was agreed by the Strategic Capital & Estates group in October 2021.

The Committee received the framework for information and endorsed it's use. This paper provides an update on the application of the framework to date and the proposed programme of work for 2022/23.

Assessment and Conclusion

The Health Board has had limited opportunity to fully apply the framework to specific proposals since the approval of its use.

The general principles are being applied in terms of consideration of agile working and 'fitting' services into GUH, eLGH and office accommodation proposals.

The Directors of Planning, Workforce and Finance recently met to agree a programme of joint work to be progressed during the first quarter of 2022/23, this will include;

Establishing a dedicated multi-disciplinary team with representation from -

- Capital Planning
- Estates
- Workforce
- Finance

This team will dedicate time to surveying all ABUHB properties to assess –

- Utilisation of the premises
- Condition Analysis
- Agile working potential
- Revised use or refurbishment for better HB use and to support rationalisation of other leased or unwanted premises.
- Be cognisant of service plans and requirements & opportunities for partnership working.

The team will be responsible to the 3 executives and will provide update reports with recommendations to the Executive team and the Strategic Capital Group.

Recommendation

The Committee is requested to note the proposed programme of work.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks of additional capital projects being progressed which are not the most beneficial to the ABUHB. Risk of the Health Board not achieving statutory financial duties and other financial targets.
Financial Assessment	This paper provides details of how an efficiency framework would provide improved Value for Money by assessing capital/lease projects and existing estate and ensuring that only those which provide the necessary levels of efficiency are progressed.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	These factors will be developed when proposals and recommendations are being considered.
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper links to the ABUHB estates strategy and will be necessary in order to progress and support the Health Board's 3 year plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** **Integration** **Involvement** **Collaboration** **Prevention** The Health Board Capital & Estates Plan has been developed based on the approved AOF/IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	*na*

Audit, Risk & Assurance Committee

Update on Governance, Financial Control Procedures and policies, Technical Accounting Issues, Public Sector Payment Policy Compliance, Single Tender Actions & Payments in excess of £100K

Executive Summary

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 Standing Orders (SOs) & Standing Financial Instructions (SFI's)
- Financial Control Procedures and Policies
- Technical accounting issues
- Public Sector Payment Policy compliance
- Single Tender Actions
- Payments Exceeding £100K

The Committee is requested to

- Note the contents of this report.
- Approve the amendments to the Charitable Funds Financial Control Procedure

The Board is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Robert Holcombe, Interim Director of Finance, Procurement and Value Based HealthCare

Report Author: Estelle Evans, Head of Financial Services and Accounting

Report Received consideration and supported by:

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 21st March 2022

Supplementary Papers Attached:

Appendix 1 – Changes made to the Charitable Funds Financial Control procedure

Appendix 2 - Single Tender Action

Purpose of the Report
To provide the Audit, Risk and Assurance Committee with an update on the standing items listed in the Executive summary.
Background and Context
See Executive summary above.

Assessment and Conclusion

1. Review of Standing Orders, SFI's and Scheme of Delegation.

There is no further update in relation to this issue.

2. Financial Control Procedures & policies

The Charitable Funds Procedure has been updated to reflect working practice, changes by the Charitable Funds Committee and recommendations from Audit Wales.

2.1 Key Issues

The procedure has been reviewed in line with the review dates as stated within the procedure. The main changes to the procedure are set out below.

Paragraph	Summary of change
All	Updated to replace charity name "Aneurin Bevan University Health Board Charitable Fund and Other Related Charities" with its working title "Aneurin Bevan Health Charity" Updated to change name of "Charitable Fund Account Managers" to "Charitable Fund Holders" Updated for grammar and spelling corrections
5.2	Additional paragraph to include the role of the Charitable Funds Committee
9.1	Additional section to show distinction between the types of funds held within the charity
9.2	Additional section identifying separate treatment of grants
10.4	Additional text to reference the allocation of unrealised gain/loss
11.4	Additional paragraph to include approval requirement for the employment of staff
16.2	Additional paragraph to include training of Charitable Fund Holders by Charitable Funds Team

Appendix 3 & 4	Additional text to request information on goods received in kind
Appendix 11	Updated to reflect recent change to Investment & Reserves Policy

A copy of the revised policy is attached for reference.

The revised procedure was reviewed and approved by the Charitable Funds Committee at the meeting held on the 3rd March 2022.

3. Technical Accounting Issues

3.1 Scheme Pays

2019/20 tax year

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

- clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction. This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff have until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

At the end of 2020/21 there was insufficient data of take-up of the scheme by the Welsh clinical staff to enable a reasonable assessment of future take up to be made. As such as no reliable estimate could be made to support the creation of a provision as at 31 March 2021, the existence of an unquantified contingent liability was disclosed in the 2020/21 Annual Accounts.

The position has changed in 2021/22 with 722 applications received by the Pensions Agency across Wales. Initially 496 applications were received with 28 confirmed application relation to Aneurin Bevan which prior to submission were ratified by NWSSP which we are now in the process of verifying. We have recently been informed that there have been a further 226 applications although the split of this number by Welsh Health Bodies is not yet available.

On the basis of the above Welsh Government have confirmed that Welsh Health bodies will be required to create a provision in our 2021/22 Annual Accounts for Scheme Pays which will be fully funded by Welsh Government.

Welsh Government are in the process of contacting Government Actuary's Department (GAD) to ask that they calculate the provision required on behalf of Welsh Health Bodies and to share the methodology so that the calculation is consistent to that applied in England. Local variations may need to be applied to the calculation with regard to life expectancy figures.

Clarification is still being sought as to the treatment of employees that are currently on our payroll but were employed by another Welsh Health body in 2019/20 and also on employees that have been identified to a Welsh NHS body by the pensions agency that no longer exists.

If we are unable to determine which body the employee relates to Welsh Government will include a provision in their accounts for these individuals.

Audit Wales have confirmed that their position in relation to scheme pays has not changed from previous discussions and that inclusion of this expenditure in the accounts would, in their opinion be considered as irregular and material by nature. This would lead to a regularity qualification in the Health Boards accounts. This is a national issue and will be the same for all Welsh Health bodies and also be reflected in the WG consolidated NHS accounts, and the overall WG accounts.

4. Public Sector Payment Policy

The following table shows the Public Sector Payment Policy performance for the month of February. The target of 95% has been achieved on a year-to-date basis.

Category	Invoices	In Mth %	YTD %
Non-NHS	Value Number	95.1 95.0	95.2 95.0

5. Single Quotation and Tender Actions – 20th January to 24th March 2022

The new SFI's set out some of the exceptional circumstances which are needed to secure goods from a single supplier (as opposed to the usual competitive process). They are set out below:

- Follow up work where the provider has already undertaken initial work in the same area.
- A technical compatibility/compliance issue.
- Genuine business continuity reasons.
- Joining collaborative all Wales agreements where there is no formal agreement in place.

Although these are not new, they are now clearly set out in the all Wales SFI's and the schedule prepared by procurement (appendix 1) now explicitly refers to these reasons which was not always the case previously.

As can be seen from the appendix, all requests for a Single Tender Action or a Single Quotation action are submitted to the Chief Executive for approval and also reported to the Audit, Finance and Risk Committee.

There have been 10 requests submitted and approved during the period with a total value of £2,744,494 Ex VAT. Appendix 1 provides the full detail. Please note, the supplier name has been redacted from the attachment as the supplier name, alongside the value may be deemed commercially sensitive.

The procurement processes have now been amended with the requirement for all future orders to be sent to the central procurement team. This will ensure that all Single Quotation and Tender Actions are recorded centrally and reported to the Audit, Finance and Risk Committee as they occur.

6. Payments In Excess of £100K

There were no exceptional issues to report.

Recommendation
The Audit, Risk and Assurance Committee is requested to approve the amendments to the Charitable Funds Procedure. The Committee are asked to note the other areas included within this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*
Quality, Safety and Patient Experience Assessment	*Not applicable*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*No applicable*

Link to Integrated Medium Term Plan/Corporate Objectives	*SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant*
Glossary of New Terms	*FCP – Financial Control Procedure* *SFIs - Standing Financial Instructions* *SOs - Standing Orders* *NWSSP - NHS Wales Shared Services Partnership*

Aneurin Bevan University Health Board

CHARITABLE FUNDS

Financial Control Procedure

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

Status: Issue 6
Approved by: Audit Committee
Owner: Director of Finance

Issue date: 19 July 2022
Review by date: 19 July 2025
Policy No: ABUHB/Finance/0244

Contents:

Appendices:

1 Introduction

Charitable Funds is the term given to money that is donated to the Aneurin Bevan University Health Board and which is administered through a registered charity, Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities, number 1098728. The Health Board is the Corporate Trustee of the charity and has appointed the Charitable Funds Committee to oversee the management of its funds. The charity uses the working name "Aneurin Bevan Health Charity" which is used throughout this document.

2 Policy Statement

Aneurin Bevan University Health Board is committed to ensuring that it has sound financial controls in place to ensure that there is good control and probity over the use of charitable funds. It is also committed to ensuring that it is compliant with charity regulations set out by the Charity Commission.

3 Aims

The document will set out procedures that are to be adopted by delegated Charitable Fund Holders in the day-to-day management of charitable funds and in setting out the corporate responsibilities of the Health Board.

4 Scope

The document is relevant to staff within the Corporate Finance Department and specifically the Charitable Funds Office. It is also relevant to staff that have been identified as Charitable Fund Holders and have been delegated a specific charitable fund account to manage on behalf of the trustee.

5 Roles and Responsibilities

5.1 Corporate

5.1.1. The Director of Finance is responsible for ensuring that proper financial controls and segregation of duties exist for charitable funds. The Assistant Director of Finance (Financial Systems & Services) assumes managerial responsibility for Charitable Funds, with the day-to-day management delegated to the Charitable Funds Manager.

5.1.2. Individuals must not set up a charity using the name of the Health Board or any of the Health Boards' hospitals without prior permission from the Health Board.

5.1.3. Individuals must not set up their own bank account to receive monies intended for the Aneurin Bevan Health Charity.

5.1.4. All correspondence relating to charitable funds must be passed to the Charitable Funds Manager immediately. Disciplinary action will be taken where monies are misappropriated or mislaid because staff have not receipted monies

promptly or not informed the Charitable Funds Manager of pertinent information.

5.2 Charitable Funds Committee

The role and responsibility of the Charitable Funds Committee is defined within the Terms of Reference of the committee and their work plan which is reviewed annually.

5.3 Charitable Fund Holders

This policy applies to all staff that have been identified as Charitable Fund Holders to manage those accounts.

6 General Information

6.1 Charitable Funds are variously described as Trust Funds, Endowment Funds, Gift Funds or Non-Exchequer Funds. Property can only be held for charitable purposes if it is for public benefit and exclusively charitable.

6.2 The legal objects of the Aneurin Bevan Health Charity are as follows:

The trustees shall hold the trust funds upon trust to apply income, and at their discretion, so far as permissible, capital, for any charitable purpose or purposes relating to the National Health Service in the area of Gwent.

6.3 All expenditure and activities of the charity and individual accounts within charitable funds must be within the scope of the objects shown above.

6.4 Charitable Funds are used for items of expenditure relating to the Health Service which are not normally paid from revenue funds either because it would be inappropriate to do so or because revenue funds are insufficient. The funds are intended to provide those additional amenities that will improve the conditions under which patients are cared for and treated or staff work. Examples of items typically purchased from charitable funds are shown in Appendix 1.

6.5 Charitable funds may not be used to supplement remuneration directly or indirectly.

6.6 Income generated through the normal course of NHS staff activities should not be accounted through charitable funds but be part of the normal revenue income of the Health Board.

7 Financial Controls

7.1 The Director of Finance is responsible for maintaining all financial records to enable the production of reports and annual accounts that comply with accounting standards and Charity Commission regulation.

7.2 All transactions must be coded correctly in the General Ledger and all supporting documentation must be retained for audit purposes.

7.3 Overdrawn funds are not permitted and therefore expenditure against a specific fund can only be allowed when sufficient funds exist.

7.4 In the unlikely event that an overdrawn fund balance occurs the account manager must ensure that the account is returned to credit within a reasonable period. Overdrawn funds must be reported to the Charitable Funds Committee.

7.5 Control accounts must be reconciled monthly by the Charitable Funds Manager and approved by the Assistant Head of Financial Accounting.

7.6 All inter-organisation balances between the charitable funds and the Health Board's revenue funds must be reviewed and cleared monthly.

7.7 The banking services for charitable funds must be in a separate bank account to those used for revenue funds.

7.8 All costs directly involved in the administration of the Charitable Funds must be identified in reports and annual accounts to reduce any subsidy from the Health Board.

7.9 Procedures, duties and controls must be reviewed for current relevance, practicability and efficiency on an ongoing basis.

7.10 Transaction listings and reconciliations must be reviewed for completion, reasonableness and evidence of posting.

8 Charitable Fund Holders

8.1 Signatories

All delegated charitable fund accounts must have two nominated signatories. The first signatory is the Charitable Fund Holder who takes primary responsibility for the management of the account and must be aware of and be compliant with this financial control procedure. The second signatory must be a person of equivalent or more senior position to the Charitable Fund Holder.

8.2 Delegation of Charitable Accounts

Charitable funds are formally delegated to Charitable Fund Holders on an annual basis by letter from the Director of Finance on behalf of the Charitable Funds Committee. The letter which will be issued in March of each financial year is shown in Appendix 2 and will cover the following areas:

- The basis that the account is being delegated.
- The terms of reference of the account.
- Authorised signatories of the account.
- The requirement to read and be familiar with the Charitable Funds Financial Control Procedure and Management Guide.
- The requirement to provide an annual return in relation to the activities and expenditure of the account.
- The withdrawal of the right to be a Charitable Fund Holder if compliance with requirements is not followed.

8.3 Reporting the Use of Delegated Funds

Charitable Funds Holders are required to submit an annual report to the Charitable Funds Committee setting out how the account has been used in the previous financial year. The reporting requirements vary depending on the fund balance on the account and is summarised as follows:

AVERAGE VALUE OF FUND	*REQUIREMENT*
Less than £25K	A simple proforma return setting out what the fund was used for and the main purchases and income activity made in the year. A proforma is attached in Appendix 3.
Greater Than £25K	A more detailed report setting out the activities and spending over the following headings: **In the last Year** Main activities Income sources Expenditure – detailing the items purchased and how they have improved the services provided by the ward/dept. **Plans for the Forthcoming Year** Main activities Income sources Expenditure **Plans for Future Years** Main activities Income sources Expenditure A proforma is attached in Appendix 4.

Reports must be submitted to the Charitable Funds Manager by 30th April following the end of the preceding financial year.

For significant funds with balances greater than £25K it is important that spending plans are in line with the strategic direction of the Board and additional level of scrutiny is required at a departmental or service level to ensure that funds are used appropriately.

8.4 **New Charitable Fund Accounts**

New charitable fund accounts must be approved by the Charitable Funds Committee by using the form shown in appendix 5. The purpose of the fund must be identified together with two signatories.

9 Income

9.1. Types of Funds

Monies may be given to be held for a specific or general purpose but how they are accounted for depends on the specific terms on which they have been given:

- Restricted Funds - can only be spent in accordance with written instructions imposed at the time the funds were donated or granted or in accordance with the specific terms of a fundraising appeal. They consist of legacies and grants where a legal document and signed agreement restricts the use to the terms of the bequest/agreement.
- Unrestricted Funds – may be spent at the discretion of the trustees in line with the objectives of the charity and fall into the following below categories.
    - Designated funds whereby a particular part of the hospital or activity was nominated by the donor at the time their donation was made. Whilst their donation is not binding on the trustee, these types of donations are allocated to the designated funds.
    - General Funds – these relate to donations received by the charity where no specific preference has been expressed by the donor as to the utilisation of the funds. This type of donation is assigned to the Charitable Funds Committee to decide how the funds are best used.

9.2 Legacies

9.2.1 The Charitable Funds Manager will: -

- Send a letter of thanks to the Executors, if appropriate.
- Process and act on correspondence to ensure that the bequest is received promptly.
- Record the legacy details in the legacy register.
- Set up a separate restricted fund for each legacy received.
- Advise the Director of Finance of any issues arising from a legacy.
- Inform the Health Board's Property Group of any land and property bequeathed to the Health Board and act on their advice.
- Ascertain paperwork when advised of bequests, to provide a full audit trail.

9.2.2 All legacies must be reported to the Charitable Funds Manager and used in accordance with the terms of the will and within a reasonable timescale.

9.3 Grants

9.3.1 Grants are usually restricted income given for a specific purpose and have terms and conditions on how it can be used by the charity.

9.3.2 Grants will often have additional requirements attached such as performance-related conditions and they are usually subject to numerous monitoring and evaluation reports.

9.3.3 Grant income can only be recognised when there is a formal offer of funding, or the income is received.

9.3.4 Where the charity is unable to meet certain agreed criteria the grant may have to be returned in full.

9.3.5 All paperwork must be ascertained when advised of/on receipt of the grant to provide a full audit trail.

9.4 Donations

9.4.1 All monetary donations, including funds raised by the staff such as raffle monies, must be receipted into Charitable Funds. Staff must not keep cash donations at a local level.

9.4.2 Charitable Fund Holders must ensure that when a donation is received any condition or direction, which is attached, is noted and complied with. It may be necessary to decline the gift if the attached conditions are unduly onerous or if the Health Board is incapable of meeting the conditions. Charitable Fund holders must report potential donations that could generate additional running costs to their Directorate Manager. The Directorate Manager must determine how these costs are to be met before accepting the donation.

9.4.3 The Charitable Funds Manager must ensure that the Charitable Funds do not contain funds received for Clinical Trials. These funds are not deemed to be Charitable as it is the sponsoring company that benefits from the trial. Funds for research are permissible providing the research is published in the public domain.

9.4.4 The Charitable Funds Manager must ensure posters and leaflets are distributed across the Health Board informing people how they can make a monetary donation to the charity. Both the poster and leaflet must emphasise that donors must obtain a receipt for their donation. The procedure for making a monetary donation, with a sample poster, is shown in Appendix 7.

9.4.5 Documentation should include an option for the donor to make a 'Gift Aid' declaration allowing the Health Board to reclaim tax.

9.4.6 Cheques should be made payable to Aneurin Bevan Health Charity.

9.4.7 The Charitable Fund Holder or their nominated individual or the Charitable Funds Manager must send a letter of acknowledgement to the donor. Some

examples of wording to be included within thank you letters can be found in Appendix 8.

9.4.8 Small personal gifts such as chocolates and flowers given by grateful patients, relatives or friends need not be accounted for in the formal sense.

9.4.9 Gift cards and vouchers can be accepted and must be recorded as a donation and used for the benefit of the ward/department.

9.5 Fundraising

9.5.1 Most health service bodies raise funds on a regular basis through fetes, coffee mornings, lotteries and appeals etc. For small society lotteries, the charity must be registered with the licensing authority in the area where the principal office of the charity is located. Aggregated proceeds from all lotteries that take place across the Health Board must not be more than £250,000 in any one year.

9.5.2 Raffles may take place in Aneurin Bevan University Health Board, providing the following points are complied with:

- Raffles must be registered with the Charitable Funds Team using the 'Raffle Request Form' in Appendix 9.
- The Charitable Funds Team will issue pre-printed raffle tickets together with a Raffle Return Form
- Every ticket in the raffle must cost the same and the ticket fee must be paid before entry into the draw is allowed
- Tickets must not be sold to, or by, those under the age of 16
- Proceeds must not exceed £5,000 for a single draw
- All proceeds of the raffle must be credited to the Charitable Funds account using the ward/department receipt book
- No single prize may be worth more than £1,000
- Alcohol donated as raffle prizes may be accepted at the discretion of the Ward/Department Manager
- Prizes may be purchased from charitable funds if sufficient funds are available, but alcohol must not be purchased. Prizes should cost significantly less than the anticipated income from the raffle
- Raffle tickets must be drawn randomly and the winners must be notified by telephone or in writing by the designated staff member
- The Raffle Return Form must be completed and returned to the Charitable Funds Team together with any unused tickets within a month of the actual draw
- The winning tickets must be attached to the Raffle Return Form
- The rules governing the use of raffles will be printed on the back of the raffle return form for ease of reference
- The Charitable Funds Team will maintain a register of raffles in order to complete the required lottery return to the licensing authority in Torfaen County Borough Council.
- Aggregated proceeds from all raffles that take place across the Health Board must not be more than £250,000 in any one year.

9.5.3 Guidelines on sponsorship are detailed in Appendix 10.

9.6 Gift Aid

9.6.1 Donations and Fundraising (Sponsorship) Income can be Gift Aided.

9.6.2 The Gift Aid scheme allows the Charity to collect an additional amount over and above the donation in lieu of income tax.

9.6.3 Donors must sign a declaration, prior to making their donation or undertaking their fundraising activity, that

- they wish the Charity to reclaim the tax relief
- they are currently UK taxpayers and the amount of tax they pay exceeds the amount of tax reclaimable

9.6.4 The Charitable Fund Manager can provide gift aid declarations and advice on the scheme.

9.7 Acknowledgement

9.7.1 The process for acknowledging donations, legacies and grants is shown in the diagram in Appendix 6

10 Investments

10.1 The investment policy is attached in Appendix 11.

10.2 The Charitable Funds Committee is responsible for appointing an investment management company or companies to manage the Charitable Fund's investments. The Investment Management Company must be informed of the Investment Policy of the charity and the trustees may rely on the professional advice of the Investment Management Company in formulating the policy. The policy should be reviewed annually to ensure it still fits with the overall aims of the charity.

10.3 The Charitable Funds Committee or a nominated representative should instruct the Investment Management Company to: -

- Provide details of all transactions undertaken on behalf of charity.
- Hold stock and share certificates for safekeeping.
- Provide details of dividends and interest received.
- Provide valuations on request.
- Attend the Charitable Funds Committee at least annually to formally present the investment performance of the period.

10.4 The Assistant Director of Finance (Financial Systems & Services) is responsible for: -

- Maintaining an Investment Register to record details of all investments held.
- Calculating realised gains or losses (profit/loss) on sale of investments.

- Calculating unrealised gains or losses on investments.
- Informing the Charitable Funds Committee at each meeting of the investment valuation.
- Ensuring all interest and dividends received are apportioned to individual funds based on the average monthly fund balance.
- Ensuring any unrealised gains or losses on investments are allocated/utilised in accordance with the wishes and agreement of the Charitable Funds Committee
- Ensuring the investments held is reflected in the charity's annual accounts.
- Ensuring working balances are kept in a Government Banking Service, interest bearing, bank account.

11 Expenditure

11.1 The detailed procedure for purchasing goods and services from Charitable Funds is detailed in Appendix 12– Purchases from Charitable Funds.

11.2 All purchases are subject to the following approval hierarchy:

Purchases Up To	Approvers
£5,000 Additional approvals for £5,001 - £15,000 £15,001 - £25,000 >£25,000	Two individual fund holders Divisional General Manager Executive Director Charitable Funds Committee

11.3 In addition to the approval hierarchy set out in the previous table for more significant funds, because of their relatively high value, an additional level of scrutiny is required at a departmental or service level to ensure that funds are used for the strategic benefit of the service or department and where a wider engagement would be desirable. Therefore, evidence of planning engagement and specific plans for the account is required to support purchases where fund balances exceed £25K.

11.4 Any expenditure relating to the employment of staff must also be approved by the Charitable Funds Committee to ensure that contracts are fixed term and under a period of two years.

11.5 An authorised signatory list is maintained by the Charitable Funds Manager. The approval hierarchy is also contained in the Oracle iProcurement module.

11.6 The Charitable Funds Manager will be responsible for ensuring that certification of expenditure by Authorised Signatories is within the limits set out in this procedure.

11.7 Expenditure can be incurred provided it falls within the remit of the fund from

which it is being paid and satisfies the following criteria:

11.7.1 It is not for the benefit of an individual (e.g., retirement gifts) unless it is a payment to an individual that benefits a wider group – an example being a training course for the benefit of the department or service.

11.7.2 Charitable funds cannot be used as funding support for staff without the approval of the Charitable Funds Committee.

11.7.3 No alcohol to be purchased.

11.7.4 Where meals are provided (for example as part of a conference for speakers) alcohol and tobacco cannot be claimed.

11.7.5 A distinction should be made between work and work networking opportunities as opposed to purely social activities; the latter being inappropriate.

11.7.6 The need to be proportionate and reasonable in expenditure.

11.7.7 Consumable items should be paid from NHS funds not charitable funds.

11.7.8 All minor works requests not available on Oracle should be submitted via the Charitable Funds Office where availability of funds and authorised signatory will be confirmed before the Works department initiates any works.

11.7.9 Where expenses and reimbursements are to be reclaimed via charitable funds, claims must be made within 3 months of the date the expenditure was incurred in line with the wider Health Board policy.

11.7.10 Loyalty cards may only be used to purchase goods if the card is registered to the department and not the individual.

11.7.11 Examples of items typically purchased from charitable funds are shown in Appendix 1.

12 Value Added Tax - VAT

12.1 Certain items purchased from charitable funds may be exempt from VAT where the goods are: -

- Purchased wholly from charitable funds.
- Purchased by an eligible body wholly from funds provided by a charity or voluntary contributions.

12.2 The following items are exempt from VAT if used for the purposes stated

- Medical, scientific, computer, video, sterilising, laboratory, or refrigeration equipment used in medical research, training, diagnosis, or treatment

- Parts and accessories for use with the above items
- Qualifying aids for people with disabilities
- Computer software solely for use in medical research, diagnosis or treatment and its repair and maintenance

12.3 Zero rating only applies when the item being purchased is used solely for the declared purpose e.g., a computer may qualify where used entirely for medical research. However, zero rating does not apply if the computer were used partly for research and partly for general administrative work.

12.4 Charitable Fund Holders should refer to the VAT Guidelines - HM Custom & Excise - Notice 701/6 (4.11) Appendix 13 to determine the eligibility of purchases for VAT exemption.

12.5 The Procurement Department will complete a VAT exemption certificate, when placing the order, for those goods that are zero rated. A proforma VAT exemption certificate is shown in Appendix 14.

12.6 The Charitable Funds Manager will be responsible for clarifying VAT issues.

13 Accounting

13.1 The Assistant Director of Finance (Financial Systems & Services) is responsible for configuring the Oracle Financials System to be able to satisfy financial reporting regulation for Charities.

13.2 Accounts must be produced annually and be subject to external audit opinion and be filed with the Charities Commission before 31 January following the accounting year end.

13.3 The accounts must be submitted to the Charitable Funds Committee for approval and signed off by the Aneurin Bevan University Health Board, who act as Corporate Trustee for the charity

14 Administration Charges

14.1 All costs of administering the funds must be charged to the Charitable Funds accounts. Exchequer funds must not be used to subsidise charges.

14.2 The administration fee should cover the cost of administering the funds on a day-to-day basis and includes charges from the investment companies, finance and general administrative costs and auditors' fees.

14.3 Administration charges are charged to the funds annually. The total charges incurred by the Charity are apportioned based on the average monthly fund balance. During the year an estimated charge may be applied to ensure that individual fund accounts do not exceed available funds.

15 Corporate Reporting

15.1 On an annual basis the Assistant Director of Finance (Financial Systems & Services) will ensure that year end accounts and reports are prepared, in line with current accounting regulation for Charities and that the Charitable Funds Committee approve the audited accounts.

15.2 The Assistant Director of Finance (Financial Systems & Services) will provide a financial report to each Charitable Funds Committee meeting giving details of the current financial position.

15.3 The Charitable Funds Manager will ensure that reports, showing opening and closing balances together with transactions, on each fund are available to view by fund managers through the Oracle Reporting Suite – Financial Business Intelligence (FBI).

16. Training

16.1 In addition to this Financial Control Procedure a Management User Guide has been developed which is issued to all Charitable Fund Holders. The guide gives practical advice to help managers know their responsibilities and to assist them in common activities such as receiving donations and purchasing goods or services from funds.

16.2 The Charitable Funds Team will meet with Charitable Fund Holders on a regular basis to ensure they understand and comply with these procedures.

16.3 Further advice and training is available if necessary and can be arranged through the Charitable Funds Office.

17. Audit

17.1 Internal Audit and Audit Wales will audit Charitable Fund Holders, General Offices and the Finance department periodically to determine the effectiveness of this procedure.

17.2 Auditors will present a report of their findings and recommendations to the Audit, Finance and Risk Committee, Charitable Funds Committee and the Health Board.

18. Review

18.1 This procedure will be reviewed every three years unless a requirement arises for this to be reviewed earlier.

Appendix 1

Aneurin Bevan Health Charity

CHARITABLE FUNDS
Examples of Items Typically Purchased from Funds

The Health Board (the trustees) are keen that funds are used as soon as practicable following donation. The list below has been developed as an aid to managers and Charitable Fund Account Managers about the type of items that charitable funds can be used for.

If you wish to discuss any specific issues in more detail, please contact:

Charitable Funds Team
Tel No: 01495 765431 (internal calls to ext 55431)
E-mail: Charitable.Funds.ABB@wales.nhs.uk
Chat with us on Teams

Patients Expenditure	Notes
Medical equipment	• Donations are often received with a wish that equipment is purchased • Individuals fundraise to purchase a particular piece of equipment • Providing additional equipment would benefit both patients and staff. For example, on a cardiology ward where patients are required to be weighed daily, there is a hoist provided at each end of the ward, but an additional hoist would improve conditions. • Medical equipment when purchased through the charitable funds is VAT exempt • Maintenance costs and consumables need to be considered as these are usually met by revenue budgets
Seasonal activities/Occasions	• Gifts for patients resident in hospital over Christmas • Easter eggs, Halloween items • Decorations for wards and departments at Christmas, Diamond Jubilee etc

	• Ward/Department buffets – open to all, patients, staff and visitors
Therapies	• Dance classes for older adult patients • Musical equipment • Gardening for Mental Health patients • Trips for diabetic and renal patients to show how they can manage their condition in normal day to day activities • Craft items
Environment	• Replacement of bay curtains that are adequate but worn • Cot bedding and mobiles • Pictures and murals • Plants at hospital entrances • Christmas trees and lights at hospital entrances • Garden furniture and benches • Refurbishment of areas to provide bereavement rooms • Redecoration to encompass new ideas of highlighting certain features by using different colours for patients to identify them more easily such as toilet doors, toilet seats
Other equipment	• Game consoles and games – as well as keeping children occupied it also improves patient co-ordination in stroke patients • Televisions • Music centres • Storage containers to tidy up areas • Dignity pegs – to clip bay curtains together • Bariatric equipment such as toilet seats, commodes, anaesthetic cushions and chairs as the Health Board provides standard items but unfortunately the physical size of patients treated is increasing and this exceeds the working load limit. • Bereavement memory boxes • Sympathy cards • Toys for children play areas
Staff Expenditure	**Donations are often given with a wish that they are spent on the staff**

Training courses and conferences (including accommodation and travel expenses)	• Knowledge gained by an individual on a training course can be passed on to other staff and will indirectly benefit patients
International conferences/courses	• Revenue budgets do not usually support international events due to the cost, but knowledge gained from this wider platform can improve practise here
Staff Awards (not cash)	• Prizes for poster presentations at Nurse Conference • Staff Recognition Award – in the form of a trophy • Team building events
Training equipment	• Provide the necessary equipment to enable in-house training • In-house training can be much cheaper than sending staff away on courses as there are no travel costs and staff are on hand in case of emergencies
Other equipment	• Kettles, Microwaves, Fridges. Additional items • as what is provided is not always within staff proximity • Laptops – so staff can access information while away from their area of work • Computers with higher specifications than Health Board standard required to run certain types of software • Storage items – to tidy areas • Smart phones – provided in areas such as district nursing so that staff can access information and also in cardiology where GPs can access on call Consultants • Educational books
Other	
Environment	• Refurbishment of areas to provide additional storage • Improvements to workstation areas
Research	• Provided it has gone through the Research and Development Committee • Provided it is for public benefit
Service Promotion	• Items for stands at Big Cheese Event in Caerphilly and the Eisteddfod

Appendix 2

Dear Charitable Fund Holder

Delegation of Charitable Funds

Fund No: Fund Name:

This letter formally delegates responsibility for the management of the above account to you as a Charitable Funds Holder for the financial year commencing 1 April 20XX.

All charitable funds within Aneurin Bevan University Health Board are managed within the umbrella of a registered charity no 1098728. Good governance is essential and therefore as the Charitable Funds Holder there are several responsibilities that you have and must be aware of and comply with as follows:

Authorised Signatories
All accounts must have two signatories identified to support all requests for expenditure from the account; the second signatory to the account must be at least of equivalent seniority in the organisation. Expenditure over certain thresholds will also require additional authorisation in accordance with the following table:

Purchases Up To	Approvers
£5,000	Two account signatories
Additional approvals for	
£5,001-£15,000	Divisional General Manager
£15,001-£25,000	Executive Director
>£25,000	Charitable Funds Committee

Use of the Charitable Account
A "*USER GUIDE"* for Charitable Fund Holders has been developed which provides essential information about how to manage an account from receiving donations and income to how to go about making purchases from the account. Please ensure you are familiar with this document which is attached.

The detailed procedures for managing charitable funds are contained in the Charitable Funds Financial Control Procedure with which you should also be familiar. This can be accessed from the Health Board's intranet.

Annual Reporting
The Charitable Funds Committee has introduced a requirement for account managers to provide an annual report on how the fund has been used in the last

financial year and what the main sources of income were. Most funds are small in value and so only a brief pro-forma return will be required.

For larger funds that exceed £25K in value a slightly more detailed return is required describing the activities of the previous year and also to set out plans for the forthcoming and future years.

The Charitable Funds Committee reserves the right, as trustee of the charity, to delegate the use of the account to another manager if the requirements set out in this letter are not observed.

I would be grateful if you would sign this letter as acceptance of these terms and return it to the Charitable Funds Team by e-mail by no later than 30th April. Charitable.Funds.ABB@wales.nhs.uk

If you have any queries, I would be grateful if you would contact the Charitable Funds Manager on 01495 765414 by TEAMS or by e-mail Charitable.Funds.ABB@wales.nhs.uk
Yours sincerely

Director of Finance

Signature 1 **Signature 2**

Name: **Name:**

Appendix 3

Charitable Fund Holder – Annual Report 20XX/20XX
For the Charitable Funds Committee
For funds less than £25K

Account No: **Account Name:**	
Provisional Fund Balance as at 28.02.20XX	**£**

Financial Summary

Income

Expenditure

Describe your main source of income for the year:

Please describe how the fund was used in the year, including the items purchased and how they were used to improve the service providing examples of benefits to patients and staff. If appropriate, please provide photographs.

Please could you provide quotes from patients and staff about the difference purchases from charitable funds have made to them.

This information is used in the Charitable Funds Annual Report and to provide information to the Charitable Funds Committee.

Non-Cash Items

Have you received goods donated during the year?
Excluding food and other perishable items, please could you list these items indicating an approximate monetary value.

Item Received from Approximate Value

Examples		
Toiletries for patients	*Abergavenny School*	*£75*
I-Pad	*Relatives of patient JB*	*£300*
Hand cream for Staff	*Patient JD*	*£5*
We have to include a value for donated goods within our accounts		

Signed:	
	Charitable Funds Holder
Date:	

Signed:	
	2nd Signatory
Date:	

If you require assistance in completing this form, please contact the Charitable Funds Manager on 01495 765414, by TEAMS or by e-mail Charitable.Funds.ABB@wales.nhs.uk

This form must be completed and returned to the Charitable Funds department by 30th April

Appendix 4

Charitable Fund Holder – Annual Report 20XX/20XX
For the Charitable Funds Committee
For funds more than £25K

Account No: **Account Name:**	
Provisional Fund Balance as at 28.02.XX	

Financial Summary

Income

Expenditure

Describe your main source of income for the year:

Please describe how the fund was used in the year, including the items purchased and how they were used to improve the service providing examples of benefits to patients and staff. If appropriate, please provide photographs.

Please describe detailed plans with estimated costs for the fund in the next twelve months and over the medium term of three years, describing the benefits these purchases will make to both staff and patients.

Please could you provide quotes from patients and staff about the difference purchases from charitable funds have made to them.

Non-Cash Items
Have you received goods donated during the year? **Excluding food and other perishable items, please could you list these items indicating an approximate monetary value.** Item Received from Approximate Value *Examples* *Toiletries for patients Abergavenny School £75* *I-Pad Relatives of patient JB £300* *Hand cream for Staff Patient JD £5*
We have to include a value for donated goods within our accounts
This information is used in the Charitable Funds Annual Report and to provide information to the Charitable Funds Committee.

Signed:	
	Charitable Funds Holder
Date:	

Signed:	
	2nd Signatory
Date:	

If you require assistance in completing this form, please contact the Charitable Funds Manager on 01495 765414, by TEAMS or by e-mail Charitable.Funds.ABB@wales.nhs.uk

This form must be completed and returned to the Charitable Funds department by 30th April

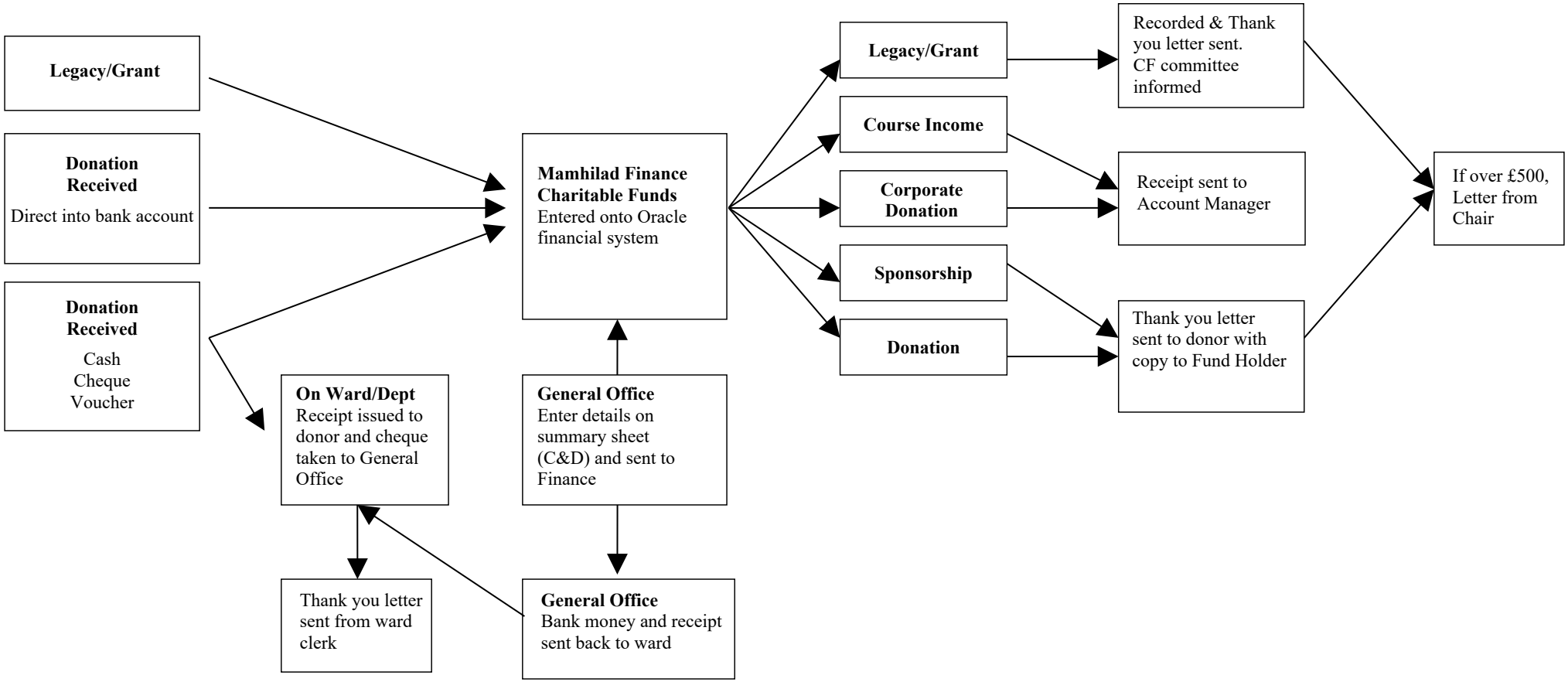
Appendix 5

Request Form to open New Charitable Fund Account Signatories

All delegated charitable fund accounts must have two nominated signatories. The first signatory is the Charitable Fund Holder who takes primary responsibility for the management of the account and must be aware of and be compliant with this financial control procedure. The second signatory must be a person of equivalent or more senior position to the Charitable Fund Holder.

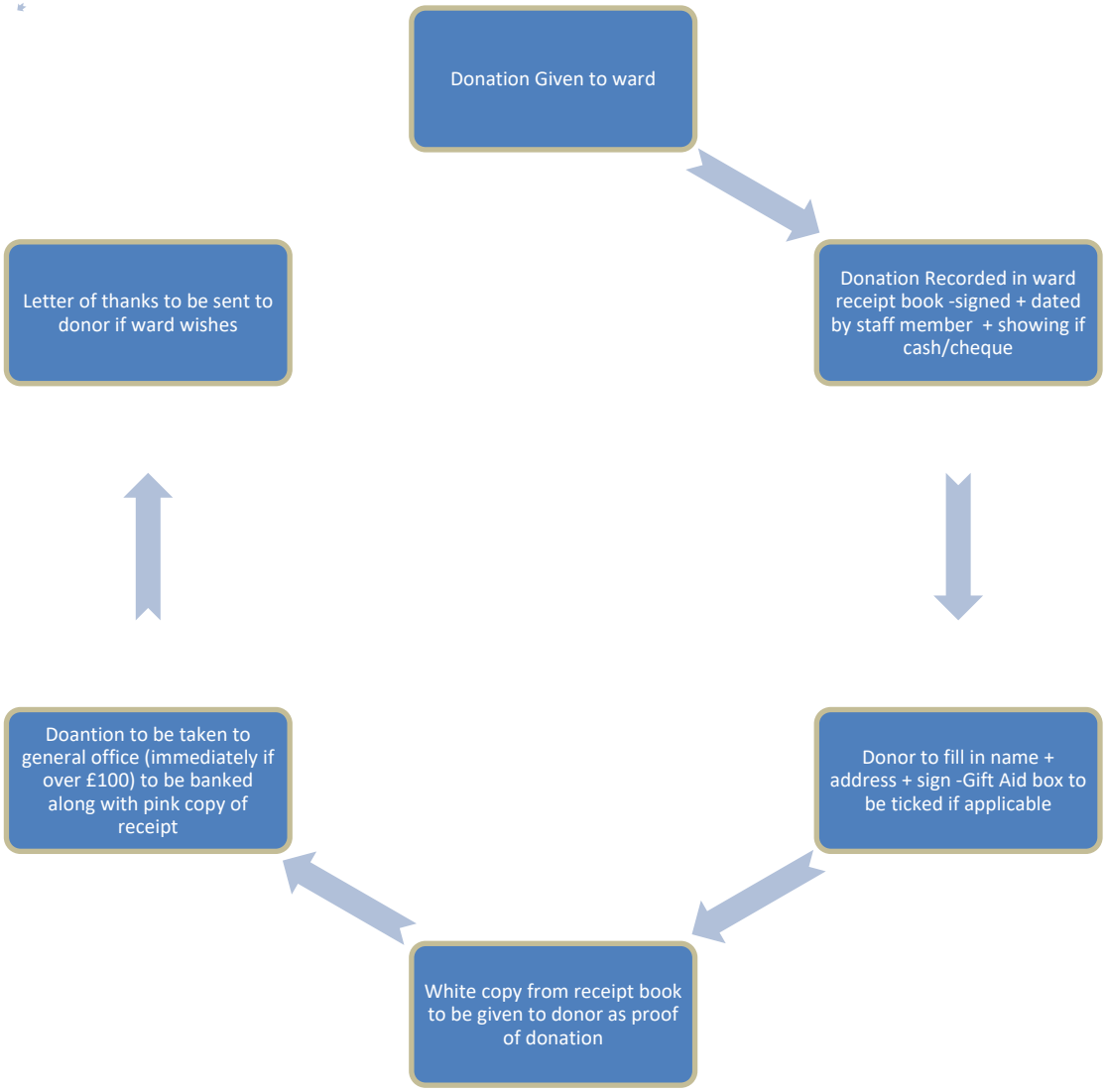
Proposed Name of Account:	
Hospital:	
Department/Ward:	
Purpose of Account:	
1st Account Signatory:	
Name:	
Designation:	
Signed:	
Date:	
2nd Account Signatory:	
Name	
Designation	
Signed	
Date	
Please note the second signatory must be of equal or higher grade	
For Finance Use	
Fund Name:	
Fund No:	
Date Set Up:	

APPENDIX 6 - PROCESS for ACKNOWLEDGING DONATIONS



Appendix 6a

Ward Donation Procedure



Appendix 7

Donations Procedure

1 Introduction

This procedure for monetary donations is based on the guidelines and recommendations of the Charity Commission and Wales Audit Office.

All donations must be receipted and paid into the Charitable Funds Account.

2 Poster & Leaflets

A poster and leaflet informing people of how to make monetary donations must be displayed in each ward/department. The poster is not designed to ask people for money but to inform potential donors of the procedure. Both the poster and leaflet emphasise that donors must obtain a receipt for their donation.

The poster is included within this appendix. The Charitable Funds Manager will supply copies of the donation leaflet on request.

3 Ward/Department Level

Authorised Officers, who have been nominated by the Authorised Signatory of each fund, are the only members of staff permitted to accept donations.

Each fund will have its own receipt book.

A receipt must be issued for each donation received. The receipt will be pre-numbered and in three parts (see Appendix 11):

- Top copy (white) to the donor
- Second copy (pink) to be sent either
  a) to the Charitable Funds Manager, Finance Dept, C Block, Mamhilad House with the donation (**please do not send cash in the post**) or
  b) taken to the General Office with the donation
- Bottom copy (yellow) to be retained in receipt book

The Authorised Officer must sign the receipt. The receipt should clearly indicate which ward or department the donation is for and whether the donation is cash/cheque or other.

Spoilt receipts (the top two copies) should be sent to the Charitable Funds Manager with the bottom copy being retained at ward level.

Fund Holders may request the Charitable Funds Manager to send a letter of thanks when a receipt is deemed to be insufficient.

Cash and cheques must be kept in a locked safe or cash box in the ward/department until it is convenient to take the donation to the General Office or send to the Charitable Funds Manager. The use of a cash box is only suitable for amounts up to £100. Cash Donations exceeding £100 must be taken to the General Office immediately.

Unauthorised persons should not accept donations but should direct the donor to one of the following: -

- An authorised person
- An information leaflet for making monetary donations
- The General Office.

Account managers should ensure that all staff within their area are aware of the donation process.

The Charitable Manager shall be responsible for: -

- Controlling and issuing pre-printed receipts to wards and departments.
- Monitoring receipts
- Ensuring continuity of receipt numbers
- Recording the income in the accounts.

4 General Office

Donations may be made at any General Office in accordance with the Charitable Funds Financial Procedure.

All receipts received from wards/departments by General Offices must be forwarded to the Charitable Funds Manager with their Cash Receipt and Bank Deposit sheets.

5 Post

All postal donations should be sent to: -

The Charitable Funds Manager
Aneurin Bevan University Health Board
PO Box 10
Pontypool
NP4 0XG

6 Banking

All donations should be banked within one week of receipt.

APPENDIX 7

Charitable Donations

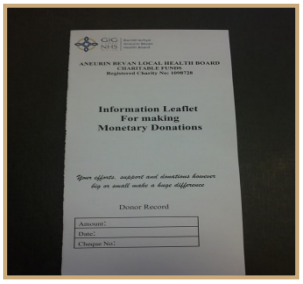
Members of the public sometimes wish to make a donation for the benefit of our patients and staff. All such donations are gratefully accepted into the registered charity of the organisation. If you wish to make a donation please follow the steps below. Thank you.

Give donation to St

OR

Hand in donation at G

Pick up a leaflet for further i



Cheques should be made payable to: -
Aneurin Bevan Health Charity

ALWAYS ASK FOR A RECEIPT

Donations are used for the general benefit of patients and staff of Aneurin Bevan University Health Board.

For more details please contact the Charitable Funds Department - Tel No: 01495 765414
Aneurin Bevan University Health Board Charitable Fund and Other Related Charities
Registered Charity No. 1098728

Receipt No: CF D00001

APPENDIX 7

Aneurin Bevan Health Charity

Registered Charity No: 1098728

RECEIPT FOR INDIVIDUAL CHARITABLE DONATION

I, *Name of Donor*		
Of, *Address of Donor*	Post Code:	
Give to Aneurin Bevan Health Charity		
The sum of	£ (Cheque/Cash/other) Please make cheque payable to Aneurin Bevan Health Charity	For the general purposes of the charity, to be used for patient and staff welfare.
Without imposing any trust it is my wish that my donation should be used for:	Ward/Dept: Hospital: Other - please specify:	

GIFT AID DECLARATION giftaid it

We are able to recover the tax on your donation which allows us to claim a further 25p for every £1 donated. In order that we can qualify for tax relief you must supply us with your full name, home address and post code and tick the box below.

The amount of Income Tax and /or Capital Gains Tax you pay for each tax year must be at least equal to the amount of tax that the charity will reclaim on your gifts for that tax year.

Please Tick if you would like Aneurin Bevan Health Charity to treat this donation as a Gift Aid donation. ☐

Donor's Signature:	
Date:	
Receiving Staff's Signature:	
Staff Name: (please print)	
For Finance Use	
Oracle Receipt No:	
Fund No:	
Gift Aid Ref:	

Appendix 8

Example of thank you letters

The information in bold will need to be changed as required. Please note this is just a guide and covers the basic elements of a thank you letter.

General Donation

Dear ***Name***

Thank you for your donation of ***amount*** *to* ***ward/department*****.**

We are grateful to receive donations which help to provide additional benefits for the care and treatment of patients, purchase medical equipment, improve the hospital environment and support the continuing education for staff.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the ***ward/department*** I would like to thank you for this kind gift.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

In Loss

Dear ***Name***

We are very sorry to hear of your sad loss. It is kind of you to think of us at this time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on ***name*** ward I would like to thank you for donations totalling ***amount*** in memory of ***name****.* This money will be placed in the charitable fund for the ***ward/ department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the ***ward/department*****.**

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

In Lieu of Flowers

Dear ***Name***

Thank you for your donation received in lieu of flowers at the funeral of ***Name***. It is so kind of you to think of us at this sad time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on ***ward/department*** I would like to thank you for donations totalling ***amount.*** This money will be placed in the charitable fund for the ***ward/ department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

Care Received

Dear ***Name***

Thank you for your donation of ***amount*** in respect of the care you received while a patient at our hospital.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the ***ward/department*** I would like to thank you for this kind gift. The money will be placed in the charitable fund for the ***ward/department*** at the ***Hospital*** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the ***ward/department***.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

APPENDIX 9

Aneurin Bevan Health Charity

Charitable Fund Procedures

Raffle Request Form

Charitable Fund No.	
Name of Requester:	
Participating Dept:	
Hospital:	

Price per Ticket:	
No of tickets required	

Tickets will be issued in booklets of 4
The maximum number of tickets issued on initial request is 200
Further tickets can be made available for the same raffle if needed.

Date of Draw:	

Please note the closing date will automatically be set to the day before the actual draw

Prize Details	
1st Prize	
2nd Prize	
3rd Prize	
4th Prize	
5th Prize	

If there are more than 5 prizes, the 5th prize will read "Runner-up prizes"

APPENDIX 10

GUIDELINES RE SPONSORSHIP

Aneurin Bevan University Health Board is grateful to individuals who wish to raise money for its hospitals and clinics through sponsorship. All monies raised in this way are placed within the charitable funds of the Aneurin Bevan University Health Board. Charitable funds are intended to provide those additional amenities that will improve the condition under which patients are cared for and treated or the conditions under which staff work.

The following guidelines are provided to help you the organiser and us to ensure that monies raised for the Health Board via sponsorship does come to us.

By giving us as much information as possible we may adapt the sponsor form to suit your needs. We need to ensure that people contributing know who is participating in the sponsorship, what type of event is being sponsored, where and when the sponsorship is taking place and most importantly what and where the money is being raised for.

1) Sponsorship Forms can be obtained from the Charitable Funds Manager.
2) If you wish to donate on-line, please visit the website www.justgiving.com and type in Aneurin Bevan and follow the instructions
3) All cheques are to be made payable to Aneurin Bevan Health Charity.
4) All forms and total sponsorship are to be returned to the Charitable Funds Manager.
5) On receiving the sponsorship, the Charitable Funds Manager will issue a receipt or certificate showing the total raised.
6) Certificates may also be obtained for presentation on the day to thank individuals for participating.
7) Arrangements can be made for formal cheque presentation to the relevant department within the Health Board.

If you have any queries or if you require further information, please contact the Charitable Funds Team: -

Charitable Funds Team
Aneurin Bevan University Health Board
P O Box 10, Pontypool NP4 0XG **Tel No: 01495 765431**
Charitable.Funds.ABB@wales.nhs.uk

Appendix 11

Charitable Funds – Investment and Reserves Policy

1. Purpose

Aneurin Bevan University Health Board, as a Corporate Trustee, needs to ensure it can demonstrate effective management of current charitable funds, whether invested or held as liquid assets to meet forecast expenditure. It also needs to ensure donations are spent on a timely basis whilst maintaining a level of reserves that will ensure the ongoing viability of the charity.

The purpose of this document is to detail the current investment and reserves policy for Aneurin Bevan Health Charity.

2. Investment Overview

The power of investment given to trustees is detailed in Section 3 of the Trustees Act 2000. This act imposes a duty on those acting as Charity trustees, when exercising their powers of investment, to consider the need for diversification, to reduce the risk of loss should an investment fail.

In addition, as Corporate Trustee, Aneurin Bevan University Health Board, in line with the ethos of promoting patient care, will attempt to ensure that all investments are ethically and environmentally sound and are not opposed to the purpose of the charity.

3. Investment Policy

The overall aim in investment of funds is to maximise total return whilst balancing risks and requirement for income. It has been agreed that:

a) The Health Board's Charitable Funds can be invested in several different forms of investments, in line with the Trustees Investment Act 1961.
b) The Charitable Fund Committee, on behalf of Aneurin Bevan University Health Board, has the delegated authority to appoint investment advisors. The investment management company will operate within the limits set down in this policy.
c) The performance of the investment management company will be reviewed annually by the trustee and will be subject to re-appointment on a 3 yearly basis with an agreement

to extend for a further 2 years. Any proposed change in provider shall be subject to a formal tender process.

d) The managed investment portfolio will be a minimum of 75% of the total funds held.
e) The working capital balance will be retained in a Government Banking Service, interest bearing, account which will be distinct from Aneurin Bevan University Health Board's 'revenue' account, to enable daily cash requirements to be met. At all times, it must be ensured that sufficient liquid resources are maintained to meet routine payment requirements.
f) Investments are to be made within the limits of the Health Board's Ethical Policy, which is to exclude those companies whose main business is related to the production or sale of tobacco or alcohol and companies with significant involvement in coal, oil and gas, armaments, gambling and pornography.
g) The Charitable Funds Committee or a nominated representative should instruct the Investment Management Company to: -
    - Provide details of all transactions undertaken on behalf of charity.
    - Hold stock and share certificates for safekeeping.
    - Provide details of dividends and interest received.
    - Provide valuations on request.
    - Attend the Charitable Funds Committee at least annually to formally present the investment performance of the period

4. Reserves Policy

The Charitable Funds Committee has considered the Charity's reserve policy, observing both Charity Commission guidance on reserves and the current level of funds held.

If reserves are too high, the charity is retaining funds without justification and this could constitute a breach of trust. If reserves are too low, the fund's ability to meet future commitments or needs may be at risk.

The Charity operates on the basis that it only spends what it has received and does not rely on future donations to meet its commitments. Therefore, the reserves should be set at a level

sufficient to cover the liabilities that face the charity, namely the cost of administering the funds and any unrealised losses.

The value of reserves held will change each year and will be maintained from several sources including those unrestricted funds that have not been committed and are freely available to spend on any of the charity's purposes and any unrealised gain.

5. Review

The Health Board's Charitable Funds Investment and Reserve policy will be reviewed annually by the Charitable Funds Committee.

Appendix 12

PURCHASES FROM CHARITABLE FUNDS

I. Purchases For Goods and Services

Purchases for goods and services, including reimbursements, should be made via the ABUHB Oracle Financial system and be supported by an official order. An order can be issued to a supplier from the procurement department on receipt of an approved requisition. When goods are received, they need to be receipted to allow invoices to be paid. The process of requisition, order, receipt and payment is shown below and included as a flow chart in appendix 12a

A. Requisition

Requisitions are raised via Oracle SSP **(**Self Service Procurement) and requisitioners must:

- Provide as many details as possible of the goods or services to be ordered and any quotations received must be attached.
- Clearly indicate "CHARITABLE FUNDS".
- Include financial code (fund number).
- Be authorised in accordance with the approval hierarchy set out in section 8 above.
- Ensure that all requisitions are submitted via the Charitable Funds Manager

Before processing the requisition, the Charitable Funds Manager will:

- Check that sufficient funds exist against the specific fund being used.
- Check the appropriateness of expenditure from Charitable Funds.
- Check eligibility for VAT exemption.
- Check authorisation as per approval hierarchy.

B. Order

Once the requisition has been approved the Procurement Department will issue an official order together with a VAT exemption certificate where necessary and the supplier will deliver goods or services in due course.

An electronic copy of the order will be available on the Oracle system.

C. Receipt of Goods/Services

When goods have been received, the account manager should immediately acknowledge delivery of goods to enable subsequent invoices to be paid. The delivery must be 'receipted' in the Receipting module of the Oracle SSP system detailing the date of receipt, number of units received etc.

D. Payment

When an invoice is issued from the supplier the Charitable Funds Section will match the invoice to the receipted Oracle order to enable payment to be processed.

E. Payment to Fund Holder

Charitable Fund Holders must obtain authorisation from a second authorised signatory when requesting reimbursement of purchases, they have made on behalf of the charitable fund.

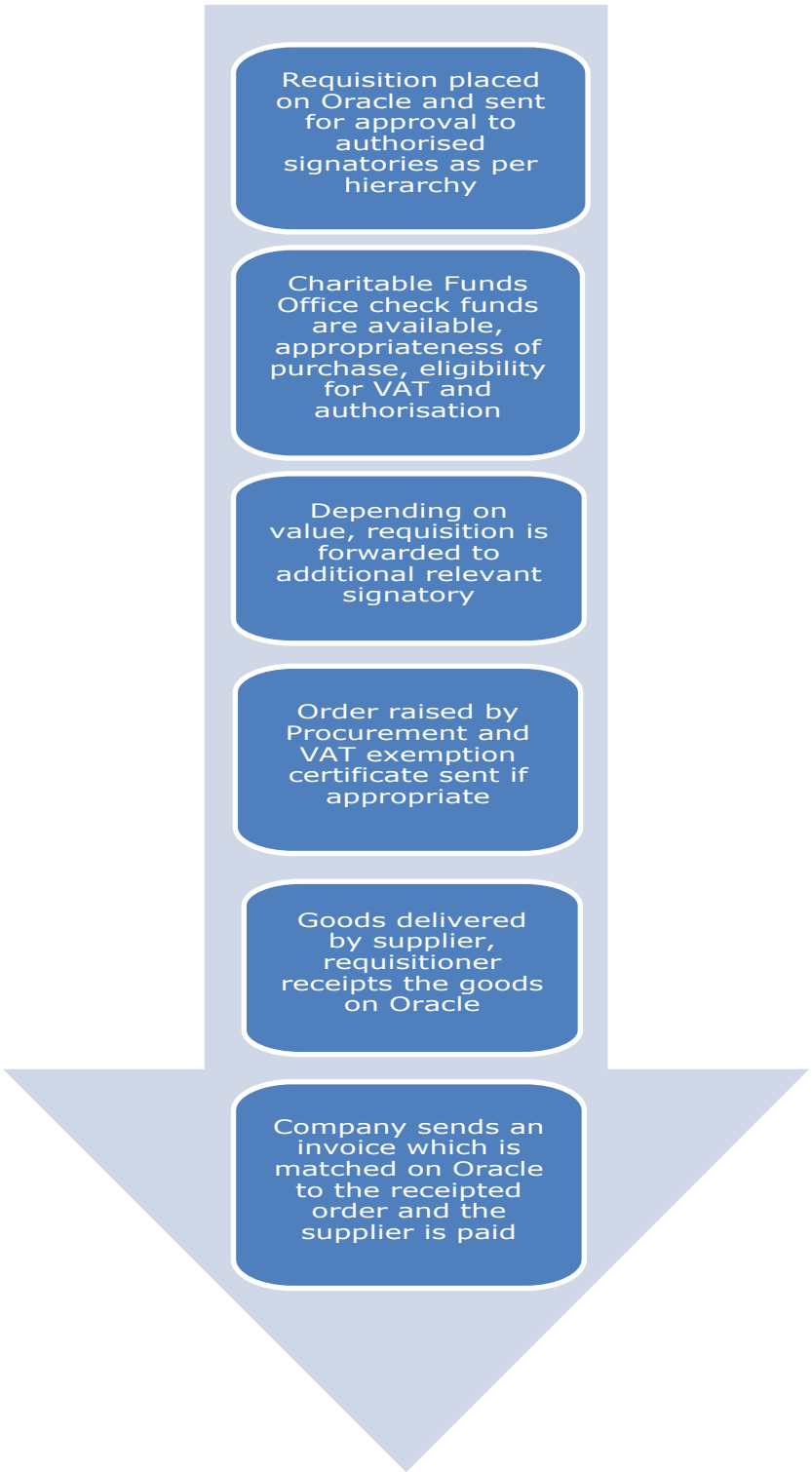
F. Requests to Pay Employees

Where an additional payment is required to be made to an individual employee for undertaking tasks relating to the objects of the charitable fund then a **Staff Payments Claim Form** must be completed. An example is shown in **Appendix 12b.**

Please note that ABUHB has a responsibility to ensure all income due to employees complies with taxation regulations and this responsibility extends to charitable funds, including staff prizes given as cash.

Appendix 12a

Charitable Funds Ordering Process



APPENDIX 12b

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
CHARITABLE FUNDS
STAFF PAYMENTS - CLAIM FORM
(For staff that are employed by Aneurin Bevan ULHB)

PAYMENTS TO STAFF THROUGH PAYROLL

To be completed by claimant

Name:

Address:

Payroll No: **Grade:**

Dates Worked	Sessions Worked	Payment Claimed

Signed: _____

Date: _____

To be completed by Authorised Signatory / Fund Holder

Payment to be made:
Fund to be charged:
Authorised by:
Date:

Please send claim to Payroll Services, Floor 4, Companies House, Cardiff or email Payroll.Services2@wales.nhs.uk

Please send a copy of this form to Charitable Funds, Finance Department, C Block, Mamhilad or email to Charitable.Funds.ABB@wales.nhs.uk

To be completed by Paymaster Services

Actioned by: _____ **Month / Week**_____

Appendix 13

Charitable Purchases – VAT Guidance
HM Customs and Excise Notice 701/6 (4.11)
Charity funded equipment for medical, veterinary etc uses

Not eligible for relief	Goods	Eligible for relief as:
X	Air Conditioners	
	Air control systems, specialist (capable of precisely controlling pressure, temperature and humi	Laboratory equipment
X	Air filters, general	
	Air filtration systems, specialist (built to meet specific circumstances)	Laboratory equipment
X	Air showers	
X	Alarms, security or smoke	
X	Alarm bracelets	
X	Alcohol spray	
	Anaesthetic apparatus	Medical equipment
	Animal cages, specialist (for example, free from chemicals and not available for consumer use)	Laboratory equipment
	Aprons, lead lined for x-ray protection	Medical equipment
X	Aprons, other	
	Artificial Limbs	Goods for use of disabled person
	Autoclaves	Sterilising equipment
X	Bactericides	
	Bandages	Medical equipment
	Barometers	Scientific equipment
	Bedding, specialist (for example, free from chemicals) for animal cages	Laboratory equipment
	Bedpans	Medical equipment
	Bedpan washers, with sterilising steam cycle	Sterilising equipment
X	Bedpan washers, other	
	Beds, highly specialised e.g. net suspension or medical water beds	Medical equipment

	Beds, hospital – with tilting action or variable height features	Goods for use of disabled person
X	Biocidal sprays	
X	Blankets	
	Bunsen burners	Laboratory equipment
	Bottle washers, animal cage specific	Laboratory equipment
	Cages, animal, specialist (for example, free from chemicals and not available for consumer use)	Laboratory equipment
X	Cameras, still	
	Cameras, video	Video equipment
X	Cameras, digital (with video capability)	
	Cameras, thermal imaging	Scientific Equipment
X	Cartridges, printer	
X	Catering equipment	
	Catheters	Medical equipment
X	CD players or recorders	
	Centrifuges	Scientific or laboratory equipment
	Clamps – medical	Medical equipment
X	Cleaning equipment	
X	Closed circuit television systems	
	Commode chairs	Goods for use of disabled person
	Computer disks and tapes	Accessory to computer equipment
	Computer keyboards	Computer equipment
	Computer mouse	Accessory to computer equipment
	Computer printers	Accessory to computer equipment
	Computer screens	Accessory to computer equipment
	Computer screen filters	Accessory to computer equipment
	Computer servers	Computer equipment

X	Computer stationery	
	Computer tablet, including iPads	Computer equipment, provided there is evidence the item is to be used mainly for medical or veterinary research, and so on.
X	Cotton wool	
X	Curtains	
X	Data	
	Deep freezers	Refrigeration equipment
	Dental chairs	Medical equipment
	Dental drills	Medical equipment
	Dental mirrors	Medical equipment
	Dental spittoons	Medical equipment
X	Disinfectants	
	Drip poles	Medical equipment
X	Drugs trolleys	
	DVD players, recorders or blank DVDs	Video equipment
	Endoscopes	Medical equipment
	Electro-cardiographs	Medical equipment
X	Ethernet	
	Eye test charts	Medical equipment
	Examination couches, adjustable	Medical equipment
	First aid kits – supplied as pre-packaged units	Medical equipment
	Forceps	Medical equipment
X	Fuel	
	Fume cupboards	Laboratory equipment
X	Gloves, nitrile	
	Gloves, surgical	Medical equipment
X	Gloves, other	
X	Gymnasium equipment	
X	Hearing aids	
	Heart pacemakers	Medical equipment or goods for use disabled person
	Hoists and patient lifting devices	Goods for use disabled person
	Howie-style lab coats (reusable)	Laboratory equipment

X	Howie-style lab coats (disposable)	
	Hypodermic needles	Medical equipment
	Ice making machines	Refrigeration equipment
	Identification bracelets for patients	Medical equipment
	iPads	Computer equipment
X	iPhones	
	Kidney bowls	Medical equipment
	Lab coats, including Howie-style reusable lab coats	Laboratory equipment
X	Laboratory animals	
	Laboratory benches	Laboratory equipment
	Laboratory glassware	Laboratory equipment
X	Lockers	
	Mattresses, specially designed for the relief/prevention of pressure sores	Medical equipment
	Medicine measures, graduated	Medical equipment
	Microscopes	Scientific or laboratory equipment
X	Mobile phones	
X	Nurse call systems	
X	Occupation therapy materials	
	Operating lights	Medical equipment
X	Overbed tables	
X	Overhead projecting units	
	Pacemakers	Medical equipment or goods for use disabled person
X	Pagers	
	Patient trolleys and stretchers	Medical equipment
	Physiotherapy equipment, specialised – other than gymnasium equipment	Medical equipment
	Pillows orthopaedic, specially designed and used for neck or spinal injuries	Medical equipment

X	Pillows, other	
	Pipettes	Laboratory Equipment
X	Power supplies, including UPS	
X	Printer cartridges	
X	Projectors (including ceiling mounted options)	
	Rack washers, animal cage specific	Medical equipment
	Radiography equipment	Medical equipment
	Renal dialysis units	Medical equipment or goods for use of disabled person
	Resuscitation equipment	Medical equipment
	Resuscitation dummies	Resuscitation training model
X	Routers	
	Scalpels	Medical equipment
X	Screens	
	Sharps bins	Medical equipment
X	Smartphones	
X	Sound systems	
	Specialist animal cages (for example, free from chemicals and not available for consumer use)	Laboratory equipment
	Specialist bedding (for example, free from chemicals) for animal cages	Laboratory equipment
	Sphygmomanometers	Medical equipment
	Splints	Medical equipment
X	Stationery	
X	Sterilising Solutions	
X	Sterilising wipes	
	Stethoscopes	Medical equipment
	Surgical gloves	Medical equipment
	Surgical gowns	Medical equipment
	Surgical masks	Medical equipment
	Suture needles	Medical equipment
	Swabs	Medical equipment
	Syringes	Medical equipment
	Tablet, computer (including iPads)	Computer equipment, provided there is evidence the item is to be used mainly for

		medical or veterinary research, and so on.
X	Tape recorders	
X	Telephones	
X	Television Sets	
	Test tubes	Laboratory equipment
	Thermal imaging cameras	Scientific equipment
	Thermometers, clinical	Medical equipment
	Thermometers, other	Scientific equipment
	Tongue depressors	Medical equipment
X	Towels	
X	Uniforms	
	USB memory sticks	Computer equipment
	Video cameras	Video equipment
	Video tapes	Video equipment
	Video players	Video equipment
	Video monitor	Video equipment
X	Wall screens or monitors	
X	Waste disposal bags, boxes, jars & snacks	
X	Waste disposal machinery	
	Weighing machines	Scientific equipment
	Wheelchairs	Goods for use of disabled person
X	WiFi systems	
X	Wipes, clean room	
X	Wipes, sterilising	
	Wound dressings	Medical equipment
	X-ray films/plates	Medical equipment
	X-ray machines-medical	Medical equipment
	X-ray machines-other	Scientific equipment
	X-ray viewers	Medical equipment

Appendix 14

Aneurin Bevan Health Charity

Certificate for purchases/imports using donated funds

Purchase/import by an eligible NHS body of medical, scientific equipment, etc

1	I	
2	of	Aneurin Bevan University Health Board PO Box 10 Pontypool NP4 0XG
3	Which is	A National Health Service Health Board
4	Declare that the above named is purchasing/importing	Relevant Goods (Medical Equipment)
5	Which I believe are	Medical Equipment, Scientific Equipment, Computer Equipment, Video Equipment, Sterilising Equipment, Laboratory Equipment, Refrigeration Equipment or parts of accessories of the equipment named above.
6	From	

and paid for this supply with funds provided entirely by charitable or voluntary contributions.

I also declare that the goods will be used in either medical research, treatment, diagnosis or training and I claim relief from value added tax under item 5, Group 15 of Schedule 8 to the Value Added Tax Act 1994.

SIGNATURE	
DATE	

Appendix 1 - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Estimated Annual Value (ex VAT)	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)

Audit, Risk & Assurance Committee

Losses and Special Payments Report

Executive Summary

- **Purpose**
  To provide the Audit, Risk & Assurance Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2021 and 28th February 2022.

- **Background and context**
  Losses and Special payments are reported in the financial position monthly and reported to the Audit, Risk & Assurance 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, Personal injury and redress claims which are currently under review. This provision is, in effect, a view into the future potential cost to the NHS in Wales of current cases.

  The report also provides details of an exgratia payment where approval to make the payment has been requested from Welsh Government due to the value. The value of the exgratia payment is £603K.

- **Key Issues**
  The losses and special payments recorded during the period 1st April 2021 to 28th February 2022 totalled £11.2m of which £9.1m is recoverable from the Welsh Risk Pool (WRP), this means the actual loss to the Health Board is £2.2m.

  In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability as advised by Welsh Health Legal Services of the maximum possible future cost for all known cases. It has decreased by £5.7m since 31st December 2021 to an overall provision of £233.0m of which it is expected that £227.3m is recoverable from WRP leaving a potential future loss to the Health Board of £5.6m.

- **Recommendation**
  The Audit, Risk & Assurance Committee is asked to note the content of this report.

The Audit, Risk & Assurance Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓

Note the Report for Information Only			
Executive Sponsor: Rob Holcombe - Interim Director of Finance, Procurement and Value Based Healthcare			
Report Author: Estelle Evans, Head of Financial Services and Accounting			
Report Received consideration and supported by:			
Executive Team	**n/a**	**Committee of the Board [Committee Name]**	**n/a**
Date of the Report: 24th March 2022			
Supplementary Papers Attached:			

Purpose of the Report

To provide the Audit, Risk & Assurance Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2021 and 28th February 2022.

The report also informs the Audit, Risk & Assurance Committee of a request submitted to Welsh Government for approval to make an ex gratia payment of £603K to Community Pharmacy Wales Contractors.

Financial Implications

1 Financial Analysis of Losses

LOSSES AND SPECIAL PAYMENTS 01.04.21-28.02.22

	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 Committee	
SPECIAL PAYMENTS:							
Loss of personal effects	48	31	0	31	Minor Losses	Losses form completed - Authorised by Division and Putting Things Right team	Lost dentures, glasses etc.
Clinical negligence with advice	222	1,484	8,343	9,827	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)	99	582	363	945	Personal Injury	As above	Completed cases
Other clinical negligence and personal injury	45	43	349	392	Clinical Negligence and Personal Injury - claims under £25K	Redress committee for payments under £25K. Lessons learnt fed back to division	Completed cases
Other	20	25	0	25	Various	Ombudsman cases - confirmed by putting things right team, other losses reports completed as appropriate	
TOTAL LOSSES AND SPECIAL PAYMENTS	**434**	**2,166**	**9,055**	**11,220**			
Of which, cases of £250,000 or more: Clinical negligence with advice	6	0	5,630	5,630			

2 Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 28th February 2022 compared to the position reported at 31st December 2021. It reflects the estimated liability in relation to cases advised by Welsh Health Legal Services for both clinical negligence, personal injury and redress with the provision updated to reflect new or changed cases.

After the expected recoveries from the Welsh Risk Pool are taken in to account the estimated liability to the Health Board at the end of February 2022 is £5.6m.

Losses & Special Payments Provisions	31-Dec-21		28-Feb-22	
	No. of Cases	£000	No. of Cases	£000
Clinical Negligence	259	234,296	250	228,697
Personal Injury	72	941	78	970
Permanent Injury Benefit	21	3,161	21	3,097
Redress	29	262	25	218
Sub Total	**381**	**238,660**	**374**	**232,981**
Less WRP Recoverable: Clinical Negligence	(129)	(231,987)	(129)	(226,464)
Less WRP Recoverable: Personal Injury	(7)	(627)	(7)	(665)
Less WRP Recoverable: Redress	(29)	(247)	(25)	(208)
Net Liability	**216**	**5,799**	**213**	**5,645**

3 Ex Gratia Payment

WP10(HP) prescriptions are issued in Secondary Care and dispensed by Community Pharmacy's. There are a number of high costs drugs whereby the amount that is reimbursed to the contractors falls below the amount that they pay the manufacturer/wholesaler for them. This is due to the drugs not being included correctly within the Drug Tariff, i.e. they are not included on the Discount not Deducted (DND) list. Reimbursement of the drug cost is made to the contractor with a discount is applied, resulting in those contractors providing these items incurring a significant loss, with some claiming to have incurred losses amounting to several thousands of pounds in the 2020/21 financial year. This is a systemic problem across Wales, but ABUHB disproportionately uses this mechanism for handling these prescriptions, when compared to other Health Boards in Wales.

Community Pharmacy Wales (CPW) have written to Aneurin Bevan University Health Board (ABUHB) concerning complaints from community pharmacy contractors regarding the on-going prescribing of high-cost medications on WP10(HP).

The initial offer to CPW was to offer a reimbursement to contractors backdated to April 2020 (estimated as £172k), however, the expectation from the CPWs is that a "full and fair resolution is reached". The total loss to contractors for baricitinib (an oral agent used to treat Rheumatoid Arthritis and Atopic Eczema) from 2017/18 to 2021/22 has been calculated as £568k. A further £35k of losses has also been attributed to the dispensing of obeticholic acid (prescribed for primary biliary cholangitis), upadacitinib and filgotinib (prescribed by rheumatology / dermatology) (all three of these have now been included in the DND list and are therefore not an issue going forward).

There is a reputational risk to ABUHB for not supporting this request from CPW, recognising that contractors should not be in a position of losing income through the WP10HP route of supply. Also, there is a risk that pharmacy contractors may not be willing to dispense 'high-cost medicines' at a loss leading to inconvenience for patients searching for a pharmacy and potentially missed doses.

A request has been submitted to Welsh Government to request approval to make an exgratia payment of £603K to Community Pharmacy Wales contractors.

Internal audit has confirmed that the proposal is a very reasonable approach and pragmatic given the circumstances.

Discussion has taken place to review our processes for the implementation of any new NICE /AWMSG approved medicine. This will ensure that WP10HPs are not automatically utilised unless the medicine is already included on the DND list, or the division confirm they will reimburse contractors via the WP10HP route if they do not wish to utilise a homecare provider for dispensing. In addition to this, the National Procurement Lead Pharmacist for Wales is undertaking enquiries with the NHS Business Services Authority in England to determine whether there is a way of influencing the addition of medicines to the DND list following the approval of any Welsh Patient Access Schemes which allow dispensing in primary care.

Recommendation

The Audit, Risk & Assurance Committee is asked to note the contents of the report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*The monitoring and reporting of losses and special payments is part of the Health Board's governance framework.*
Financial Assessment	*The financial impact of losses and special payments detailed in this paper are included in the reported financial position of the Health Board.*
Quality, Safety and Patient Experience Assessment	*This report has no direct impact on Quality, Safety and Patient Experience Assessment.*
Equality and Diversity Impact Assessment (including child impact assessment)	*Not relevant to this summary paper.*
Health and Care Standards	*This paper provides governance and assurance to the committee.*

Link to Integrated Medium Term Plan/Corporate Objectives	*The financial impact of losses and special payments are included in the Health Board's reported financial position. This links into the underlying financial position that supports the Health Board's 3-year plan.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant to this summary paper.*
Glossary of New Terms	*WRP – Welsh Risk Pool*
Public Interest	*Report to be published in the public domain.*

Aneurin Bevan University Health Board

Audit, Risk & Assurance Committee
Finance Report – February (Month 11) 2021/22

Executive Summary

This report sets out the financial performance of Aneurin Bevan University Health Board, for February 2022.

The 2021/22 financial performance is measured by comparing the expenditure with the budgets as delegated in the Budget Delegation papers agreed at the March, July, September 2021 and January 2022 Board meetings. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

Feb-22
Performance against key financial targets 2021/22
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	145	0	⇔	**0**
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £51,826	7,401 14.4%	38,844 75.7%	⇔	**0**
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	95.0%	95.0%	⇑	**>95%**

Performance against requirements 20/21		**18/19**	**19/20**	**20/21**	**3 Year Aggregate**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	✓	**(235)**	**(32)**	**(245)**	**(512)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	**(41)**	**(28)**	**(13)**	**(82)**
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓				

Underlying Financial Position (Brought Forward ULP)	**18/19**	**19/20**	**20/21**	**21/22**
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	**£19.763m Deficit**	**£11.405m Deficit**	**£16.261m Deficit**	**£20.914m Deficit**

Note: The Health Board is in it's 3rd year of the approved IMTP, the HB has submitted a refreshed Annual Plan for 21/22 in place of a revised 3 year IMTP, as directed by WG.

Key points to note for month 11 and year to date position include:

- A year to date break-even position (in-month movement of £0.14m overspend),
- Income - includes anticipated and confirmed Covid-19 funding,
- Pay Spend – has increased by c.£0.1m, primarily due to increased enhancement costs and an increase in medical and nursing variable pay costs for elective activity and covering operational pressures such as enhanced care.
- Non–Pay Spend (excluding capital adjustments) - has decreased by £3m, this in comparison to high levels of spend in January for one off, funded expenditure.
- Savings – expected achievement remains on plan & at the same levels as previously reported for both the in year and recurrent position.

Significant issues for the Health Board's forecast financial plan include;

- Improving and achieving the level of savings and efficiency programmes on a recurrent basis to support long term financial sustainability, and
- Ensuring that service and workforce solutions, in response to the challenging demands being faced, are achieved in the most cost-effective way.

At Month 11, the forecast revenue and capital positions are break-even for the 2021/22 financial year.

The latest financial assessment of income levels, service and workforce costed plans is that the Health Board should be able to deliver these plans within anticipated available funding.

The underlying financial deficit (£20.9m) will need to be addressed to support financial sustainability and recurrent balance in future years.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	

Executive Sponsor: Rob Holcombe – Interim Director of Finance, Procurement & VBHC

Report Author: Suzanne Jones – Interim Assistant Director of Finance

Report Received consideration and supported by:

Executive Team	**X**	**Committee of the Board [Public Partnerships & Wellbeing Committee]**	

Date of the Report: 21st March 2022

Supplementary Papers Attached:

1. Glossary

Purpose of the Report

This report sets out the following:

- The financial performance at the end of February 2022 and forecast for 2021/22 – against the statutory revenue and capital resource limits,
- The revenue reserve position on the 28th of February 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy, and
- A financial assessment of the risks and opportunities which may impact on delivering the financial forecast for 2021/22.

Assessment & Conclusion

- **Revenue Performance**

  The month 11 position is reported as break-even year to date (in-month movement of £0.145m overspend) with a forecast year-end out-turn break-even position. A summary of the financial performance is provided in the following table.

Summary Reported position - February 2022 (M11)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	277,284	(1,578)	(1,324)	(254)
Prescribing	106,494	433	811	(378)
Community CHC & FNC	67,888	(398)	(282)	(116)
Mental Health	112,925	605	81	524
Director of Primary Community and Mental Health	565	(97)	(70)	(27)
Total Primary Care, Community and Mental Health	**565,156**	**(1,035)**	**(784)**	**(251)**
Scheduled Care	238,051	1,741	584	1,157
Medicine	120,845	2,703	1,842	862
Urgent Care	40,715	2,996	2,395	601
Family & Therapies	119,555	(1,144)	(692)	(453)
Estates and Facilities	83,905	822	630	192
Director of Operations	5,689	1,359	1,175	184
Total Director of Operations	**608,760**	**8,477**	**5,934**	**2,543**
Total Operational Divisions	**1,173,916**	**7,441**	**5,150**	**2,291**
Corporate Divisions	128,553	(4,197)	(3,930)	(268)
Specialist Services	174,530	(3,144)	(3,049)	(96)
External Contracts	77,033	3,071	2,543	528
Capital Charges	30,931	(233)	(210)	(23)
Total Delegated Position	**1,584,962**	**2,937**	**504**	**2,433**
Total Reserves	6,319	(2,937)	(649)	(2,288)
Total Income	(1,591,281)	(0)	0	(0)
Total Reported Position	**0**	**0**	**(145)**	**145**

Financial impact of service and workforce pressures

- During February 2022, pay expenditure increased due to enhancements payments for bank holidays and holiday pay on WTD enhancements. Variable pay costs were incurred on reinstated recovery plans for elective activity as well as significantly increased enhanced care. Non-pay expenditure decreased due to funded WHSSC costs linked to Cystic Fibrosis drugs in January however these were off-set by increased costs resulting from the stock-takes undertaken in February mainly within the theatres directorate.
- The number of Covid-19 positive patients in hospital has decreased throughout February. The temporary staffing costs to operate in areas such as ICU remain significant. All services still need to operate in a Covid-19 safe environment leading to a workforce and financial pressure.

- Demand for emergency and urgent care across all services – including primary care, mental health and acute/community hospitals – has increased significantly and in many cases is above the levels seen pre-pandemic. Winter plans have been approved and implemented which are designed to mitigate further operational pressures across all areas of the UHB.
- Delays in patient discharges are adding to the flow challenges being experienced resulting in greater bed demand and workforce and financial pressures.
- The operational factors above coupled with enhanced care predominantly within GUH as well as increasing elective activity result in significant financial pressures.

Additional costs are being incurred due to the following:

- Additional workforce capacity to support the significant pressure on the Emergency Department and other urgent care services,
- Workforce costs for covering increased sickness absence and self-isolation periods,
- Maintaining 'green' patient pathways to minimise infection,
- Additional hospital bed capacity to ensure the safe and timely flow of patients,
- Increased acuity of patients presenting and demand for enhanced care, and
- Commissioning step-down capacity to support patients in their discharge back home or to a longer-term care home placement.

To mitigate, key areas of focus for the Health Board are:
- System level working to expedite patients to the most appropriate care setting,
- Urgent & emergency care programme actions,
- Enhancing same day emergency care and flow,
- Securing additional capacity,
- Increasing Nurse staffing levels,
- Other actions to underpin the operational management and leadership to support clinical teams, and
- Prioritising utilisation of workforce.

Workforce

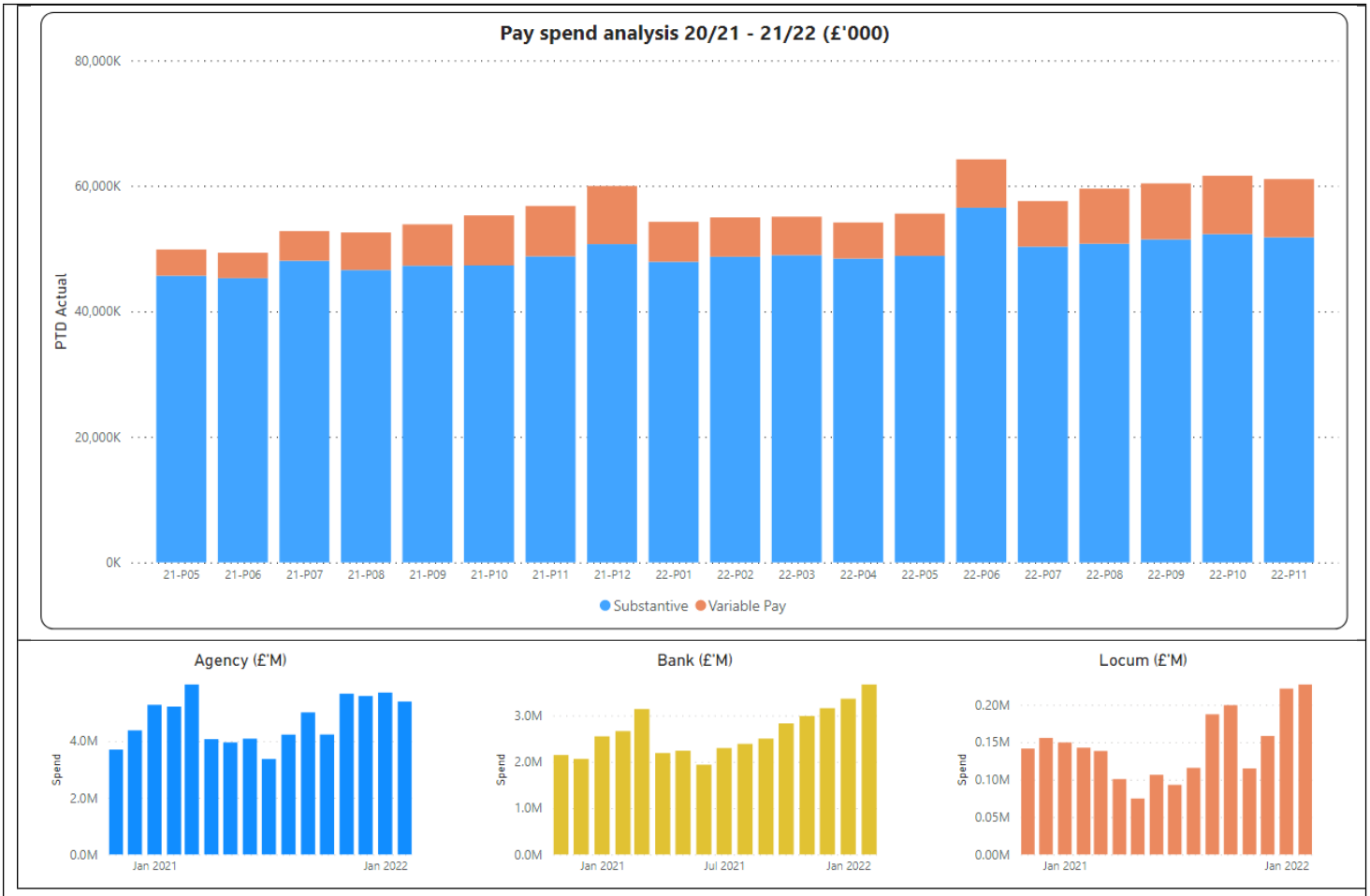
Workforce costs (allowing for the wage award) have maintained a consistent average level of monthly spend of c.£58m for months 1-11 of 2021/22.

Substantive staffing costs have decreased by £0.5m (1.0%), including the 1% non-consolidated payment for Bands 1-5 made in Month 10 (£2.3m) offset by other costs for several specific funded schemes such as DOLS in Mental Health. There was a reduction in overtime compared to month 10 for mass vaccination. Bank costs have increased by £0.3m (9.2%). Agency costs have decreased by £0.36m (6.3%) compared to month 10. This is linked to increased enhanced care across the UHB.

It is expected that the expenditure run-rates for agency staffing will remain and possibly increase for the remainder of the financial year given the requirement to deliver agreed recovery and winter plans. There is still a continued and significant reliance on the use of agency and bank staff.

Workforce expenditure is shown below differentiating between substantive and variable pay[1]:

[1] *To enable useful comparisons and trends all references to 20/21 pay expenditure exclude the month 12 expenditure for: Covid-19 annual leave provision (£17m), Covid-19 bonus payments (£14.7m), and Additional employer pension contributions (6.3%/£25m).*



Substantive staff
Substantive pay was £51.8m in February – a decrease of £0.5m compared to January. Substantive pay has decreased by £0.2m for A&C, £0.33m for HCSW, £0.2m estates and ancillary. These decreases were spread across most areas of the UHB and are linked to 1% non-consolidated pay award.

Variable pay
Variable pay (agency, bank and locum) was £9.3 in February – comparable to January.

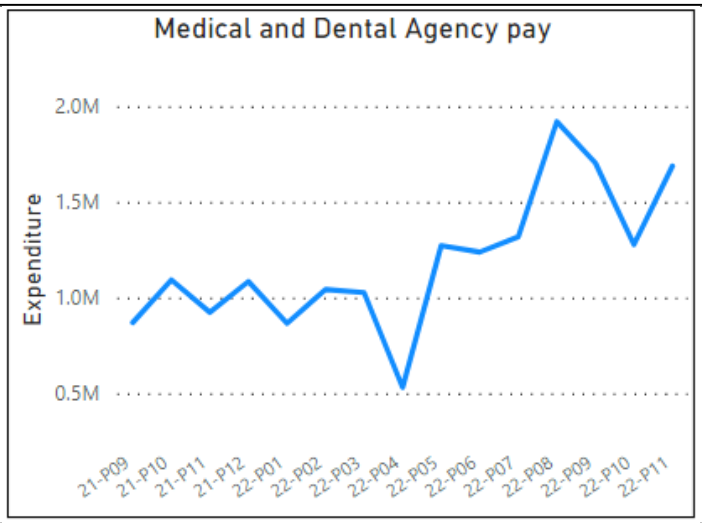
The Executive Team previously agreed the block booking of registered nurse (RN) agency and over recruitment of health care support workers (HCSW) to ensure safety of service provision.

It should be noted that the number of unfilled registered nursing shifts remains at a high level throughout the UHB. If all these shifts were filled through variable pay the cost impact would be significant.

Bank staff
Total bank spend in February was £3.7m - an increase of £0.3m compared with January, this is mainly due to increased activity as part of recovery plans coupled with a continued increase in enhanced care shifts. Areas where bank usage continues to be significant are ICU and GUH ED / Acute Medicine due to on-going Covid-19 additional support requirements.

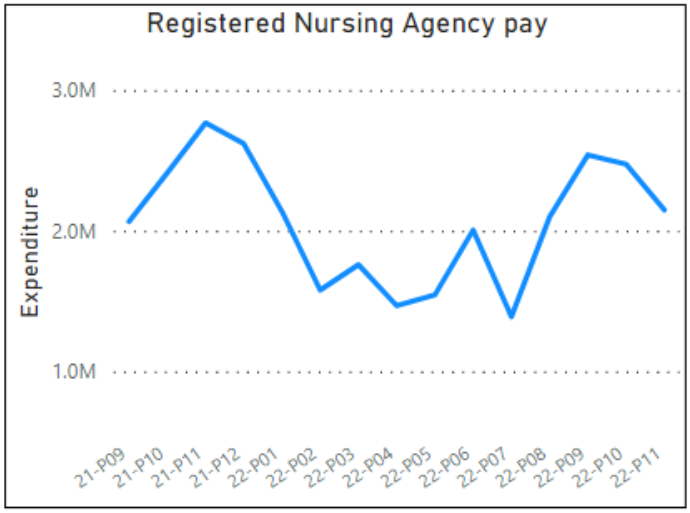
Agency
Total agency spend in February was £6.1m – a decrease of £0.4m compared to January. Medical agency costs have increased partly linked to a review of previous shifts coupled with elective activity resuming in February.

	• Increase in month £0.4m due to

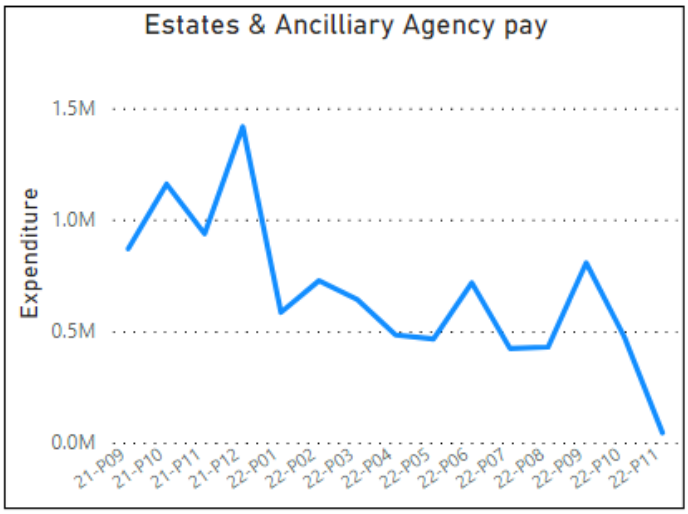


- Continued pressures in COTE and YYF medical staffing backfilling a number of staff who are non-patient facing and numerous vacancies.
- Ophthalmology and radiology costs linked to cover of vacancies.
- Costs to provide additional elective activity.
- Increased costs in Urgent Care and Mental Health.

- Medical agency spend is averaging c.£1.3m per month in 2021/22.



- In-month spend of £2.2m, at a slightly lower level to January.
- Reasons for use of registered nurse agency include:
  - Enhanced Care on Medicine wards in NHH and YYF.
  - Additional service demand including opening additional hospital beds,
  - Enhanced care and increased acuity of patients across all sites,
  - On-going sickness,
  - vacancies, and
  - enhanced pay rates.
- Registered Nursing agency spend is averaging c.£1.9m per month in 2021/22.



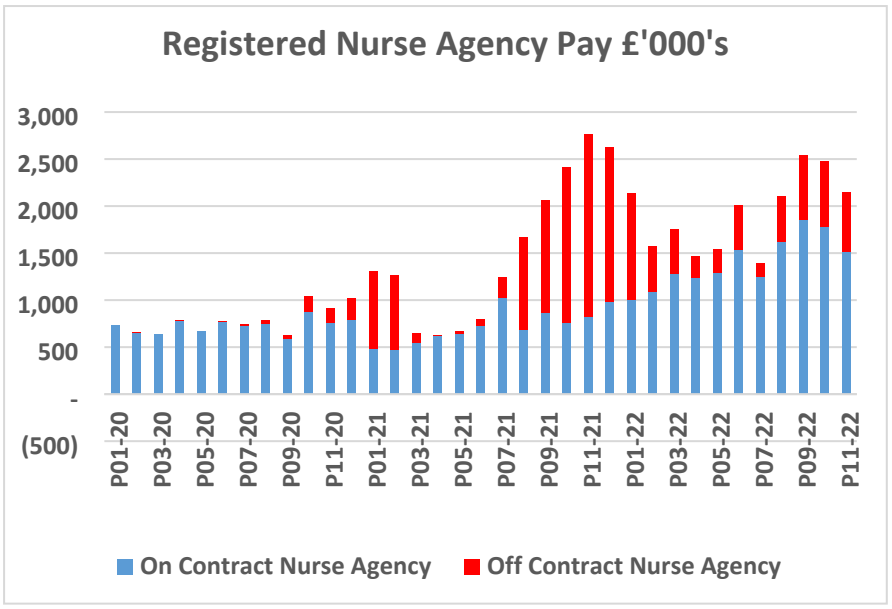
- In month spend of £0.1m on Estates & Ancillary, which is primarily within GUH and related to Covid. This includes a retrospective adjustment linked to previous months.
- Reasons for use of agency include:
  - Meeting enhanced cleaning standards,
  - Enhanced care and increased acuity of patients,
  - Sickness,
  - Vacancies,
  - Recruitment difficulties, and
  - Supporting the Mass Vaccination Programme.
- Estates and Ancillary agency spend is averaging c.£0.5m per month 2021/22.

Registered Nurse Agency

Registered nurse agency spend totalled £18.1m in 2020/21 and £10.2m in 2019/20.

If spend continues at the current rate, the Health Board will spend £23.1m on nurse agency in 2021/22, a 21% increase from 2020/21.

The use of "off-contract" agency – not via a supplier on an approved procurement framework – usually incurs higher rates of pay.



The Health Board spent £0.63m on 'off' contract RN agency in February which is slightly lower than January and reflects the reduction in Covid-19 response. The main reasons for its usage are:

- Enhanced care,
- Additional capacity,
- Nursing vacancies,
- Patient safety,
- Covid-19 responses, and
- Increased sickness and cover for staff in isolation.

A Registered Nurse Agency Reduction Plan was approved by the Executive Team in May 2021, there is considerable pressure on this plan because of the on-going service and workforce pressures but needs to be implemented in full for 2022/23.

Medical locum staff

Total locum spend in February was £0.23m a small increase compared with January 2022 of £6k. Pathology and Anaesthetics remain areas of high expenditure relating to on-going operational pressures and substantive vacancies.

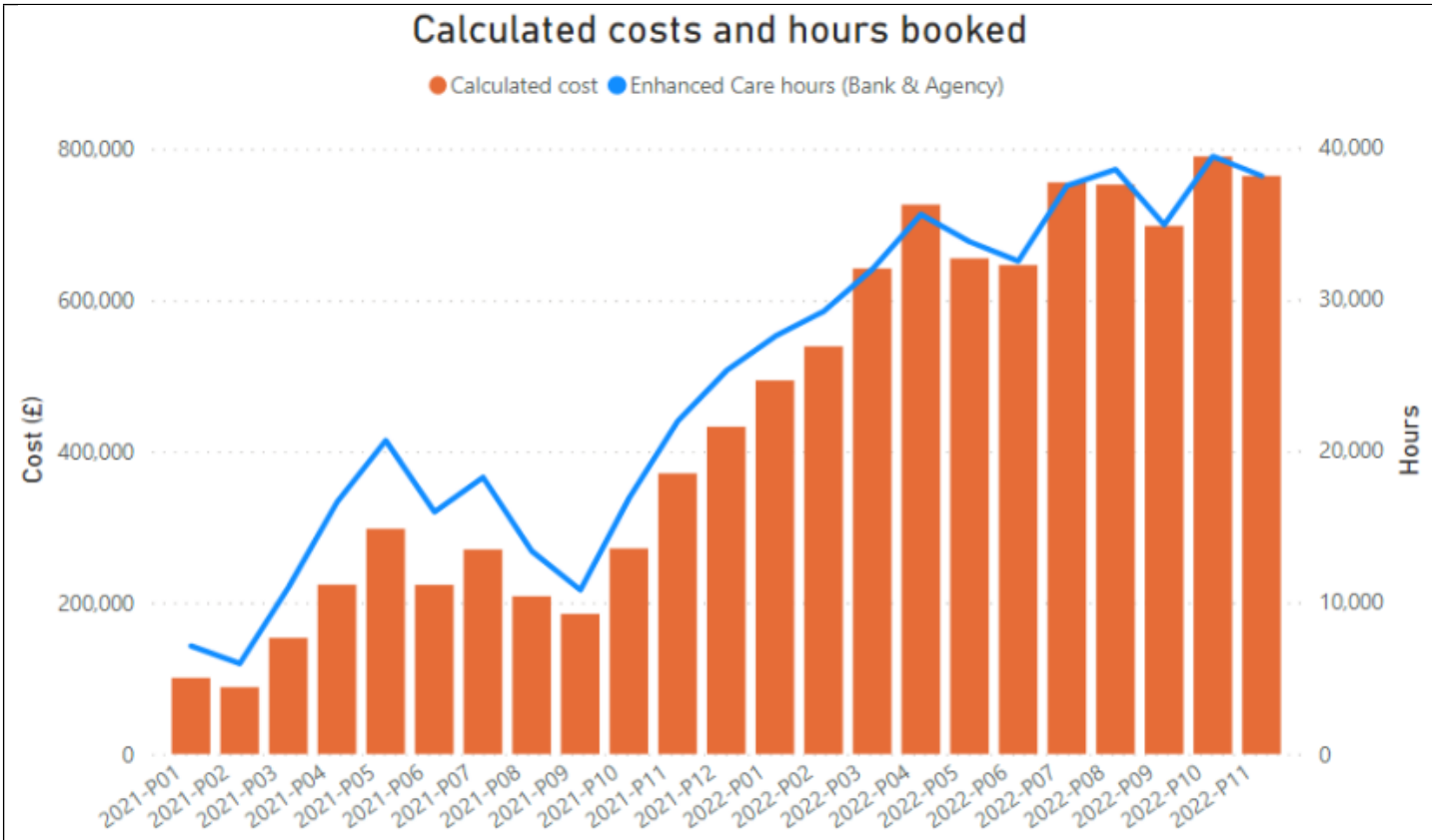
Enhanced Care

Enhanced Care, also known as 'specialling', can include a spectrum of interventions ranging from the provision of assistance to help a patient mobilise, through to one-to-one patient monitoring. Enhanced care is designed to ensure a patient centred safe approach for patients with additional care needs whilst also managing any associated impact on established staffing levels.

A review of the financial impact of 'enhanced care' – including the use of bank and agency staff – has identified the following use of nursing staff:

	2020/21	**2021/22**	**Increase**
Average number of hours used per month	15,305	34,458	125%
Increase in average cost per month compared to prior year			**£0.4m**
Estimated increase in the calculated annual cost based on current trend			**£5.3m**

The following graph highlights the increase in hours attributed to enhanced care for the period April 2020 (P01-2021) to February 2022 (P11-2022) using bank and agency registered nurse and health care support workers. In February (P11-2022), enhanced care hours and associated costs increased mainly within the Medicine and Mental Health Divisions.



Non-Pay

Non-Pay spend (excluding capital) decreased by £3m in February compared to January due to increased costs due to the annual stock adjustment reported in February offset by one off funded costs in January.

Other areas of increase to note are:

- CHC Mental Health – there has been a net increase of 4 MH patients in month with high cost packages. The newer packages increase the overall average cost per package compared to the previous financial year. The overall total patient numbers have increased by 23 since April 2021 (LD increase by 9, Mental Health increase by 14).
- CHC Adult / Complex Care - 655 active CHC and D2A placements (increase of 3 from January). There was an increase of 1 D2A patient with a decrease of 4 placements on the 'Step Closer to Home' pathway (32 total) in February. A cost of £0.7m is included in the forecast spend.

- CHC Adult / Complex Care –

Activity	January 2022	February 2022	Movement
D2A	72	73	+1
Step Closer to Home (A cost of £0.7m is included in the forecast spend.)	36	32	-4
All Other CHC	544	550	+6
Total	652	655	+3

- For FNC - currently 843 active placements, which is an increase of 3 from January.
- Primary Care medicines - the full year forecast is an over-spend of £0.7m. The year to date growth on items is 1.88% and the forecast is based on continued growth of 1.88%. In addition, there has been a decrease in the average cost per item (currently £6.82) and Category M drugs prices resulting in an overall forecast decrease of c.£0.5m.

Service Pressures & Activity Performance

Bed Capacity

Additional medical beds have been opened as part of responding to the system pressures described previously. Additional capacity beds in Medicine were 155 in February as described in the table below:

No. of Additional Beds							
Site	**Ward**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Description**
RGH	B3 Winter Ward	28	28	28	26	27	28 Additional Capacity
	C5E	0	0	0	0	0	28 (flexed up from 24)
NHH	3rd Floor	10	10	11	11	11	32 (flexed up from 28)
	4th Floor	11	7	5	4	3	28 (flexed up from 32)
	4/1 winter			32	32	27	Winter ward from 27th Dec (flexed up from 28)
GUH	C4	16	16	8	8	2	2 Covid beds in february
	A4	2	2	2	2	2	Using Ringfenced beds
YYF	Risca	30	30	30	30	0	30 Covid Ward (funded ward)
	Bargoed	30	15	0	0	0	30 Covid Ward (funded ward)
	Oakdale	15	0	0	30	15	50%->100% Covid Ward (funded ward). Return to Amber wef 14/2/22.
	Rhymney		14	14	28	28	Supporting 50% of SC ward for Winter capacity. Wef 7/1 100% Medicine additional capacity for Winter
	Penallta				28	28	100% of Ward (Red capacity under Dr Davies, Cons)
RGH AMU	D1W	15	17	23	21	12	15 Beds 2 additional RN 24/7
Total		**157**	**139**	**153**	**220**	**155**	

It should be noted that ward D1W is now assumed to be open for the remainder of the 2021/22 financial year. Risca ward in YYF has now closed as a surge capacity ward.

There was also a continued use of surge beds throughout the Community hospitals. These are described as follows:-

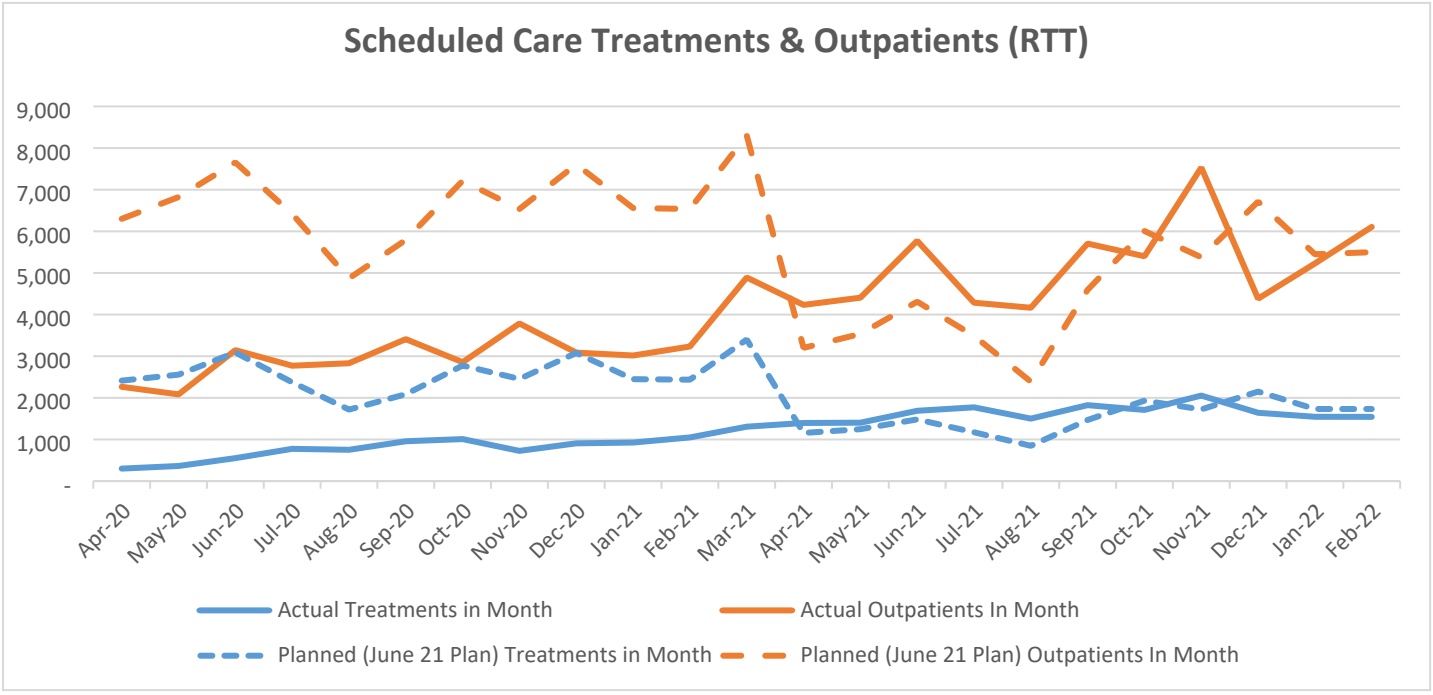
No. of Additional Beds							
Site	**Ward**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**
STW	Ruperra	12	20	20	24	24	24
	Holly					10	10
YAB	Tyleri	10	15	15	15	15	15
Total		**22**	**35**	**35**	**39**	**49**	**49**

Scheduled Care treatments and outpatients

Elective activity has increased in February due to increased available capacity following the reducing impact of the Omicron variant of Covid-19. Activity is at similar levels to plan but is variable across specialities. Whilst most routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

Scheduled Care elective activity for new outpatients has significantly increased in comparison to January where activity was reduced due to the Omicron variant and holiday period. Increases in almost all specialities including T&O (+163), General Surgery (+209), Dermatology (+104) and Max Fax (+111). New outpatients were overall above plan by 607 appointments in month.

Treatments are marginally lower compared to last month. Key movements include Ophthalmology (+22), Dermatology (+12), General Surgery (-14) and Max Fax (-24). The decrease in treatments is due to a decrease in WLI Sessions being offset by Core Time and Backfill increasing.



- Elective Treatments for February '22 were 1,543 with year-to-date treatments of 18,078.
- Outpatient appointments for February '22 were 6,106 with year-to-date activity of 57,215.

Medicine Outpatient Activity

Medicine Outpatient activity for February '22 were 1,134 attendances with year-to-date activity of 14,171 this is presented by specialty below:

YTD February 22	Assumed monthly activity	Actual activity	Variance	Variance
Gastroenterology	5,610	2,551	- 3,059	55%
Cardiology	6,083	2,640	- 3,443	57%
Respiratory (inc Sleep)	6,666	2,835	- 3,831	57%
Neurology	2,849	2,422	- 427	15%
Endocrinology	2,662	1,633	- 1,029	39%
Geriatric Medicine	2,541	2,090	- 451	18%
Total	**26,411**	**14,171**	**- 12,240**	**46%**

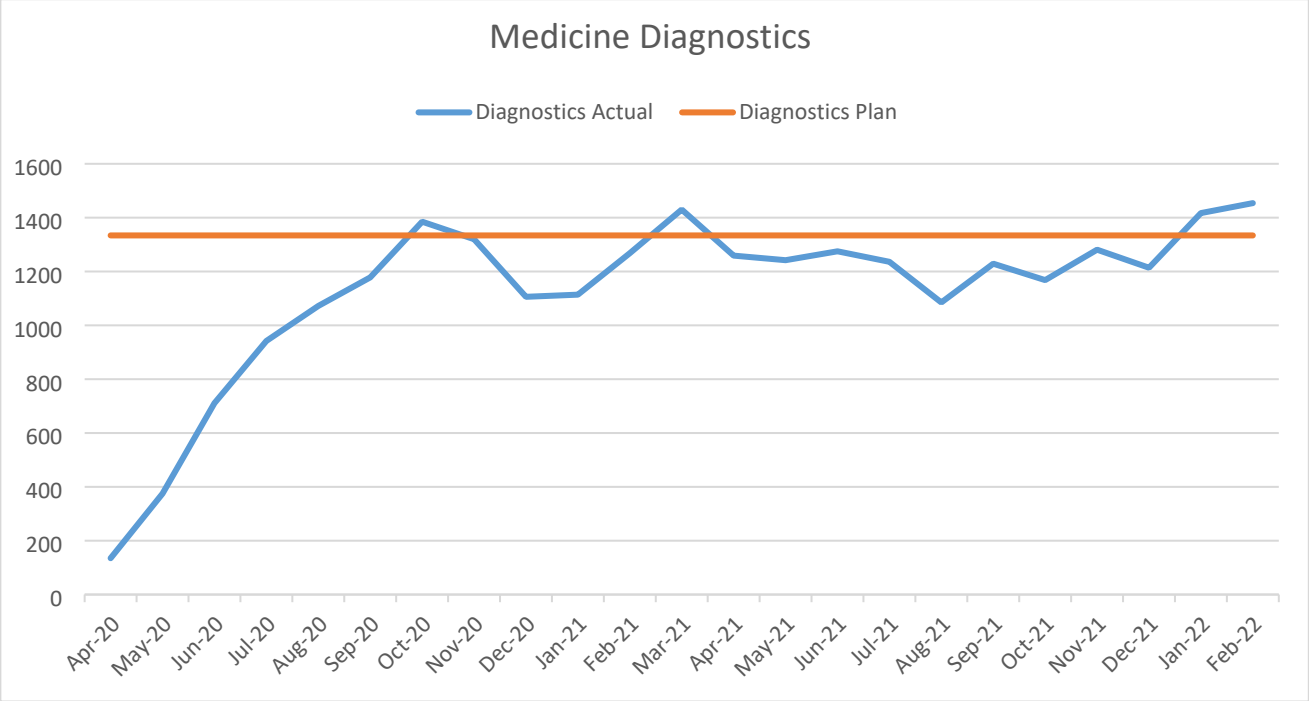
A year to date underperformance of 46% is presented.

Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for February '22 was 1,454 procedures with year-to-date activity of 13,860 which is 814 cases less than planned for the year to date. Endoscopy insourcing plans started on 25th October and a step-up in activity has been achieved despite the reduction in January. The expectation remains activity will continue at an increased rate for the remaining months of the financial year.

The Health Board has commissioned St Joseph's Hospital to support further endoscopy delivery and committed £1.3m for an additional 14 sessions per week, via an insourcing provider, to reduce waiting times.

The activity undertaken since April '20 is shown below;



Service Recovery Plans 2021/22

The Health Board received recovery funding allocations as part of recovering the backlogs in routine elective services because of the Covid-19 pandemic. The Health Board has assessed the forecast spend associated with recovery bids as £24m. Performance is closely monitored given the level of slippage identified.

Slippage was identified by Divisions for schemes not performing to plans and has been taken back into reserves so further recovery plan options can be developed. The revised reserves position is £2.799m for any further schemes. The Divisional summary of these delegations are shown below:-

	£'000		
Recovery funding delegated - Division	**Bids approved**	**Clawback (to M11)**	**Funding delegated**
Scheduled Care	11,258	(2,113)	9,145
Family & Therapies	2,035	(291)	1,744
Mental Health	1,840	(284)	1,556
Primary Care & Community	3,185	(738)	2,447
Medicine	2,154	(195)	1,959
Estates & Facilities	131	0	131
CHC	502	992	1,494
Corporate	151	(69)	82
Commissioning	2,200	0	2,200
Reserves	101	(101)	0
Sub-total	**23,557**	**(2,799)**	**20,758**
	Balance of funding in Reserves		2,799
Total			**23,557**

Any recurrent proposals will be considered alongside other IMTP priorities.

Covid-19 – Revenue Financial Assessment

Covid-19 reporting can be broken down into the following categories.

- Covid-19 costs: £168.84m
- WG Funding: £177.41m (as at Month 11)

The Health Board is assuming funding of £177.4m for Covid-19 service responses and Covid-19 recovery for the 2021/22 financial year.

Confirmed and received funding has been a mixture of reimbursement for actual costs and forecast costs and formula shares.

The table below summarises the funding assumed, delegated, and held in reserve relating to Covid-19.

Type	Covid-19 Specific Allocations - As at February 2022	£m
HCHS	Initial Recovery Plan Covid19	16.27
HCHS	Covid19 response April-September 2021	32.02
HCHS	Testing (inc Community Testing) Qtr 1	1.63
HCHS	Tracing Qtr 1	3.47
HCHS	PPE Qtr 1	1.04
HCHS	Mass COVID-19 Vaccination QTR 1	1.98
GMS	Mass COVID-19 Vaccination QTR 1	1.58
HCHS	Tracing - Q2 (M1-6 less June funding)	3.00
HCHS	Covid 19 Mass Vaccination costs Q2	2.20
GMS	Covid 19 Mass Vaccination costs Q2	0.09
HCHS	Covid 19 Impact on b/f underlying position	8.57
HCHS	Covid 19 Cleaning standards Q1 + Q2	0.95
HCHS	Covid 19 Testing Q2	2.03
HCHS	Covid 19 Adferiad Programme	0.94
HCHS	Covid 19 response funding Oct 21 to Mar 22	56.58
HCHS	Covid 19 support - Tranche 2 Revenue Recovery	7.14
HCHS	Covid 19 - PPE Q2	1.50
HCHS	Covid 19 - Additional Flu programme yrs 7-11	0.78
HCHS	Community Infrastructure Programme (UEC-C19)	0.18
HCHS	Additional Covid Response funding	7.38
HCHS	C19-Adult Social Care Package	2.01
HCHS	C19 Support for Comm Health Checks	0.19
HCHS	C19 Recovery funding - Planned Care Recovery Fund	0.14
HCHS	C19 Cluster funding	0.38
HCHS	C19 Recovery - Healthchecks Learning Disability	0.11
HCHS	MCA Funding-Gwent Consortium-C19 recovery-DoLS	0.17
HCHS	Recovery of balance of NHS Bonus accrual	(1.44)
HCHS	C19 - Tracing Funding balance	7.07
HCHS	C19 - Winter Pressures - ICF (RPBs)	1.85
HCHS	C19 - Testing Qtr 3 and 4	5.37
HCHS	C19 - PPE Q3 and Q4	2.98
HCHS	C19 - Cleaning Standards Q3 and Q4	1.16
HCHS	C19 - Mass Vaccinations Q3 and Q4	4.25
HCHS	C19-Adult Social Care Package Qtr 3&4	1.12
HCHS	Community Pharmacy Winter Pressures Enhanced Services	0.46
	Total Confirmed Covid-19 Allocations	**175.16**
HCHS	Urgent & Emergency Care	1.51
HCHS	Extended Flu	0.35
HCHS	Covid Mass Vaccinations - final allocation adj.	0.39
	Total Anticipated Covid-19 Allocations	**2.25**
	Total Covid-19 Allocations	**177.41**

Covid Funding Delegated v Held in Reserves @ Month 11	Period covered	Delegated as at Month 11
Covid Funding Delegated		
Testing	M1-12	9.04
Tracing	M1-12	13.55
Mass Vaccs	M1-12	10.10
Cleaning Standards	M1-12	2.11
PPE	M1-12	5.52
CHC Provider payments	M1-12	3.13
Recovery funding (tranche 1 & 2)	M1-12	20.85
Recovery funding - Planned Care Recovery Fund	M9-12	0.13
Urgent Primary Care Centre Pathfinder	M1-12	1.51
Adferiad Programme	M1-12	0.94
Covid response funding	M1-12	103.27
Additional Flu Programme	M7-12	0.78
Recovery of balance of NHS Bonus accrual	M7-12	(1.44)
Winter Pressures (ICF)	M9-12	1.85
LD and Community health checks	M9-12	0.30
MCA Funding-Gwent Consortium-C19 recovery-DoLS	M9-12	0.17
Community Infrastructure Prog (UEC-C19)	M9-12	0.18
Cluster funding	M1-12	0.38
Extended Flu	M1-12	0.35
Covid element of 21-22 Pay award	M1-12	0.88
Community Pharmacy Winter Pressures	M1-12	0.46
Mass Vaccination - final allocation adju.	M1-12	0.39
Total Covid funding delegated		**174.44**
Retained in reserves		
Recovery funding (tranche 1 & 2)		2.57
Covid response funding		0.39
Total Covid funding held in reserves		**2.97**
Total reported Covid funding		**177.41**

- **Revenue Reserves**

Health Board reserves are held by the Board, until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer. Some funding allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific purpose.

The following reserves, relating to WG Funding, were approved for delegation by the CEO.

£68k Operational Lead Nurse (22/23)	£88k Communication team Band 5 and 6
£162k Communications and Engagement	£500k reprovision (22/23) reversal back to reserves
£350k Clawback of outpatient recovery funding from Divisions	£197k Shared Services income
£349k Environmental fund	£1.1m Clawback of recovery funding from Divisions
£1.2m Covid support to Care Homes	

The Health Board has received the majority of Covid monies with an additional £2.25m anticipated for National priorities. The balance of recovery monies including clawback elements held in reserves will be delegated as plans are approved by the Executive Team.

- **Underlying Financial Position (ULP)**

As at month 11 the underlying financial position is a **deficit of £20.9m**.

This is based on the current assessment of available recurrent funding and the recurrent financial impact of existing service and workforce commitments. **It excludes any potential recurrent impact of Covid-19 decisions.**

The Health Board's IMTP & Annual Plan identifies several key priorities where the application of Value-Based Health Care principles – improving patient outcomes along with better use of resources – should result in delivering greater service, workforce and financial sustainability whilst improving the health of the population. The actions being taken to improve financial sustainability are integral to this approach.

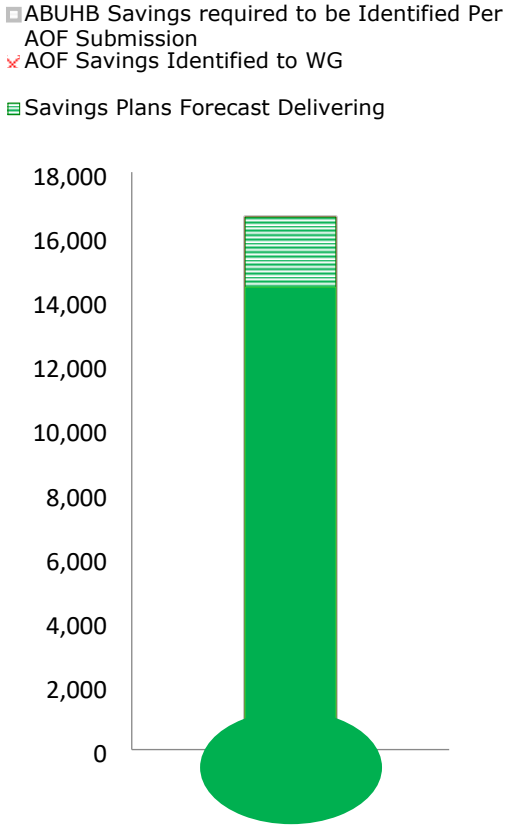
The proposed approach to the refreshed 22/23 IMTP financial plan is to focus on making previous investment decisions sustainable before new investments are committed to. The WG allocation funding 22/23 provides the Health Board with the opportunity to address its historic underlying financial position and prioritise current challenges and commitments as part of the 2022/23 IMTP.

The Executive are developing savings schemes for 2022/23 as part of the IMTP financial plan but are considered at this point to be required to manage future cost pressures rather than beneficially impact on the underlying position, this position will be reviewed along with further intelligence on the IMTP process and WG allocation uplifts.

Savings delivery

As part of the Annual Plan submitted by the Board to Welsh Government (June 2021), the financial plan for 2021/22 identified a savings requirement of £16.6m for 2021/22. Recurrent full year effect of savings are identified as £13.6m.

Actual savings delivered to February '22 amounted to £14.4m, which is in line with plan profile. The following tables present the progress against the full year target.



Month 11 Savings Plans

Green Savings schemes	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	3,105	202	2,903	3,232
Commissioned Services	126	4	122	122
Medicines Management (Primary and Secondary Care)	2,758	77	2,681	3,109
Pay	5,594	956	4,639	6,818
Non Pay	5,013	4,225	788	305
Total	16,596	5,464	11,132	13,586

Month 03 Savings Plans

M03 Green Savings schemes	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	3,500	500	3,000	3,002
Commissioned Services	122	0	122	122
Medicines Management (Primary and Secondary Care)	2,446	44	2,402	2,406
Pay	6,191	10	6,181	7,428
Non Pay	4,336	3,865	471	627
Total	16,596	4,419	12,177	13,586

Total savings plans remain in line with the AOF agreed earlier in the financial year, however, recurrent schemes have slipped and have been replaced with non-recurring schemes, this has particularly impacted Pay savings plans. At this stage the full year recurring impact has remained unchanged, however, this movement from recurrent to non-recurrent does put the underlying savings position at risk of not being achieved.

To deliver greater levels of savings and to achieve better use of resources, which improves health outcomes – and doesn't adversely impact on safety and quality – a greater focus is required on savings and efficiency improvement related to:

- Eliminating unwarranted clinical variation - e.g. in the use of medicines where there have been some savings, medical devices and consumables,

- Transformational service change – e.g. savings and efficiency improvement resulting from changes in service models which reduce use of hospital beds (admission, timely discharge, reduce length of hospital stay), reduce the requirement for workforce (particularly agency / locum), reduce spend on clinical interventions which have no positive effect on health outcomes.

The Health Board can no longer just rely on transactional efficiency savings and future plans also need to focus on shifting resources to improve health outcomes, support reinvestment and deliver

recurrent savings. This will require transformational change in the way the Health Board delivers services so that it is more effective for patients and more financially sustainable.

Opportunities exist within the Annual Plan priorities agreed by the Health Board, including the following areas:

- MSK pathway redesign,
- Eye Care integration,
- Outpatients' transformation, and
- Digital solutions as an enabler to service change and financial improvement.

These programmes have been affected by unprecedented systems pressures over the last 2 years but given the likely challenging funding settlements in future years, progress in delivering some of these changes is required to improve the underlying financial position in 2022/23 and onwards.

Further transformation programmes identified as 2022/23 IMTP priorities will offer opportunities for efficiency and improved sustainability.

Risks & Opportunities

There remain risks and opportunities to managing the financial position during 2021/22, which include:

- Responding to the ongoing impact of Covid-19 – both direct and indirect consequences of the pandemic,
- Responding to any specific Covid-19 impacts e.g. current and further new variants, outbreaks,
- Workforce absence / self-isolation, availability of staff for priority areas alongside re-deployment and reduction in elective recovery activity,
- Risks associated with anticipating the remaining Covid-19 funding,
- Addressing backlogs in waiting times for some services, due to the Covid-19 pandemic – restart and recovery,
- Continued and potential increasing use of additional capacity,
- Addressing any surge in Covid-19,
- Maximising the opportunity to change services resulting in improved health outcomes for the population,
- Addressing the underlying financial deficit, through reducing costs and increasing recurrent savings, and
- The implications of the Ukraine crisis.

Capital

The approved Capital Resource Limit as at Month 11 totals £50.404m. In addition, the Health Board has confirmed asset disposals generating further funding of £1.422m. The Capital Resource Limit was agreed and fixed with Welsh Government at the end of October. The Health Board is now required to manage any subsequent variations from the fixed resource limits via brokerage with the Discretionary Capital Programme (DCP). The current forecast outturn is breakeven; however, this position now includes brokerage of £1.667m with the DCP to manage slippage against All Wales Capital Programme schemes described below.

The Grange University Hospital outturn is forecast to be an underspend of £0.824m which reflects the delays anticipated in the Well-being and Admin and Temporary Carpark works. The Same Day Emergency Care works are a further £200k underspent against the approved allocation for 2021/22. Both underspends are factored into the brokerage with Discretionary to allow the spends to occur during next financial year.

Slippage totalling £0.336m is being reported against the NHH Satellite Radiotherapy (£0.078m) and Mental Health SISU (£0.258m) schemes as the completion of these cases has slipped to 2022/23. In addition, the NHH SRU Enabling works to the Ante Natal Department are now expected to run into the new year creating further anticipated slippage of £0.4m. Conversely, anticipated overspends against forecast have been built in for Tredegar H&WBC (£0.205m) and YYF Breast Centralisation (£0.019m).

The forecast outturn for the HSDU scheme is expected to be an overspend of £0.740m. As additional funding cannot be secured from Welsh Government for the scheme, the overspend will be met from the Discretionary Capital Programme. Practical completion of the building works was achieved in February.

The Full Business Case for Newport East Health and Well-being Centre has been submitted to Welsh Government for approval. The Business Case for the proposed Endoscopy Unit at RGH has also been submitted to Welsh Government for approval in month.

All the original DCP funding and the majority of the additional £1.667m brokerage required to offset the AWCP slippage has been released as approved schemes. Currently a contingency of £0.036m remains which will be allocated during March utilising remaining end of year reserve schemes.

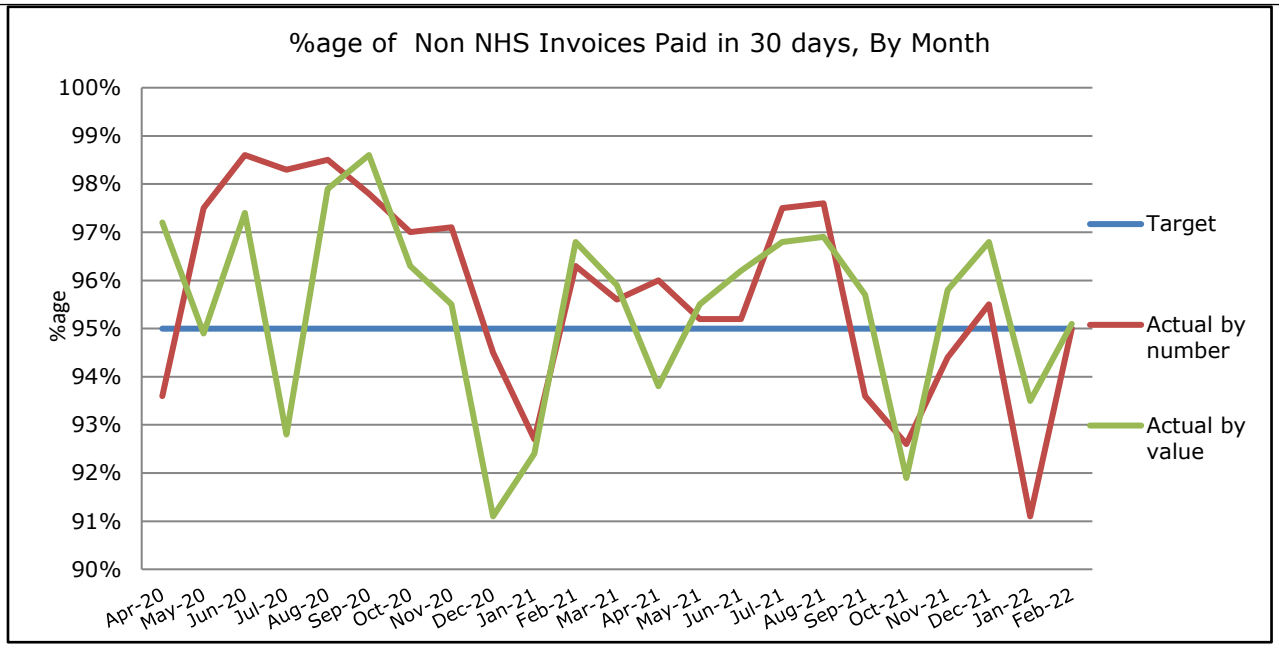
The Health Board has received notification that the annual Discretionary budget allocation for 2022/23 has been reduced by 24% to £8.227m (expected allocation - £10.814m). The decrease results from a reduction of circa £100m in the Welsh Government Overall All Wales Capital Programme budget for 2022/23. When the brokerage of AWCP scheme slippage of £1.667m is deducted from the confirmed budget, only £6.560m remains to address existing Discretionary scheme commitments and new 2022/23 proposals. The draft 2022/23 Discretionary programme is being developed in the context of the reduced funding and will be presented to Board for approval in March.

Cash

The cash balance on the 28th of February is £5.1m, which is below the advisory figure set by Welsh Government of £6m.

PSPP

This month the HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods, both in month & on a cumulative basis.



Recommendation

The Committee is asked to note:

- The financial performance at the end of February 2022 and forecast for 2021/22 – against the statutory revenue and capital resource limits,
- The revenue reserve position on the 28th of February 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy, and
- A financial assessment of the risks and opportunities which may impact on delivering the financial forecast for 2021/22.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks of achieving the Health Board's statutory financial duties and other financial targets are detailed within this paper.
Financial Assessment, including Value for Money	This paper provides details of the year to date and forecast financial position of the Health Board for the 2021/22 financial year.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its AOF/IMTP priorities and opportunities to improve efficiency and effectiveness.
Equality and Diversity Impact Assessment (including child impact assessment)	The Assessment forms part of the AOF service plan.
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.

Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the financial position that supports the Health Board's 3 year plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Long-term financial linked to IMTP completion **Integration –** Regional partnership and integration with other NHS Wales organisations **Involvement –** use of environmental fund and specific investment as well as on-going links with services for engagement **Collaboration** – collaboration with external partners **Prevention** – long-term strategy in order to provide investment and savings through preventative measures across the UHB. The Health Board Financial Plan has been developed based on the approved AOF/IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	See Below
Public Interest	Circulated to board members and available as a public document.

Glossary

A		
A&C – Administration & Clerical	A&E – Accident & Emergency	A4C - Agenda for Change
AME – (WG) Annually Managed Expenditure	AQF – Annual Quality Framework	AWCP – All Wales Capital Programme
AP – Accounts Payable	AOF – Annual Operating Framework	ATMP – Advanced Therapeutic Medicinal Products
B		
B/F – Brought Forward	BH – Bank Holiday	
C		
C&V – Cardiff and Vale	CAMHS – Child & Adolescent Mental Health Services	CCG – Clinical Commissioning Group
C/F – Carried Forward	CHC – Continuing Health Care	Commissioned Services – Services purchased external to ABUHB both within and outside Wales
COTE – Care of the Elderly	CRL – Capital Resource Limit	Category M – category of drugs
CEO – Chief Executive Officer		
D		
DHR – Digital Health Record	DNA – Did Not Attend	DOSA – Day of Surgery Admission
D2A – Discharge to Assess	DoLS - Deprivation of Liberty Safeguards	DoH – Department of Health
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	eLGH – Enhanced Local general Hospital
ENT – Ear, Nose and Throat specialty	EoY – End of Year	ETTF – Enabling Through Technology Fund
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		

GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital	GIRFT – Getting it Right First Time	
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus
HSDU – Hospital Sterilisation and Disinfection Unit	H&WBC – Health and Well-Being Centre	
I	IMTP – Integrated Medium Term Plan	INNU – Interventions not normally undertaken
IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure	ICF – Integrated Care Fund
L		
LoS – Length of Stay	LTA – Long Term Agreement	LD – Learning Disabilities
M		
MH **–** Mental Health	MSK - Musculoskeletal	Med – Medicine (Division)
MCA – Mental Capacity Act		
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre		
P		
PAR – Prescribing Audit Report	PCN – Primary Care Networks (Primary Care Division)	PER – Prescribing Incentive Scheme
PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis	PSNC –Pharmaceutical Services Negotiating Committee
PSPP – Public Sector Payment Policy	PCR – Patient Charges Revenue	PPE – Personal Protective Equipment
R		
RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit

RTT – Referral to Treatment	RPB – Regional Partnership Board	
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	TAG – Technical Accounting Group
U		
UHB / HB – University Health Board / Health Board	USC – Unscheduled Care (Division)	UC – Urgent Care (Division)
ULP – Underlying Financial Position		
V		
VCCC – Velindre Cancer Care Centre		
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	YYF – Ysbyty Ystrad Fawr

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Risk and Assurance Committee
Thursday 8th April 2022
Agenda Item:XX

Aneurin Bevan University Health Board

Internal and External Audit Recommendations Tracking

Purpose

The paper presents the Audit, Risk & Assurance Committee with a Draft Procedure for the Management of Internal and External Audit Recommendations, for approval.

The paper also provides the Audit, Risk & Assurance Committee with an overview of the current position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit and External Audit (Audit Wales), following an in-depth review of audit tracking to-date

The paper presents the Audit, Risk & Assurance Committee with a revised tracking tool, overview reporting and a summary of audit activity within the current and previous years.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Rani Mallison, Director of Corporate Governance

Report Author: Rani Mallison, Director of Corporate Governance

Report Received consideration and supported by :

Executive Team	✓	**Committee of the Board**	N/A

Date of the Report: 31 March 2022

Supplementary Papers Attached:

- **Appendix A –** Draft Procedures for the Management of Internal and External Audit Recommendations
- **Appendix B -** Internal Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix C -** External Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix D -** Internal Audit and External Audit Recommendations that Not Yet Due for Implementation
- **Appendix E –** Master Internal and External Audit Recommendations Tracker (inclusive of overdue and not yet due actions)

Detailed Assessment

Procedure for the Management of Internal and External Audit Recommendations

This paper provides the Audit, Risk and Assurance Committee with a draft procedure for the management of recommendations for improvement, arising from internal and external audit reviews. The draft Procedure, attached at **Appendix A**, sets out the:

- requirement to have a comprehensive and considered management response and action plan in response to Internal and External Audit Reviews (signed off by the lead Executive Director);
- requirement for management responses and action plans to facilitate scrutiny and provide assurance that actions have been implemented in a robust and timely way;
- the role of the Audit, Risk & Assurance Committee in:
    - receiving final Internal and External reports, alongside management responses and action plans;
    - being assured of the adequacy of the management response to issues identified by internal and external audit and the arrangements for monitoring respective actions going forward;
    - challenging the pace of delivery of actions and approving any changes to the agreed timescales of actions;
    - agreeing the frequency of monitoring based on the level of risk and priority of actions; and
    - overseeing the closure of action plans;
- requirement to have one central point for the receipt, logging, tracking, monitoring and reporting of progress against internal and external audit reviews and associated recommendations.

It is intended for the Procedure to support a structured approach to the management of internal and external audit recommendations, with clearly defined actions that will enable the Health Board to have a comprehensive oversight of its internal and external audit activity.

The draft procedure does not extend to the management of improvement actions arising from Regulatory Inspections or Independent Reviews (such as those undertaken by the Community Health Council). The nature of which are dealt with under a separate process and overseen by the Board's Patient Quality, Safety and Outcomes Committee.

The Audit, Risk and Assurance Committee is asked to APPROVE the draft procedure attached at Appendix A, for implementation with immediate effect.

Audit Recommendation Tracking Tool

The paper introduces to the Audit, Risk & Assurance Committee a revised audit recommendation tracking tool, to support the Committee in fulfilling its role in respect of audit recommendation tracking (as set out above and within the draft procedure attached at **Appendix A**).

The revised tool, used as the basis of reporting at **Appendices B-D**, will enable the Committee to have comprehensive sight of:

- Column A – ABUHB reference (to be linked to the establishment of a central database of for audit reports)
- Column B – Audit Type (Internal or External)
- Column C – Report Title
- Column D – Overall Assurance Rating provided in the Review
- Column E – Director Lead responsible for recommendation/action
- Column F – Officer Lead responsible for recommendation/action
- Column G – Prioritisation of the recommendation/action (high, medium, low, not rated)
- Column H – the detail recommendation raised by the relevant audit team
- Column I – the final management response to the recommendation/action
- Column J – agreed deadline for implementation as per the final audit report
- Column K – any revised deadline in agreement with the Audit, Risk & Assurance Committee
- Column L – date of agreement by Audit, Risk & Assurance Committee to a revised deadline (to link with formal minutes of the discussion held)
- Column M – Status of the recommendation (not yet due, overdue, complete, closed and no longer applicable)
- Column N – Number of months past original agreed deadline (column J)
- Column O - Number of months past revised agreed deadline (column K)
- Column P – if action closed (no longer applicable), detail of justification and evidence available
- Columns Q to T – Progress in implementing overdue actions, including an outline of any barriers/interdependencies and how the identified risk is being mitigated pending implementation
- Column U – Reporting date (to determine column N/O)
- Column V – Date added to the tracker (following presentation of the final audit report to the Audit, Risk & Assurance Committee)

Considerable work has been undertaken to transfer those recommendations presented as outstanding to the Audit, Finance and Risk Committee in December 2021 into the revised tool, along with the inclusion of audits reported during 2021/22 that had not been included. The Master Tracker is attached at **Appendix E** for reference.

As set out within the draft procedure at **Appendix A**, it is proposed that the Audit, Risk and Assurance Committee will focus its attention at each meeting on those recommendations that are overdue past the original agreed timeframe for completion, those that have been closed during the last reporting period which require noting and the number of audit recommendations that are not yet due for implementation. Ongoing reporting to the Audit, Risk and Assurance Committee will therefore adopt this structured approach, with the Master Tracker included should Committee Members wish to access further detail.

The Board Secretary (Director of Governance) will ensure that all completed actions are retained for any potential future reference. There is currently no up-to-date record of previously completed internal or external audit recommendations.

Internal and External Audit Recommendation Tracking, March 2022

As mentioned above, considerable work has been undertaken to transfer those recommendations presented as outstanding to the Audit, Finance and Risk Committee in

December 2021 into the revised tool, along with the inclusion of audits reported during 2021/22 that had not been included. The Master Tracker is attached at **Appendix E** for reference.

It is important to note that at the time of writing this paper, due to time constraints, the Executive Team had not been offered the opportunity to review and update progress in implementing internal and external audit recommendations. The focus over recent weeks has been on fully establishing the master tracker. The position reported within this paper is therefore a worst-case scenario and it is likely that several recommendations will have been implemented. The Executive Team will be asked to review the detail of the master tracker ahead of the Audit, Risk & Assurance Committee's next meeting in May 2022 where a calibrated position will be reported.

Internal Audit

The position reported to the Audit, Risk and Assurance Committee, as at 31st March 2022, in respect of overdue internal audit recommendations is:

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017/18 2018/19 2019/20 2020/21	13	12	6	23	54
2020/21	4	18	10	0	32
				Grand Total	86

The detail provided at **Annex 1**, provides the Audit, Risk & Assurance Committee with an overview of progress in implementing the totality of audit recommendations arising from internal audit reviews; demonstrating the number of actions implemented, overdue and not yet due at an individual audit review level. It is proposed that this oversight is provided to the Audit, Risk & Assurance Committee with each audit tracking report to enable the Committee to focus its attention on those actions overdue for implementation as well as being able to take assurance that action plans are being completed.

The detail provided now includes all Internal Audit Reviews reported in 2021/22 to the Audit, Finance and Risk Committee. The Internal Audit Reviews reported to the Audit, Risk & Assurance Committee on 8th April 2022 will be added into the Master Tracker thereafter.

The following appendices are attached to support the Audit, Risk & Assurance Committee's review of internal audit recommendations tracking:

- **Appendix B** - Internal Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix D -** Internal Audit and External Audit Recommendations that Not Yet Due for Implementation
- **Appendix E –** Master Internal and External Audit Recommendations Tracker (inclusive of overdue and not yet due actions)

External Audit

The position reported to the Audit, Risk and Assurance Committee, as at 31st March 2022, in respect of overdue external audit recommendations is:

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017 2018 2019 2020	7	0	0	3	10
2021 2022	1	1	0	1	3
				Grand Total	13

The detail provided at **Annex 2**, provides the Audit, Risk & Assurance Committee with an overview of progress in implementing the totality of audit recommendations arising from external audit reviews; demonstrating the number of actions implemented, overdue and not yet due at an individual audit review level. As with Internal Audit, it is proposed that this oversight is provided to the Audit, Risk & Assurance Committee with each audit tracking report to enable the Committee to focus its attention on those actions overdue for implementation as well as being able to take assurance that action plans are being completed.

The detail provided now includes those actions deemed outstanding from previous years within the Structured Assessment 2021.

The following appendices are attached to support the Audit, Risk & Assurance Committee's review of external audit recommendations tracking:

- **Appendix C -** External Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix D -** Internal Audit and External Audit Recommendations that Not Yet Due for Implementation
- **Appendix E –** Master Internal and External Audit Recommendations Tracker (inclusive of overdue and not yet due actions)

Next Steps

The Executive Team will be asked to review the tracker with a request for updates on progress ahead of the Audit, Risk & Assurance Committee's meeting in May 2022.

The master tracker will be updated as and when internal and external audit reports are reported to the Audit, Risk and Assurance Committee.

Recommendation

The Audit, Risk & Assurance Committee is asked to:

- APPROVE the draft procedure attached at Appendix A, for implementation with immediate effect;
- NOTE the adoption of a new audit recommendation tracking tool;
- DISCUSS and NOTE the position reported in respect of internal and external audit recommendations, noting that these are subject to review by the Executive Team.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational actions for audit activity are key elements of the Health Board's overall assurance arrangements.
Financial Assessment, including Value for Money	There may be financial consequences of individual actions however there is no direct financial impact associated with this report at this stage.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual actions and assurance requirements contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality issues associated with this report at this stage, but equality impact assessment may be a feature of the work being undertaken as part of the actions.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The actions will be aspects of the delivery of key priorities in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the consideration of individual actions.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

Internal Audits (where there is an outstanding action)

- **2017/18**
- **2018/19**
- **2019/20**
- **2020/21**

ABUHB Ref	Audit Title	Assurance Rating: Substantial / Reasonable / Limited / No	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
				H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
TBC	Health & Safety, (2017/18)	Limited	**5**	2	3			0	3			2	0							×
TBC	IT Service Management (2017/18)	Limited	**11**	4	7			3	7			1	0							×
TBC	Medical Equipment & Devices (2017/18)	Limited	**5**	2	3			0	3			2	0							×
TBC	Wellbeing of Future Generations Act (Wales) 2015 (2018/19)	Reasonable	**3**	1	2			0	2			1	0							×
TBC	Management of Balance Sheet Assets (2018/19)	Reasonable	**12**	1	9	2		0	9	2		1	0	0						×
TBC	Clinical Audit Follow-up of actions from 2016/17 (2018/19)	Limited	**3**	3				0				3								×
TBC	Job Planning (2019/20)	Limited	**5**	3	2			2	2			1	0							
TBC	Pay Incentives (2019/20)	Limited	**7**	2	4	1		0	4	1		2	0	0						×
TBC	IM&T Control and Risk Assessment (2020/21)	Advisory	**14**				14				1				13					×
TBC	High Voltage Electrical Systems Management, (2020/21)	Reasonable	**6**		3	3			0	0			3	3						×
TBC	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	**7**		7				1				5				1			×
TBC	Clinical Futures – Workforce (2020/21)	Substantial	**1**		1				0				1							×
TBC	Clinical Futures – Transport (2020/21)	Reasonable	**4**		2	2			0	0			2	2						×
TBC	Mass Vaccination Programme	Substantial	**1**		1				0				1							×
TBC	Mental Health and Learning Disabilities Divisional Review	Reasonable	**4**		2	2			2	1			0	1						×
TBC	Staff Experience (2020/21)	Advisory	**3**				3				0				3					×
TBC	Covid-19: Reducing Nosocomial Transmission (2020/21)	Advisory	**7**				7				0				7					×
TOTAL			**98**	18	46	10	24	5	33	4	1	**13**	**12**	**6**	**23**	0	1	0	0	

2021/22 Internal Audits (All)

ABUHB Ref	Audit Title	Assurance Rating: Substantial / Reasonable / Limited / No	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review			Audit Recs Implemented to-date			Audit Recs Overdue (against original agreed timescale)			Audit Recs Not Yet Due			All Audit Recs Implemented
				H	M	L	H	M	L	H	M	L	H	M	L	
2021.06	Mental Capacity Act	Reasonable	**5**	1	3	1	0	0	0	1	3	1				×
2021.01	Gifts, Hospitality and Declarations of Interest	Reasonable	**2**		2			0			2					×
2021.03	Clinical Negligence Costs	Substantial	**2**		1	1		0	0		1	1				×
2021.02	Putting Things Right	Reasonable	**2**		2			0			2					×
2021.04	Charitable Funds	Substantial	**1**		1			0			0			1		×
2021.12	IT System Controls (WRIS)	Reasonable	**10**	1	9		0	2		0	0		1	7		×
2021.05	Pathology	Reasonable	**9**		3	6		0	0		3	6				×
2021.07	Occupational Health	Substantial	**2**			2			0			0			2	×
2021.10	Tredegar Health and Well Being Centre	Reasonable	**12**	4	6	2	0	1	0	3	5	2	1	0	0	×
2021.08	GUH: Financial Assurance (Follow-up)	Substantial	**0**	0	0	0										
2021.09	GUH: Technical Assurance	Substantial	**1**			1			0			0			1	×
2021.11	GUH: Follow-up	Reasonable	**2**		2			0			2			0		×
	Corporate Governance	Not yet Reported														
	Risk Management	Not yet Reported														
	Financial Sustainability	Not yet Reported														
	Continuing Healthcare	Not yet Reported														
	Flu Immunisation	Not yet Reported														
	Medical Equipment and Devices	Not yet Reported														
	Medicines Management (including Controlled Drugs)	Not yet Reported														
	Falls Management	Not yet Reported														
	Datix	Not yet Reported														
	NIS Directive	Not yet Reported														
	Operational Plan for Resumption of Services	Not yet Reported														
	Flow Centre	Not yet Reported														
	Facilities Directorate Review	Not Yet Reported														
	Waste Management	Not yet Reported														
	GUH: Quality	Not yet Reported														
	Follow-up on Previous Recommendations	Not yet Reported														
TOTAL			**48**	6	29	13	0	3	0	**4**	**18**	**10**	2	8	3	

ABUHB External Audits (where there is an outstanding action)

- **2017**
- **2018**
- **2019**
- **2020**

ABUHB Ref	Audit Title	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
			H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
TBC	Structured Assessment 2017	**7**	7				3				4								×
TBC	Structured Assessment 2018	**5**	5				2				3								×
TBC	Structured Assessment 2019	**4**				4				1				3					
TBC	Structured Assessment 2020	**0**																	
TOTAL		**16**	12			4	5			1	**7**			**3**					

ABUHB External Audits 2021 & 2022 (All)

ABUHB Ref	Audit Title	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
			H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
202101	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	**5**	2	2	1		0	0	0		1	1	0		1	1	1		×
202102	Radiology Services - Follow-up of 2017 recommendations	**1**				1				0				1					×
202103	Audit of Accounts Report – ABUHB Charitable Fund and Other Related Charities (Dec 2021)	**1**		1				0				0				1			×
202104	Taking Care of the Carers (Oct 2021)	**6**				6				4				0				2	×
202105	Structured Assessment 2021	**5**	4			1	0			0	0			0	4			1	×
	Quality Governance Arrangements	**Not yet Reported**																	
	Orthopaedic Follow Up of Recommendations Made in 2015	**Not yet Reported**																	
	Arrangements for Securing Efficiencies	**Not yet Reported**																	
	Unscheduled Care Arrangements	**Not yet Reported**																	
TOTAL		**18**	6	3	1	8	0	0	0	4	**1**	**1**	**0**	**1**	5	2	1	3	

PROCEDURE FOR THE MANAGEMENT OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS
March 2022

Purpose

The purpose of this Procedure is to set out the:

- requirement to have a comprehensive and considered management response and action plan in response to Internal and External Audit Reviews (signed off by the lead Executive Director);
- requirement for management responses and action plans to facilitate scrutiny and provide assurance that actions have been implemented in a robust and timely way;
- the role of the Audit, Risk & Assurance Committee in:
    - receiving final Internal and External reports, alongside management responses and action plans;
    - being assured of the adequacy of the management response to issues identified by internal and external audit and the arrangements for monitoring respective actions going forward;
    - challenging the pace of delivery of actions and approving any changes to the agreed timescales of actions;
    - agreeing the frequency of monitoring based on the level of risk and priority of actions; and
    - overseeing the closure of action plans;
- requirement to have one central point for the receipt, logging, tracking, monitoring and reporting of progress against internal and external audit reviews and associated recommendations.

This procedure does not extend to the management of improvement actions arising from Regulatory Inspections or Independent Reviews (such as those undertaken by the Community Health Council). The nature of which are dealt with under a separate process and overseen by the Board's Patient Quality, Safety and Outcomes Committee.

The Role of the Board in respect of Internal and External Audit

As set out within Standing Orders, the Board is expected to set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Health Board business, its governance and the effective management of the organisation's risks in pursuance of its aims and

objectives. The Board shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

In doing so, the Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit, Risk & Assurance Committee.

The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards.

The Board will also seek assurance from the work carried out by external audit on the adequacy of the Health Board's assurance framework. However, that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

The Role of the Audit, Risk & Assurance (ARA) Committee

The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 *[WHC (2006) 090]* establishes the requirement for every NHS Board to establish an Audit Committee, and this has been incorporated into Standing Orders for Local Health Boards. At its meeting on 23rd March 2022, the Board reviewed its committee structure and approved the establishment of the Audit, Risk & Assurance Committee (https://abuhb.nhs.wales/files/key-documents/public-board-meetings/abuhb-public-board-meeting-3-5-technical-appendices-pdf/).

The ARA Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by an effective system of assurance.

The ARA Committee's primary role is to ensure the system of assurance is valid and suitable for the Board's requirements. The ARA Committee will review whether:

- The system of assurance is appropriate for the organisation;
- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;
- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

In fulfilling its role, the ARA Committee will rely on the organisation's internal arrangements and take into account audit work.

The role of Internal Audit

Internal Audit is a key source of independent internal assurance to the Board and Accountable Officer (Chief Executive Officer). The Public Sector Internal Audit Standards (PSAIS_1_April_2017.pdf (publishing.service.gov.uk)) describe the role of internal audit as enhancing and protecting organisational value by providing risk-based and objective assurance, advice and insight.

As such, its role embraces two key areas:

1. The provision of an independent and objective opinion (the Head of Internal Audit Opinion) to the Accountable Officer, the Board, and the Audit, Risk and Assurance Committee based on an objective assessment of the framework of governance, risk management and control; and
2. The provision of an independent and objective advisory service, with the aim of supporting management to improve governance, risk management and control and contributing to the overall opinion of the Head of Internal Audit.

The Public Sector Internal Audit Standards provide an essential reference source for the Audit, Risk and Assurance Committee in understanding what it can expect from internal audit and also when assessing the service provided.

To support the system of assurance, Internal Audit will develop a risk based annual internal audit plan which details all the audit reviews to be undertaken in the coming financial year.

The Role of External Audit

The Auditor General for Wales (the Auditor General) is the external auditor of NHS Wales. The statutory duties of the Auditor General in respect of individual NHS bodies fall under two broad headings – to review and report on:

- The audited body's financial statements, and on its Annual Governance Statement; and
- Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The external audit role is exercised in accordance with statutory provisions and the work of external auditors is subject to the 'Code of Audit Practice of the Auditor General for Wales' (Code of Audit Practice | Audit

Wales) and 'the Statement of the responsibilities of the Auditor General for Wales and of the bodies that he or she audits'.

The Auditor General's representatives (the External Audit Team) will develop an annual audit plan designed to deliver a safe opinion on the accounts and to enable the Auditor General to draw conclusions on whether the NHS body has made proper arrangements for securing economy, efficient and effectiveness in its use of resources.
The audit plan will also cover issues such as regularity, propriety and value for money.
In developing the annual audit plan the Auditor General's representatives will take into account the audit needs of the organisation, using a risk-based approach.

Internal and External Audit Reports and Management Responses/Action Plan

For each review in both the internal and external audit plans, an audit report will be issued which includes an assurance opinion on how effective the internal controls are in the scope of that review.

Draft reports are issued to management to support discussion and a review for factual accuracy. Management responses and responding action plans are then developed, particularly in response to any recommendations that may have been made. Officers should use the draft report clearance process to highlight for the attention of auditors any concerns they have about the wording, practicality or relevance of audit recommendations.

When developing the management response and action plan, management must ensure consideration is given to the capacity and costs required to deliver the actions and any associated risks, ensuring value for money. Where actions require capital investment, consideration also must be given to managing the risk in the interim as capital funding to enable progress may not be available within the timescales committed to in the management response. In these circumstances, other action should be taken to manage the risk which must also be detailed in the action plan and, where appropriate, be added to operational risk registers.

There may also be occasions where recommendations fall outside the gift of the division/directorate/service/team audited to implement and therefore other functions within the Health Board, for example corporate teams such as IT or Estates, will be required to develop appropriate actions for management responses, and be responsible for the delivery of these.

Management responses must:-

- Respond directly to the finding and its recommendation(s);
- Provide specific actions that the Health Board commits to take to correct the finding;
- Exclude information that is not pertinent to the finding or its corrective action plan;
- Identify a specific individual for the implementation of an action;
- Provide a specific and realistic timetable for implementation; and
- Be SMART (Specific, Measurable, Achievable, Realistic, with a clear timeframe);
- Approved by the relevant Executive Director prior to finalising with internal or external audit.

It is also important to assess, at an early stage, whether or not the recommendations can be actioned by the Health Board alone or whether implementation is outside of the Health Board's direct control because of the involvement and dependency on third parties. Such situations should be made clear at the outset (to both auditors and the Committee) and should be formally recorded in updates to the tracking database.

Once the management response and action plan has been approved by the relevant Director and has been accepted by the respective audit team as addressing the risks and the timescales are acceptable, the report is issued as final.

A copy or summary of each report is then presented to the Audit, Risk & Assurance Committee at its next available meeting. The Audit, Risk & Assurance Committee will be required to know the level of assurance that has been given, the recommendations for improvement that have been made to management, and management's response. In this way the Audit, Risk & Assurance Committee will receive prompt notification of internal audit findings and assurances.

The Board Secretary (Director of Corporate Governance) will maintain a database of all Internal and External Audit Reports, inclusive of management responses/action plans.

A flowchart setting out the process for the management of audit reports when issued is set out at **Appendix A**.

Monitoring Implementation of Internal and External Audit Recommendations

An important responsibility of the Audit, Risk & Assurance Committee is to monitor the implementation of agreed audit recommendations. The Audit, Risk & Assurance Committee should ensure the organisation adopts a robust process for monitoring the implementation of agreed audit recommendations and that regular progress reports are provided to the

Audit, Risk & Assurance Committee identifying any that have not been implemented within agreed timescales.

The process for monitoring and reporting progress against the implementation of internal and external audit recommendations within the Health Board will be led by the Board Secretary (Director of Corporate Governance).

The key principles associated with the monitoring of internal and external audit recommendations include:

- Audit Recommendations will be added to the Audit Recommendations Tracker, once the final Audit Report has been received by the Audit, Risk & Assurance Committee;
- Executive Directors will be responsible for respective audit recommendations and ensure oversight of progress within respective teams;
- The Audit, Risk & Assurance Committee will monitor progress against the implementation of all audit recommendations, regardless of priority rating (high, medium, low and not rated), as set out in **Appendix B**;
- Executive Directors, with their teams, will be asked to update on progress against the implementation of audit recommendations as the completion date arises and an update will be reported to the next meeting of the Audit, Risk & Assurance Committee;
- Executive Directors will be responsible for approving the closure of audit recommendations, which will be subject to reporting to the Audit, Risk & Assurance Committee;
- The Audit, Risk & Assurance Committee will focus its attention at each meeting on those recommendations that are overdue past the original agreed timeframe for completion, those that have been closed during the last reporting period which require noting and the number of audit recommendations that are not yet due for completion;
- Both the Executive Team and the Audit, Risk & Assurance Committee will undertake an in-depth review of the Audit Recommendation Tracker twice-yearly;
- The Audit, Risk & Assurance Committee will be asked to approve the revision of any previously agreed dates within action plans, on the advice of internal or external audit;
- Internal and External Audit Teams will assess the position against previous audit recommendations as part of any relevant follow-up audit work.

Where the Audit, Risk & Assurance Committee or Head of Internal Audit/External Auditor are concerned about the lack of implementation of audit recommendations in a particular area, the Audit, Risk & Assurance Committee has the authority to invite the respective Director to attend

and provide an update. This will be with a view to ensuring risks and identified weaknesses in internal control are mitigated, recognising that the initial action plan will have been approved by management.

Where it is possible to do so, as part of the updates to the Audit, Risk & Assurance Committee, and particularly as part of a proposed closure of recommendations, reports will provide an indication of the impact that implementing the recommendation will have had on the Health Board in terms of quality improvement, the provision of more efficient and effective patient care, improved governance, increased security or better use of resources etc.

Appendix A

Management of Internal and External Audit Reports and Management Responses

1. • Draft internal/external audit report issued to the Health Board via the relevent Officer Lead and copied to the Board Secretary (Director of Corporate Governance) and relevant Executive Director
2. • Officer Lead to consider draft findings for accuracy and populate the management response ensuring the principles covered within this procedure are adhered to
3. • Draft Managament Response to be reviewed and approved by respective Executive Director
4. • Management response sent back to relevant audit team for consideration and to be accepted
5. • Auditors issue final report (including management response) to the respectice Officer Lead and copied to the Board Secretary (Director of Corporate Governance) and relevant Executive Director
6. • Board Secretary (Director of Corporate Governance) arranges for:
   • 1. Final Report to be logged in central database
   • 2. Final Report to be presented to Executive Team
   • 3. Final Report to be presented to Audit, Risk & Assurance Committee
7. • Once Final Report has been considered by Audit, Risk & Assurance Committee, the audit recommendations and management response will be moved into the central audit recommendation tracker for monitoing and reporting, in-line with this procedure

Appendix B

Prioritisation of Internal/External Audit Recommendations

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*
* Unless a more appropriate timescale is identified/agreed at the assignment.		

ABUHB	Audit	Report Title	Assurance	Director	Responsible	Ref /	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of	If closed	Progress being made to implement recommendation				Reporting	Date Added to
	Internal	IT Service Management, May 2018	Limited	Director of Planning, Digital & IT	Associate Director of Informatics	High	R3 Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	AcceptedWe recognise that this is a priority and that Service Point does not meet the needs of the service to develop the KCS (also identified by this audit) and therefore, Informatics will undertake a scoping and options appraisal exercise to define the requirements, including the resource needed.A business case has been developed for ICT only that seeks to address the concernswithin ICT; this work will inform the requirements of a similar review for Informatics.	31/10/2018	Feb-22	Jan-19	Overdue	**41**	2		November 2021 Update: Existing knowledge artefacts have been migrated to share point online and are fully searchable and available across Informatics teams. A review of information architecture is underway which will further consolidate knowledge and categorise by service facilitating a KCS approach. For Service Desk Knowledge, this will be complete by end of Feb 2022 in readiness for our Service Desk Institute Accreditation Audit.			Implement revised information architecture Define and Implement governance around permissions, review timescales and formats for new artefacts Establish links to service catalogue Ensure criteria for SDI Audit are met	31/03/22	
	Internal	Job Planning, March 2020	Limited	Medical Director	Interim Director of Operations	High	R1 The Health Board should: · review the escalation process to ensure that it includes appropriate action following escalation to the Medical Director and holds medical staff to account for failure to have an in date job plan; · produce action plans to address poor compliance and review these as part of the monthly divisional meetings with the COO; · complete job plans on an annual basis, as opposed to a 15-month cycle. · consider the process for reviewing job plans and look at ways of increasing compliance, such as aligning job planning dates with other activities (i.e. IMTP /Corporate Planning cycle); and; · agree the job plan and implement an escalation / disciplinary process if there is not a legitimate reason for failure to agree a job plan.	Medical Director to formally write to all DDs with the outcome of this Internal Audit.Escalation Process will be refined giving timelines for response by DDs to Medical Director escalation.Tracker of escalations to be maintained by Medical Directors office.	01/03/2020	N/A	N/A	Overdue	**25**	#VALUE!		November 2021 Update: • Agreement by Executive Team to develop specification and instigate procurement process for E-Systems including job planning • Job planning procedure continue to be developed. • development of a standard operating procedure for Team Job Planning • Paper presented to Audit Committee October 2021 updating on action plan and achievement • Update provided to People & Culture Committee October 2021 • The Medical Director has written to Divisional Directors emphasising the need for their CDs to undertake job plan review meetings. He has also asked that a named member of the divisional				31/03/22	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager/ Service Lead / General Manager	Medium	R1 The Health Board should periodically review feedback from WAST / staff and patients, incidents, ongoing and expected future costs, overall performance and volume of patients etc. to ensure the expected benefits versus costs are still being achieved.	Agreed.The cost benefit analysis was reviewedagainst the original model and flagged as part of the Clinical Futures Readiness Assessment on 23rdJune. There will be ongoing monitoring of key KPIs.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Medium	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performancee.g. logging in times and periodically listening to callsand to feedback onperformance;•addressing any training needs that ariseand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. WAST incident numbers, GP surgery etc.;•providingregular refresher training;and•hosting team meetings to share case studies / best practiceand address any issues / concerns that arise.	30/09/2021	N/A	N/A	Overdue	**6**	#VALUE!						31/03/22	

	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021	N/A	N/A	Overdue	**6**	#VALUE!						31/03/22	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R4 We recommend the Flow Centre Team undertake periodic test runs of the business continuity plan against different continuity events. Any learnings or improvements should be detailed specifically in the plan.	Agreed. We will finalise the business continuity plan(BCP)and undertake a test run, including a relocation planto the Grange University Hospital, if required. Any learning or improvements will be incorporated into the BCP.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Mass Vaccination Programme, April 2021	Substantial	Director of Public Health and Strategic Partnerships	Deputy Director of Public Health	Medium	R1 The Health Board should review:•how it engages with members of the public who do not have access to the internet; and•advertising the telephone number for the appropriate appointment booking team.	The need to review how the Health Board engages with members of the public who do not have access to the internet is accepted. As part of that review, the Health Board will consider advertising the telephone number and whether the significant operational implications of doing so can be overcome. If advertising the number continues to be too big a risk to the pace of delivery of the programme, alternative options will be provided.	30/06/2021	N/A	N/A	Overdue	**9**	#VALUE!						31/03/22	
	Internal	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Director of Primary, Community Care and Mental Health	SISU - Strategic Capital and Estates Programme Director and WPWS Programme Manager	Low	R3 We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:•the collection of baseline data;•targets or success measures with which to compare what is actually achieved;•the measurement and recording of the benefit metrics;•responsible managers; and•the oversight body of the benefits, to ensure these are achieved.	Agreed. We acknowledge that a robust benefits realisation plan needs to be developed and we are looking to commission external support to assist with this process for the SISU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.WPWS –to review benefits realisation plans for supporting projects	30/09/2021	N/A	N/A	Overdue	**6**	#VALUE!		November 2021 Update: Further work has been undertaken through the clinical workshops on developing the benefits register and this is still work in progress. Benefits realisation plan will be developed once the consultants have been engaged to inform the OBC prior to submission to the Board in March 2022. New Programme support for WPWS workstream has strengthened benefits management. Baseline data is/will be collected to support benefits realisation.					31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R1 The Health Board should ensure it clearly documents roles and responsibilities in its governance structures and plans.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R2 Where possible, the Health Board should endeavour to incorporate accountability,reportingand assurance into existing structures, rather than as additional processes which are not sustainable in the longer term.Using the example of the CIP, going forward this could include:i.accountability,reportingand assurancethrough the existing quality and patient safety governance mechanisms;ii.reporting integrated into existing divisional/site-based reports; andiii.CIP compliance assurance integrated into the divisional/site-based clinical audit plans.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	

	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R3 The Health Board should clearly document reporting requirements within its governance structures and plans, at each level of the organisation. This should include:i.expected frequency of reporting;ii.level of detail / assurances expected;iii.type of reporting expected, for example, tracking progress, reporting by exception, monitoring key metrics or performance indicators (KPIs), etc;iv.nature of the reports expected, for example, verbal, formal, set template, etc;	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R4 Where KPIs or data-driven reporting is used, the Health Board should ensure:i.the data is accurateand can be efficiently accessed; andii.KPIs are presented consistently between the divisions, for example, by clearly defining how KPIs are calculated.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R5 The Health Boardshould consider developinga protocol pack for any future surges of the pandemic.This could be implicit within the Health Board's pandemic framework and include, for example:i.Formally identifying governance structures for different surge levels;ii.For each governance structure, identifyinggroups that are required to meet, with clearly documented terms of reference identifying:a.roles and responsibilities;b.anticipated membership, including leadership of the group;c.frequency of meetings;d.reporting requirements (see recommendation6below);ande.records required to demonstrate monitoring, scrutiny and decision-making, for example, minutes, action log, decision log, etc(see recommendation4below).This should take into accountrecommendation 2 above.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R6 The Health Board should ensure meetingminutes appropriately demonstrate monitoring, scrutiny,decision-makingand assurance, particularlyif reporting isinformal /verbal.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R7 When developing action plans, the Health Board should ensure:iii.the plans contain clear timescales and milestones;iv.clarity is provided on demonstrating progress, for example, RAG rating definitions and requirements for validating progress; andv.benefits and key metrics are defined within the plan.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R1 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	A review of categories of well-being support will be undertaken to ensure staff can readily locate the support that best fits their need.	31/03/2022	N/A	N/A	Overdue	**0**	#VALUE!		November 2021 Update: This will be supported by the development of our internet and intranet resources and also the creation of a single point of access (phone and email). We are following and evidence based approach which advocates that the simplest route to seeking support is considered the most effective.				31/03/22	

	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R2 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same).However, the team will review a system of describing what others found helpful. This will enhance the current offer of feedback and satisfaction questionnaires completed by staff following an intervention. The development of an evaluation framework that has commenced with Cardiff Metropolitan University to evaluate the implementation of the Well-being Centre of Excellence will also support this recommendation.	31/03/2022	N/A	N/A	Overdue	**0**	#VALUE!		November 2021 Update: This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same). However clinical outcome data is collected by all clinicians in the service as part of good (standard) practice. More specifically the recently developed Trauma Pathway (within the Psychological Therapy Service) has now been evaluated				31/03/22	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R3 RecommendationThe Health Board should:•Review each initiative versus the time and financial cost to provide the service against the staff uptake and value / benefit of the initiative. •Consider additional analysis to help assess and target wellbeing initiatives to staff requirements.•Consider establishing wellbeing KPIs or other performance metrics to measure the success of the strategy and specific initiatives.	Calculating the relationship between financial investment and value is a complex process due to the range of clinical and individual variables. Outcome data is regularly collected and evidence based practice followed, the evidence base is evolving and ABUHB is at the forefront of developing this evidence and outcome data.The additional analysis recommended will be provided via the quarterly well-being surveys and deep dive work within divisions. The next well-being survey has enhanced questions that link back to the 6 pillars of the Employee Experience Framework.•The Employee Well-being team will take the recommendation around KPI'sunder consideration and further explore the additional functionality of the new version of the clinical recording system(CORE)now in use.	31/03/2022	N/A	N/A	Overdue	**0**	#VALUE!						31/03/22	
2021.11	Internal	GUH – Equipment Procurement Assurance - Follow up	Reasonable	Director of Planning, Digital & IT	Project Director	Medium	Management should ensure the ability to utilise "as fitted" water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Lessons learnt from equipment has been picked up as part of the broader lessons learnt report but a review by procurement alongside other projects would be beneficial.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.11	Internal	GUH – Equipment Procurement Assurance follow - up	Reasonable	Director of Planning, Digital & IT	Project Director	Low	R7 Single Tender / Single Quotation Actions should be reported to the Audit Committee in a timely manner, in line with SFIs, to enable effective scrutiny (O).	Agreed, all outstanding STAs will be taken to the next Audit Committee.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	MCA Lead/Head of DOLS	Low	R1 We recommend that procedural documents that have passed their stated review date are updated where required to reflect current legislation.	Agreed This procedure will be reviewed and updated with pace.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R2 We recommend that the 'best interests' discussion for patients assessed as lacking capacity is documented in the designated pages of the capacity assessment document in all cases.	Agreed A reminder will be issued across the organisation regarding robust completion of documentation.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	HIgh	R3 We recommend that, excepting where there is no reason to doubt that the patient has capacity, DNACPR decisions forms are accompanied by completed Health Board patient capacity assessment forms in all cases.	Agreed A reminder will be issued across the organisation regarding completion of DNACPR and Capacity Assessment forms.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!						31/03/22	25/03/2022

2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Clinical Executives	Low	R4 The All Wales DNACPR policy must be complied with in full without exception. We recommend that succinct but sufficient details of patient or relatives' discussions are recorded on the All Wales DNACPR forms in all casesin order to ensure that the policy is complied with.	Agreed Correspondence will be sent to clinicians outlining the importance of detailing discussions with relatives.	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R5 We recommend thatmanagement remind ward staff conducting capacity assessments of the need for competency in this area and that theyseek competency status from each relevant member of staff and if necessary ensure that relevant training is accessed and completed.	Agreed Correspondence will be issued to Divisions, for cascade, highlighting the training available.	30/11/2021	N/A	N/A	Overdue	4	#VALUE!						31/03/22	25/03/2022
2021.02	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent	31/10/2021	N/A	N/A	Overdue	5	#VALUE!						31/03/22	25/03/2022
2021.01	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	N/A	N/A	Overdue	5	#VALUE!						31/03/22	25/03/2022
2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Head of Legal Services	Low	R1 Management should update the policies and procedures available to staff on the intranet and ensure only those that are in date and reflect current practice are maintained.	Agreed.Outdated Policies will be removed & existing policies will be updated to reflect changes to WRP and portfolios.	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Director of Nursing	Medium	R2 Before payment is processed,clinical negligence cases which have damages in excess of £100k,mustprovide evidenceas having been approved by the LitigationGroup. Where payment needs to be made before the next Group meeting and the Group is unable to reconvene before this date, the Legal Services Team should issue an email to the members of the Group informing them payment will be made before the next meeting and any objections to this payment should be identified immediately. Additionally, the BACs payment sheet should be updated to include the date the case will be brought to the Litigation Group for retrospective approval. This should serve as one of the final checks prior to payment.	Agreed for immediate action	15/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R1 Divisions should provide assurance that actions arising from a complaint investigation areaddressed,with ongoing monitoring, depending on the significance of the action. Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The Assistant Director of Nursing will confirm this requirement with all Divisions and a process of audit will be introduced, led by the Corporate PTR Team, for assurance.	31/10/2021	N/A	N/A	Overdue	5	#VALUE!						31/03/22	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R2 Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The functionality of the new Datix system will be confirmed for all Divisions prior to implementation, together with the expectation that reports generated from Datix will be formally discussed in Divisional QPS meetings to monitor performance and learning.	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022

2021.05	Internal	Pathology	Reasonable	Director of Operations		Low	R1 The Pathology Team should consider updating the External inspection Policy to include one centralised repository for all external reportsthat incorporatetimescales for a responseand provides a clear overviewof progressacross all areas.	Will ensure reportsare maintained in a centralised repositoryand ensure the policyis updated accordingly	24/02/2022	N/A	N/A	Overdue	1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 a.All instances of non-conformance identified in the reports should be recorded centrally to support periodic trend analysisand in particular theCAPA module within QPulse.	a.Log UKAS inspection as one single CAPA within QPulse and update progress as per any other non-conformity	24/02/2022	N/A	N/A	Overdue	1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R3 Liaise with the ABUHB emergency planning team to go through their process for completion of all business continuity planningdocumentation.	Discipline Managers have been liaising with emergency planning team and will continue to do so.	24/02/2022	N/A	N/A	Overdue	1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R4 Establish aschedule for testing BCPsat all locationsand across a range of likely continuity events.	Will establish a schedule for testing across Pathology	24/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R5 The Pathology Team should seek to automate as much of the performance reporting as possibleand includeall test results within the KPIs.	Will horizon scan for new technologies to deliver automated TATs	24/02/2022	N/A	N/A	Overdue	1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R6 If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis appropriate.	If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis appropriate.	24/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R7 A scorecard/ dashboard reportshould be developedto provide an overview of performance against the key measures/ risks withinPathology.	Scorecard currently in progress and being populated	24/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Assistant Directorate Manager	Low	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2021	N/A	N/A	Overdue	13	#VALUE!						31/03/22	25/03/2022
2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R1 The Health Board should:a)Remind clinical staff of the need to promptly update the administration section of a patient's file.b)Consider the value and benefit derived from using the administration section versus the effort required to maintain the latest position.	a.Issue included on the agenda(item 11a) of the Occupational Health Senior Clinical and Administration team meeting held on the 20thOctober 2021.b.All membersof the occupational health team involved in the process have been communicated with on the 8thNovember 2021to improve management of this data set.c.A monthly report query will be introduced from the 1stDecember 2021 to capture any outstanding issues as an additional assurance layer.	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with external Project Manager	Medium	R1 The Project Execution Plan should be updated to reflect the current stage of the project / programme.	Agreed. Will liaise with the external Project Manager to issue an updated version.	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R2 To enhance current arrangements, the terms of reference for the Project Team and Project Board should be reviewed and updated accordingly to include: • Coverage of frequency of meetings; • Quoracy for decision making; • Requirement for delegated deputies to be in attendance when there are periods of absence; and • The correct membership (named as generic roles / departments) reflective of both the project named management and current stage of the project.	Agreed. The terms of reference are currently being reviewed and updated for the recommended points including reference to the current stage of the project and the expectations of ownership by the members of the Project Team / Project Board.	30/11/2021	N/A	N/A	Overdue	4	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with the Cost Adviser.	Medium	R3 The Cost Adviser reports should be updated to incorporate a summary cumulative position to better visualise the current financial position of the project	Agreed. Whilst there is additional information available to the project team to understand the current financial position, it would be helpful to have the 'snapshot' in the Cost Adviser report. Will liaise with the Cost Adviser to include within the reports.	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R5 Confirmation notice 1 should be finalised as soon as possible for both the Cost Adviser and Project Manager..	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Overdue	4	#VALUE!						31/03/22	25/03/2022

2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R6 Recognising that main construction works have commenced on site, Confirmation Notice 2 should be executed as soon as possible.	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Overdue	4	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R7 Agreed. Both recommendations are being addressed as a matter of urgency.	Agreed. Discussions will be held with all relevant parties to confirm the delay damages calculation, and agreed amount, to be included in Confirmation Notice 2.	30/11/2021	N/A	N/A	Overdue	4	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R9 The Project Director should advise the UHB Board of the actions taken to award the Enabling Works element of the contract and the non-compliance with the NHS Wales Investment Infrastructure Guidance.	Agreed. The issue was raised at Project Board and will be raised / discussed further in the first instance at the Strategic Capital and Estates Workstream. It should be noted that the demolition process was conducted via a separate contract and the provision of compensation event for the subsequent grouting was, and is considered, to be the correct approach. It is accepted that the Advance Works should have had a separate contract.	30/11/2021	N/A	N/A	Overdue	4	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R10 Post submission of KPIs, the Project Board should discuss the collective output [and trend of previous submissions] to ensure issues with performance are reviewed and addressed in an appropriate and timely manner.	Agreed. Collective discussions are now being held for the returns on all current projects. It would be preferred if these discussions were held prior to submission of returns to NWSSP:SES, but it is acknowledged this is not the expectation for collation of DfL data	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R11 The risk register should be reviewed to incorporate applicable costs; with the costs regularly reviewed to facilitate monitoring of the project.	Agreed. The initial project risk register informed the FBC contingency pot [September 2020]. Work is underway to complete a reconciliation for the current financial position to review how much of the contingency sum will be consumed with the correct projected overspend for the project. This will then be further analysed to cost the risks, as applicable, on a line-by-line basis.	31/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R12 The risk register should be updated to reflect the current risk regarding the financial position of the project, and the proposed mitigating actions / countermeasures.	Agreed. This risk, and any other new ones identified, will be included in the next risk register review scheduled with the external Project Manager.	30/11/2021	N/A	N/A	Overdue	4	#VALUE!						31/03/22	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	N/A	N/A	Overdue	9			November 2021 Update: Digital Delivery Board is now in place and divisional representation required. It will form part of the formal governance process. Updates will be provided from this Board to Exec Team.				31/03/22	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R2 A register of compliance requirements for all IM&T related legislation and standards across the whole organisation should be developed for the IGC along with a process for assessing status and reporting upwards to Committee.	Agreed. Currently the establishment, processes and mandate of informatics in ABUHB does not extend (with the exception of IG) beyond the directorate. In terms of accountability where devolved responsibility exists for information assets the same level of scrutiny and compliance should be applied. A corporate risk will be submitted with the recommendation of a strategic options appraisal for Board consideration and within this the role of Informatics as a Directorate will be considered along with other corporate and clinical divisions.	31/12/2021	N/A	N/A	Overdue	3			November 2021 Update: The Health Board has engaged Templar to review the Information Asset owners, compliance and current risk and this work will be taken forward with the Office of the SIRO to be established as part of the overarching objectives.				31/03/22	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R3 Management should consider enhancing the risk management process in place within the Health Board by providing an annual report that identifies risks that have a low likelihood, have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.	Accepted. Part of the new governance will focus on the objectives of the CDO as SIRO for the Health Board. Following the review and adoption of the Target Operating Framework and HB exec oversight a programme will commence to adopt new policies, training and performance management of ICT and Information Asset including training for Information Asset Owners.	31/03/2022	N/A	N/A	Overdue	**0**			November 2021 Update: The Templar Cyber risk report has been presented to the Digital Oversight Board and scheduled to go to Exec team and future board briefing and the to consider the implementation of the Office of the SIRO which will ensure that the strategic aims are				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	ADI Governance and Assurance	N/A	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: The release of the Corporate Risk Management Strategy will inform the final updated of the Informatics Directorate processes. The approach to the Clinical Assurance, including the risk approach, of the development and implementation of Informatics Services will be ratified at the January Digital Delivery Oversight Board (strategy and process). Risk categories pertinent to the work of the directorate have been agreed; the local risk management processes, aligned to the organisation strategy will be taken to the oversight board in January as well for approval. A directorate risk register has been				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics	31/03/2021	N/A	N/A	Overdue	**12**							31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of "Once for ABUHB" which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Exec Team Q1 and Board Q2 2021.	30/09/2021	N/A	N/A	Overdue	**6**			November 2021 Update: A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs.				31/03/22	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	N/A	N/A	Overdue	**9**			November 2021 Update: The establishment of a small PMO within Informatics, aligned to P3O Portfolio Management, has progressed in recent months with the permanent appointment of both a PMO Portfolio Analyst and PMO Support Officer. The appointment of an interim Head of PMO will further support the work being undertaken over the coming quarter to carry out a structured maturity assessment of current PPM capabilities within Informatics, to enable the development of a comprehensive roadmap and as a means of measuring the success of capability over time.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	N/A	N/A	Overdue	**6**			November 2021 Update: A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs. This includes the recommendation for Business partner roles to propogate a network of champions.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R10 The Informatics Directorate budget should be set to reflect the actual need of the organisation. Where funding cannot be fully granted, the impact on the underfunded position of Informatics work and Digital Strategy delivery should be clearly stated and agreed with Executives.	Agreed. The Portfolio approach and executive oversight governance will provide the framework in which difficult prioritisation decisions must be taken to avoid historical best endevours approaches. Part of the recommendations from the review of informatics in ABUHB is to establish a dedicated Digital Investment Panel which will provide performance management and oversight to investments in digital. The Health Board recognises the need to prioritise and invest in order to deliver benefits and supports the principle of a benefits management realisation framework and strategy. Budget setting is taking place for next financial year with the aim to agree a growth commensurate with strategic objectives. The Target Operating model is designed to ensure capacity and capability of Informatics is fit for purpose and is currently being costed to inform a case for consideration.	01/10/2021	N/A	N/A	Overdue	**6**			November 2021 Update: A final internal challenge session is scheduled for December within the Division to ensure capacity and capability meets the Health Board requirements and will be presented in January 22 to the Digital Delivery Oversight Board before returning to Exec Team.				31/03/22	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021	N/A	N/A	Overdue	**6**			November 2021 Update: The Informatics service is engaging iwith Health Education and Improvement Wales to further develop Health Informatics apprenticeship pathways from entry level. The service is actively engaged with HR &OD, Finance colleages to ensure the best route to recruitment and retention of staff. The TOF provides the resoure/skills gap that currently exists and the resource requirement to support it.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R12 Once the team has been re-established, the key security tasks should be in place:•regular review of firewall rules;•regular vulnerability testing; and•development of a security incident response plan.	Accepted. Active recruitment has been taking place with a Cyber Security Team leader successfully recruited. Emergency Planning colleagues have been collaborating with the cyber teamand the Health Board has contracted with specialist consultancy to accelerate the development of a Information Risk and Cyber Security operating model. Work will commence Q1 including cyber resilience and response plans.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: The Informatics service has engaged a specialist company, Templar to review the current Cyber arrangements and the specific Information Security requirements that need to be addressed. This report has been provided to the Exec Team and there will now be further engagement to ensure that the recommendations are addressed and the Target Operating Model with the Office of the SIRO established.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: A report commissioned by the Health Board has been presented at the Digital Delivery Oversight Board and accepted. A proposal on next steps will be presented with associated costs to Executive Team in Q3 2021.				31/03/22	

	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R1 The function and membershipsof the Statutory Compliance Group and Electrical Safety Sub-Group should be reviewed to ensure:a)Both groups meet with the required frequencies set out in their Terms of Reference; b)Responsibilities and memberships across the two groups meet the recommendations of WHTM 06-01;c)Anelectrical-specific Terms of Reference, or as a minimum, a standard agenda, is developed for the Electrical Safety Sub-Group and approved by the SCG;d)Awritten report be submittedby the ESSG to each SCG meeting, providing assurance on thekey areas of compliance required byHTM 03; ande)Minutes from all meetings should be retained for future reference, in line with the UHB's agreed document retention policy and WHTM/HTM requirements (O).	Agreed. The next meeting of the ESG has now been scheduled for 24th March 2021.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R3 a)An audit / recommendation tracker should be put in place, to monitor the status of compliance-related recommendations received.b)Progress should be monitored at the Electrical Safety Sub-Group (and other sub-groups as appropriate),and reported to the Statutory Compliance Group(O).	Agreed, an action tracker will be implemented. We recognise this may also facilitate funding allocations.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R6 Limitation of Access forms should be used where appropriate for work undertaken by the maintenance contractor (e.g. circuit breaker protection trip testing) (O).	Agreed. Appropriate documents will be in place from now onfor relevant works.	30/04/2021	N/A	N/A	Overdue	**11**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R2 The NWSSP: SES website should be periodically checked to ensure Works & Estates are in receipt of all relevant hazard notices(O).	Agreed, the website will be periodically checked from now on. The omission was not the fault of the UHB, and further we would normally expect input from NWSSP:SES to provide additional assurance in this area. Under normal circumstances, we would also monitor alerts for reporting to the Statutory Compliance Group / ESG (as discussed above).	30/04/2021	N/A	N/A	Overdue	**11**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R4 a)Operational Procedure and Operations & Maintenance files should be reviewed, with out of date documents archived and current documents filed, as required by HTM 06-03.b)Site/substation log books should be maintained in the format required by HTM 06-01 (section 8).c)Records of inspections / replacement of equipment for which the UHB is responsible for should be maintained in the HV files(O).	Agreed, we recognise the benefits of improved record keeping, to make current documents more accessible.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R5 The UHB's HV policy requirement for inclusion of specific wording on the Limitation of Access forms should be reviewed, and removed if no longer considered feasible / necessary (D).	Agreed. We have reviewed the policy and agree the reference will be removed.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R1 The UHB should have appropriate procedures in place to ensure that when determining the preferred supplier to inform the design, confirmation is received of willingness to participate in the subsequent procurement/market testingexercise (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Overdue	**10**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R2 Lessons learnt from the development of the design and equipment procurement exercise should be captured, either separately or as part of the formal post project evaluation (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Overdue	**10**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R5 The monthly Welsh Government dashboard reports should be submitted in accordance with expectation (O).	Agreed. The Welsh Government reports will continue to be submitted.	31/03/2021	N/A	N/A	Overdue	**12**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R6 An HDSU Project Board should be established to take through to completion / handover (as a minimum) (O)	Agreed. The GUH Project Board currently fulfils this function and alternative arrangements will be made after the April 2021 meeting.	30/04/2021	N/A	N/A	Overdue	**11**							31/03/22	

	Internal	Clinical Futures - Workforce (2020/21)	Substantial	Director of Workforce & OD		Medium	R1 The Health Board should reinstate the completion of the Action and Delivery Frameworks to assist in the delivery of the IMTP objectives.	It is acknowledged that the monitoring of the WOD IMTP Objectives and milestones changed during the pandemic. The WOD function is planning on introducing a revised internal monitoring process in line with the 2021 People Plan which will be aligned to the Health Board's approved Annual Plan.	31/01/2022	N/A	N/A	Overdue	**2**						31/03/22	
	Internal	Management of Balance Sheet Assets (2018/19)	Reasonable	Director of Finance, Procurement & Value	Head of Capital Finance	High	R1 The Health Board should introduce tagging / identity marking of all relevant assets.	Agree the Recommendation.For clarification, whilst capital assets are not tagged with the individual Fixed Asset Register number, a significant proportion of assets are tagged by other departments such as Medical Electronics and IT. Current processes involve the asset register being updated with serial numbers and the appropriate Medical Electronics reference, however, this information is not available for all historic assets.To improve the security of assets, and identification as part of the annual verification process, the Capital Team will, in consultation: Develop a policy for asset tagging which defines where tagging is appropriate; Investigate options for the purchase of an asset tagging system, considering existing systems in use in ABUHB and potential for linking to the Medical Electronics database and research the systems employed at other health boardsand trusts; Develop a business case and plan for the implementation of a preferred option in 2019/20 including outline specification, cost/benefits analysis, procurement options, funding requirements and resource implications.	31/03/2020	N/A	N/A	Overdue	**24**			November 2021 Update: Training sessions held, software integration issues remain - meeting to resolve to be held on 29th October 2021. Tagging on-going and full live roll out will be implemented once integration resolved.				31/03/22	
	Internal	Clinical Audit Follow-up (2018/19)	Limited	Medical Director		High	R1 1.1The Health Board should develop a Quality & Patient Safety Improvement Strategy and Assurance Framework, based upon a reviewofits approach to clinical audit and other QPS assurance mechanisms. This should incorporate an assurance mapping exercise against the organisation's quality and patient safety risk registers, focusing on major clinical risks.Such a Strategy and Framework should bring together the quality and patient safety improvement work undertaken throughout the Health Board, including clinical audit, ABCi, Value Based Healthcare, etc, and explicitly cover: the Health Board's approach to quality and patient safety improvement; how this work addresses the Health Board's major QPS risks; the governance and accountability structures within the organisation that support the delivery of the work; and the reporting mechanisms to bring this work together to form an overview of QPS improvement work and the assurance it provides to the organisation; how quality improvement activities comply with information governance legislation; and howservice users are involved and engaged in quality improvement activity.The Strategy and Framework should either make reference to, or incorporate, the existing strategies for individual elements of quality and patient safety improvement work ongoing throughout the Health	A Quality Improvement Leaders Group will be set up, with the leaders of ABCi, Value based healthcare, clinical audit and R and D and innovation,toseek todevelop a new way of usingclinical information for improvement and from this, a Quality and Patient Safety Improvement Strategy and Assurance Framework. It will incoprrporate a review of known clinical risks and those on the patient safety risk registers, focussing on major clinical risks.From this, the Executive Team will assess the level of clinical audit required by the organisation and the resource needed to support this,in order to undertake the Health Board wide audit above and beyond the NCAORP,ensuring that the clinical audit activity is effective in bringing about improvement.The Medical Education Team will be charged with randomly selecting 100 non-identifiable Consultant re-validationquality improvement domains, to identify the volume and subject of the audit activity in a year. This will be mapped against the broad areas where clinical risk has been identified, not withstanding large scale work undertaken via other QPS improvement mechanisms.	31/03/2020	N/A	N/A	Overdue	**24**			November 2021 Update: The clincal audit policy and strategy are currently being reviewed and updated to reflect a more targeted approach to local and corporate audit designed to provide assurance around quality and safety priorities.				31/03/22	

	Internal	Clinical Audit Follow-up (2018/19)	Limited	Medical Director		High	R2 The Health Board is required to participate in a certain level of clinical audit, as noted in section 6. Therefore, it is necessary to have appropriate governance and reporting structures in place to support this. We have set out our recommendations to improve the current structuresfor national and Health Board wide clinical auditbelow.2.1The Clinical Audit Strategy and Policy should be updated to incorporate the recommendations of this review. The QPSC should formally approve the Clinical Audit Strategy and Policy. 2.2The MDST should ensure that relevantstaff are aware of, and adhere to, the requirements of the Strategy and Policy.2.3The MDST should bring together the top twotiers of the clinical audit plan (nationalandHealth Board wide) into one document, 'the Clinical Audit Programme'. TheClinicalAudit Programme should explicitly state which QPS risks it addresses and should be formally approved by the QPSC.2.4Governance mechanisms should be sufficient for the QPSC to regularly monitor delivery of the Clinical Audit Programme. This could be in the form of anoverall summary within the QPSreport that is currently written and presented by the Assistant Director of QPS. The summarycould be in a narrative or dashboard style. .2.5There should be a clearly defined and documented mechanism for the dissemination of results and recommendations throughout the Health Board and the escalation of significant findings to the appropriate forums. Escalation of results could be done via the	2.1-2.6.The Clinical Audit Strategy and Policy will be updated to include the outputs from the recommendations from this review once the process has been completed. This will be approved at Exec Board and QPSC and communicated across the organisation, through dissemination to the Clinical Directors.The MDST will bring together the NCA and health board wide audit into a clinical auditforimprovement programme, through discussion at QPS Operational Group. It will be approved at QPSC.Set up a Clinical Effectiveness and Standards Group('CESG'), chaired by the AMD for Clinical Effectiveness and with ADD representation from all Divisions, which will monitor the delivery of the Clinical Audit for Improvement Programme and monitor the implementation of recommendations. It will receive the results of the NCAs and Health Board Audits and determine which require escalation and reporting to QPSC.2.7. The MDST wil develop over a number of meetings, a report on participation in NCAs within the Quality Performance Report for QPSC.2.8.One to one supporton clinical auditis always available to staffthrough the MDST. The training resources available will be clarified on the Clinical Audit Intranet	31/03/2020	N/A	N/A	Overdue	**24**			November 2021: The Health Board participates in the National clincal audit and outcome review programme and is currently reviewing resources and registration arrangements to ensure participation in all audits.				31/03/22	
	Internal		Limited	Medical Director		High	R3 The Clinical Audit Policy states that the Divisional Directors"are responsible for maintaining the overview of local clinical audits within the Directorates, to ensure they complywith the Policy". However, there is no mechanism for holding the divisions to account in this process. We have set out our recommendations to ensure appropriate accountability in the divisional clinical audit process below.3.1The divisions should produce anannual workplan of assurance against their major clinical risks, including, but not limited to, clinical audit.3.2The divisions should provide a clinicalassurance report to each QPSOG meeting, detailing the assurance work undertaken against the annual workplan. The reports should also highlight any significant issues arising from the assurance workand detail the action being taken to address these	3.1-3.3.Whilst the Divisions willproduce andpresent annual workplans of assurance against their major clinical risks, and significant issues arising from the work plan,alignment of these risks to clinical audit for improvement will be highlighted within the work plans.These will be presented to the CESG, and this will be summarised in an annual over view of Clinical audit to QPSC every Septemberfrom 2020.3.4 The clinical audit registration form and checklist will be updated and be available on the Clinical Audit intranet site.	31/03/2020	N/A	N/A	Overdue	**24**			November 2021: A procurement exercise has commenced to purchase a digitial platform to manage clincal audits and actions plans.this will provide oversight of all audits at directorate divisional and health board level and dashboards to support monitoring of perfromance and actions				31/03/22	
	Internal	Well-being of Future Generations (Wales) Act 2015 (2018/19)	Reasonable	Medical Director		High	R1 The Wellbeing of Future Generations Act Programme Boardshould include a review of the objectives and the progress against them as part of itsagenda, to ensure objectives are fit for purpose and the activities required to meet them are identified and monitored. 2) EachProgramme Board should be chaired by the Executive Lead in order to provide leadership, monitor effectivenessand highlight the importance of attendance. 3) Poor attendance at the Programme Board should be taken forward by the Executive Lead in order to ensure that it is rectified.	Agreed1.Thereview of the Wellbeing Objectiveswill be undertaken in conjunction with a broader review of where these objectives sit in the context of other Organisational priorities and ambitions. A landscape review/mapping of these various aspects will need to be undertaken in conjunction with the ABUHB Planning Teamtoinform the review of Well-being Objectivesas part of the IMTP process.The Programme board will include a review of progress against objectives as part of its agenda. 2.Programme Board meetings will be moved from a monthly to a quarterly basis and will be chaired by the Executive Director of Public Health and Strategic Partnerships. This will be supported bysub-Board meetings.3.The Executive Director of Public Health and Strategic	31/12/2019	N/A	N/A	Overdue	**27**			November 2021 Update: the review of the Wellbeing objectives has been put on hold due to the prioritisation of the response to the Covid-19 pandemic'				31/03/22	

	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: how service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	N/A	N/A	Overdue	**47**			November 2021 Update: the position has not changed since the last update in August 2021, however, a meeting is planned with colleagues in the Facilities Division this month to work collaboratively to develop a health and safety monitoring programme. The programme will include H&S management audits, thematic audits and 'walk the ward' inspections. The roll out of the new programme is planned for April 2022. In addition to this we are also planning the development of self-assessment inspection tools for wards and departments to be conducting their own health and safety monitoring. Finally, there is evidence that				31/03/22	
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	N/A	N/A	Overdue	**47**			August 2021: Due continued demands and impact from the pandemic within the Corporate Health and Safety Department the programme of health and safety monitoring has not re-started. However, monitoring has been conducted relating to COVID Safety				31/03/22	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	N/A	N/A	Overdue	**48**			November 2021 Update: Radio frequency ID tagging has commenced for all medical devices and will progress over the next 12 months. This will support the management and localtion of all devices including servicing history. Thetares are developing a register of all medical devices.				31/03/22	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	N/A	N/A	Overdue	**48**			November 2021 Update: Options are being explored to record compliance on ESR. A more sustainable approach to infusion device training is being explored with the practice educators currently taking a lead and a more measured approach to reassessment for regular users being				31/03/22	

	Internal	Pay Incentives (2019/20)	Limited	Director of Workforce & OD		High	R1 The Health Board should restrict additional session payments to standard levels, but where this is not possible; maintain an approved schedule of enhanced rates ratified by the Executive Team with appropriate justification / reasoning included. The schedule of enhanced rates should be reviewed frequently e.g. every three months.	Approval to continue paying WLI rates from Executive Team – taken forward to RATS Committee. Review as part of IMTP demand and capacity discussions each year.	30/09/2019	N/A	N/A	Overdue	**30**			November 2021 Update: Rate card has been revised and drafted across all divisions and will be shared and signed off by the Divisonal Director's with a view to sign of at Execs for the end of November, with the agreement of the MD				31/03/22	
	Internal	Pay Incentives (2019/20)	Limited	Director of Workforce & OD		High	R2 In relation to the non-automated process only, consultants should submit signed claim forms for all additional sessions they are claiming payment for, listing appropriate details in respect of session dates, start/ finish times etc. and including a declaration that all sessions claimed are in addition to contracted work. The submitted claim form should be reviewed, validated and checked for accuracy before any payment is made.	Agreed. Executive Team will agree the approved system for claiming for all additional sessions and communicate with the Health Board. This must simplify the process for claiming to maximise compliance.	30/09/2019	N/A	N/A	Overdue	**30**			November 2021 Update: General Managers for Family & Therapies, Medicine and Scheduled Care have all confirmed this process is in place. Scheduled Care noted Radiology email once additional sessions are completed and is checked against activity before being signed off by the DM.				31/03/22	

ABUHB	Audit	Report Title	Assurance	Director	Responsible	Ref /	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of	If closed	Progress being made to implement recommendation				Reporting	Date Added to
	External	Structured Assessment 2019	Not Rated	Board Secretary		Not rated	R2 There is scope to improve the quality of the corporate risks register (CRR). The Health Board should review the CRR by the end of March 2020 to ensure it clearly articulates cause and effect, reduces overlap between controls and mitigating actions, specifies controls such as policies and procedures, aligns assurances to controls, indicates whether mitigating action is effective and includes timescales to monitor progress.	The Health Board is in the process of reviewing our Risk Management Strategy, in readiness for approval by the Board in March 2020. 'Risk on a Page' has been introduced and is being further refined to ensure clear links with the IMTP priorities and	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021
	External	Structured Assessment 2019	Not Rated	Director of Planning, Performance, Digital & IT		Not rated	R3 Board updates on Clinical Futures do not include information on whether planned actions/mitigation are effective, and it is unclear whether risks no longer reported have been eliminated. The Health Board should include information on the effectiveness of risk mitigation in its board updates.	This will be added to future reports.	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021 - As the Health Board moves into the recovery phase of the pandemic, it should consider how progress on the Clinical
	External	Structured Assessment 2019	Not Rated			Not rated	R4 The recent report to the Finance and Performance (F&P) Committee on progress against the IMTP SCPs did not include progress against the relevant high-impact priorities aligned to them. The Health Board should ensure that committee reports on SCP progress clearly link relevant high-impact priorities with the achievements set out.	Reports have been made on SCPs to Finance and Performance Committee and the Board. This will be regularised in 2020 through the committee and Board forward work programme.	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021 - The Health Board is developing a monitoring and outcomes framework that will enable the Board to monitor, scrutinise and challenge
	External	Structured Assessment 2017	Not Rated	Director of Finance, Procuement and Value		High	R1 The Health Board should provide more detail to Executives and Independent Members in respect of progress against savings schemes. This should help them to provide sufficient scrutiny and challenge to schemes which are off target.	Current reporting to Board and Finance and Performance Committee (F&PC) provides a summary of savings plans, risk and deliverability. We will look at how to enhance the reporting to ensure that the level of delivery/financial risks is clearly understood both at Board level and where further scrutiny is required at F&PC. This is in addition to the detailed information which is already produced monthly to support Divisional financial assurance meetings	30/04/2018	N/A	N/A	Overdue	**47**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021 - Finance reports provide an overview of Health Board savings progress to date and performance of its high level 'green' savings schemes.
	External	Structured Assessment 2017	Not Rated	Board Secretary	Head of Risk	High	R3 The Health Board should review risk management arrangements to ensure that corporate risks are appropriately escalated and managed by: a. developing upon its current risk reports to ensure that the context of the risk and progress in managing it are clearly set out; and b. revising the risk rating based on the mitigating actions.	The Health Board undertook a range of revision work to its approach to corporate risk management in 2017 prior to the conclusion of the Structured Assessment with additional training provided for the Board and Executive Team. New reporting formats adopted. The Board is in the process of further developing its approach and will introduce a documented risk and assurance framework following development work planned in line with the risk of non¬delivery of the IMTP.	30/05/2018	N/A	N/A	Overdue	**46**							31/03/22	Identified as outstanding in Structured Assessment 2022 - The Health Board has reviewed its risk management arrangements and is currently introducing a new approach for
	External	Structured Assessment 2017	Not Rated			High	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	N/A	N/A	Overdue	**44**							31/03/22	Identified as outstanding in Structured Assessment 2022 - With the merger of the communications and engagement functions, the Health Board, will review and refresh both the

	External	Structured Assessment 2017	Not Rated	Director of Planning, Performance, Digital & IT		High	R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Boards plans	A Strategic Outline Plan was developed for the Welsh Government in October 2016, which asked for a cost analysis to implement the Welsh Government E-Health and Care Strategy to assess the potential resource implications for Wales. The Health Board is currently revisiting the Strategic Outline Plan and Strategy in the light of the financial context and has also developed a new IMTP for Digital with ten priority areas linked to this Plan. The Health Board has undertaken a review and benchmarking exercise in order to	31/03/2019	N/A	N/A	Overdue	**36**							31/03/22	Identified as outstanding in Structured Assessment 2022 - There has continued to be increased investment in informatics both in terms of capital and revenue to help progress the
	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R4 The Health Board should address areas for improvement in relation to informatics, specifically updating ICT disaster recovery plans and test these to ensure they worked as intended.	key appointments have now been made against a number of positions relating to cyber security. Work is being completed on key personnel polices plans and underlying services. Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team.	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!							31/03/22	Identified as outstanding in Structured Assessment 2022 - progress made but not complete
	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R3 The Health Board should improve its information governance arrangements by: • improving compliance with the information governance training programme to reach the national rate of 95%;	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020	N/A	N/A	Overdue	**25**	#VALUE!		November 2021 Update: IGDG meetings will now include Cyber respresentation to ensure a comprehensive coverage of Governance across the organisation. The meetings have been sporadic due to COVID and winter pressures. IG have plans in place to target specific areas of non-compliance service areas. This work will commence at the beginning of 2022 due to winter pressures. Compliance has increased to 78% and the team are working towards achieving the 85% compliance which is mandated in the Information Governance Toolkit.		Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non-complance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		31/03/22	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress against achieving the national rate of 85% with compliance for the organisation currently reported at 74%

	External	Structured Assessment 2018	Not Rated	Board Secretary		High	R1 The Health Board should: • ensure board member induction and training meets the needs of Independent Members;	The Health Board has already introduced a new Induction and training programme for 2018/2019. Several elements of this have been completed. The programme will be completed during 2019. The Health Board is also participating in the redesign of the national NHS Wales Induction Programme.	31/12/2019	N/A	N/A	Overdue	**27**						31/03/22	Identified as outstanding in Structured Assessment 2022 - The Health Board does not have local induction arrangements for Independent Members.
202102	External	Radiology services: follow-up of 2017 recommendations	Not Rated	Director of Operations	Radiology Directorate Manager	Not rated	R4 The Health Board should look to further develop its collection of patient experience information across its sites and seek to identify any common trends that can be actioned to improve the service. Follow up 2021 - Whilst the Health Board has made positive progress against this recommendation, we feel unable to close this recommendation until the Health Board has implemented the site-specific PREM and reintroduced the comments box. In terms of learning, it would be helpful for the Health Board to identify how learning from patient feedback has made a difference and led to improvements.	TBC	31/03/2018	N/A	N/A	Overdue	**48**						31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		High	The HealthBoard should hold workshops with Audit Wales to discuss what information is required to provide assurance for the audit, and what are the best ways of obtaining this.	A workshop will be arranged with Audit Wales in January 2022 to ascertain the information required in order to substantively test payroll transactions. Relevant Health Board employees will be invited to attend this workshop to ensure that going forward information is provided in the format required and on a timely basis.	31/01/2022	N/A	N/A	Overdue	**2**						31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Planning, Performance, Digital & IT		Medium	The HealthBoard should consider strengtheningtheirIT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Wellsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the	31/12/2021	N/A	N/A	Overdue	**3**						31/03/22	25/03/2022

ABUHB	Audit	Report Title	Assurance	Director	Responsible	Ref /	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of	If closed	Progress being made to implement recommendation				Reporting	Date Added to
2021.04	Internal	Charitable Funds	Substantial	Director of Finance	Charitable Funds Manager	Medium	R1 The Health Board should:a)Engage with ward staff via alternative mediums, e.g.,Teams presentations, presentations to Divisional Management Team meetings.b)Establish a timeframe for restarting ward visits and training sessions.c)Continue to promote the Charitable Funds Financial Control Procedure.	a.Agreed. Presentations to be prepared by December 2021 with roll out to commence in the new year with a view to completing by March 2022, confirming suitable dates with the divisions. b.Agreed. Face to face meetings will be dependent on advice from Infection Prevention and Controlbut meetings will be arranged by Teams liaising with relevant ward staff to arrange meetings prior to March 2022.c.Agreed. There will be follow up e-mails by the Charitable Funds Team to a and b above providingthis information.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMBfor an integrated electronic process cannot be delivered.The Health Boardshouldcarryout an analysis to fully identifyits needsfor a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	High	R3 Whilst we understand the Health Board isin the process of planning to upgrade to the 2016 version we highly recommend that the Health Board expeditesthe upgrade.	This upgrade took place on 14thNovember however only application server was upgraded. DHCW and ABUHB are working closely to plan the rest of the upgrade. However DHCW will not touch the RadIS local database which stores all of our crystal reports and letters. This is a risk and we havegone to our server team internally to plan anbackupsolutionfor the RadIS local database.	30/04/2022	N/A	N/A	Not yet due	**-1**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R4 The Health Board should seek clarity over what maintenance tasksare expected and establish a process to ensure that these are completed.	There is a backupregimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R5 a.The Board should investigate an electronic solution to uploading requestsinto WRIS.b.The Board should introduce a completeness check to ensure that all requestsreceived have been entered into WRIS.	a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	N/A	N/A	Not yet due	**-1**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R8 The Health Boardshould request that this logging function be developed.The Health Board shouldconsider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	N/A	N/A	Not yet due	**-1**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022	N/A	N/A	Not yet due	**-1**	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 b Periodic trend analysis / pattern identification should be completed across all instances of non-conformanceand used to identify common areas of concern for corrective/preventiveaction.	.Try to identify themes and trends across Pathology, though inspections are held at different times of the year for each discipline so not as straightforward.	Ongoing	N/A	N/A	Not yet due	**#VALUE!**	#VALUE!						31/03/22	25/03/2022

2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R2 The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately.b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1stNovember and is planned to conclude on March 31st2022. Health function. A detailed service review is	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R8 Noting that no action can be taken at this project, management should ensure that the requirements of the NHS Wales Investment Infrastructure Guidance are applied at all future projects with regard to Enabling Works and Advanced Works.	Agreed. NHS Wales Investment Infrastructure Guidance will be followed on all future projects.	At future projects	N/A	N/A	Not yet due	**#VALUE!**	#VALUE!						31/03/22	25/03/2022
2021.09	Internal	GUH: Technical Assurance	Substantial	Director of Planning, Digital & IT	Estates Manager	Low	Management should ensure the ability to utilise “as fitted” water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Agreed. A capital bid has been submitted by the division to (a) employ full time CAD staff to keep records up to date and (b) to have access to the third-party software.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD		High	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	N/A	N/A	Not yet due	**-1**							31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Board Secretary	Head of Corporate Governance	Medium	The draft Annual Reportand Annual Governance Statement should be subject to a Quality Assurance review to ensure compliance with the Manual for Accounts, with evidence of this review submittedfor auditas part of the supporting working papers.	A checklist will be prepared to identify each area within the Manual for Accounts and link to the relevant part of the Annual Report and Annual Governance Statement. This checklist will be submitted to Audit Wales with the draft documents to facilitate review.	31/05/2022	N/A	N/A	Not yet due	**-2**							31/03/22	25/03/2022

202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		Low	The new asset tagging system should be implemented as soon as possible, and in readiness for the audit of the 2021-22 financial statements.	The interface between the Fixed Asset Register (Asset 4000) and the new RFID system is complete. The team are working through final issues identified on the user testing of the interface between the EBME equipment register and the RFID system during November 2021, with a view to going live with the system by the end of the month. The user training sessions have taken place. The tagging of new and existing equipment assets has commenced with around 1400 assets tagged to date. The programme of tagging of existing assets will run into the 2022/23 financial year due to the volume of assets and current capacity of staff. However, the finance team are progressing a fixed term appointment to support the delivery of this work over the next year.	31/03/2023	N/A	N/A	Not yet due	**-12**							31/03/22	25/03/2022
202103	External	Audit of Accounts Report – ABUHB Charitable Fund and Other Related Charities (Dec 2021)	Not Rated	Director of Finance, Procurement & Value		Medium	FCPs not being updated to reflect the changing profile of the investment portfolio. In addition, the Charitable Fund should consider having clearer procedures regarding the classification of income.	The Charitable Funds financial control procedure is reviewed on a 3-year rolling basis and is due for review in July 2022. Going forward, additional reviews will be carried out on an annual basis to ensure that the procedure remains relevant and that no significant changes have occurred since the last review.For clarity, the income section (section 9 of the current financial control procedure) will be enhanced to include a more detailed section on the types of income received by the Charity and how the classification is determined, eg grant, donation, legacy etc. and the documentation required to be obtained/retained to verify this classification.	31/07/2022	N/A	N/A	Not yet due	**-4**							31/03/22	25/03/2022
202104	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		Not rated	R1 NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	Occupational Health are piloting an Occupational Therapy Service until the end of March 2022 to support staff with post covid syndrome. The work has been supported and funded by the Post COVID Recovery Service and work is ongoing to formalise the service pathway to ensure equitable provision for the whole workforce. A review of this pilot will be conducted in March to identify whether there is scope to expand this service to support our workforce with other underlying ill health conditions.	31/03/2022	N/A	N/A	Not yet due	**0**							31/03/22	25/03/2022
202104	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		Not rated	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called "#PeopleFirst, #CynnalCynefin, reconnecting our workforce". The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-executive support.	31/12/2022	N/A	N/A	Not yet due	**-9**							31/03/22	25/03/2022

202105	External	Structured Assessment 2021	Not Rated	Director of Planning, Performance, Digital & IT	Associate Director of Communications and Engagement	Not rated	R1 The Health Board's website contains some outdated information relating to its governance arrangements and incomplete performance data which is not supported by appropriate explanatory information. The Health Board, therefore, should take immediate action to ensure: • Content is well-organised, easy to navigate, clear and concise, and • Key information / data is up-to-date and in a format that the public and stakeholders can interpret and understand.	The Health Board accepts this recommendation. The website is in the process of being reviewed and updated to reflect suggestions made including, ensuring all fundamental Health Board information (related to Board, Committees, and governance arrangements) is accurate and up to date for the public and stakeholders. Further developmental work will be required to ensure Divisional engagement around local pages on the website are kept up to date with useful and meaningful information. However, it should be acknowledged that the resource required in order to conduct such a substantial review is not inconsequential.	31/03/2023	N/A	N/A	Not yet due	**-12**							31/03/22	25/03/2022
202105	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R2 Some Board members have expressed concerns about the volume of work now undertaken by some of the committees and the robustness of the arrangements for ensuring flows of assurance. The Health Board, therefore, should complete its review of the new governance structure by its intended deadline of April 2022 to be assured that it is operating as intended.	The Health Board accepts this recommendation. A complete and robust Committee and Board effectiveness exercise will be undertaken by April 2022. The Health Board accepts this recommendation. A complete and robust Committee and Board effectiveness exercise will be undertaken by April 2022.	30/04/2022	N/A	N/A	Not yet due	**-1**							31/03/22	25/03/2022
202105	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R3 Recent staff turnover within the Corporate Governance Support Team has impacted on the quality of service it is able to provide to the Board and its Committees. The Health Board, therefore, should review the effectiveness of its Corporate Governance Support Team as soon as possible to ensure that it has sufficient resilience and capacity to support all governance functions. Arrangements should also be put in place to ensure staff are able to access suitable training / learning opportunities to develop their knowledge and skills within their respective roles.	The Health Board accepts this recommendation. The Health Board will undertake a review and endeavour to ensure adequate and appropriate corporate governance capacity to fulfil the statutory functions of the Board and the Committees, enabling it to discharge its functions. It should be noted that external training in specific corporate governance, information governance and accredited risk management has been undertaken over the last two years, despite the pressures of the pandemic. This demonstrates the Health Board's commitment to develop and enhance skills within its governance team. However, it is also recognised that further mentorship and training programmes could be developed in order to 'future proof' the department and provide a robust corporate governance function.	30/09/2022	N/A	N/A	Not yet due	**-6**							31/03/22	25/03/2022

202105	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R4 The Health Board has experienced significant changes in its Executive Team and cadre of Independent Members resulting in several interim Executive Director appointments and is currently recruiting to two independent member vacancies. However, maintaining these temporary arrangements indefinitely alongside the turnover of Independent Members present risks at a time of significant operational pressures. The Health Board, therefore, should seek to make permanent appointments to these key Executive Director roles at the earliest possible opportunity. In addition, there remains a need for the Health Board to strengthen its induction and training for new Independent Members in line with our recommendation in 2019	The Health Board accepts this recommendation. Independent Members Interviews have now been undertaken for Independent Members for Finance and Digital and the recruitment process for this continues to progress. Continued liaison with the Public Appointments Team to progress the substantive recruitment of the Vice Chair and an Independent Member for Community is anticipated to progress from February 2022. Executive Team: Chief Executive Officer (CEO) – interim arrangement to be continued during 2022. Director of Primary Care, Community & Mental Health – recruitment in process. Director of Finance & Procurement – interim appointment to be extended in line with Interim CEO arrangement. Deputy CEO – interim appointment to be continued in line with Interim CEO arrangement. Interim Director of Operations – current interim appointment until April 2022. Recruitment	30/04/2022	N/A	N/A	Not yet due	**-1**							31/03/22	25/03/2022
202105	External	Structured Assessment 2021	Not Rated			High	R5 The Health Board has not finalised its monitoring framework due to the pandemic, subsequently there continues to be limited oversight and scrutiny at Board-level on overall delivery against priorities outlined in the 2021/22 Annual Plan. The Health Board, therefore, should complete the development of its monitoring framework as soon as possible to allow the Board to review and if necessary, challenge delivery of its strategic priorities and progress against the Annual Plan and future Integrated Medium-Term Plans.	The Health Board accepts this recommendation. The delivery framework of the 3 year IMTP process did include a quarterly monitoring report structure which has not been completed this year against the annual plan due to the challenges of the Health Board's response to the pandemic and other priorities. The shared objective of developing a comprehensive outcomes based framework for the organisation is a developmental one and progress has been limited in this area due to the challenges associated with the pandemic, a change in leadership of the performance function (due to the Exec team changes referenced in the report) and due to Welsh Government developing an All Wales outcomes framework that would enable the Health Board to align a local framework to. The Health Board will therefore develop the first iteration of an outcomes framework for 2022/23 to support the 3 year IMTP and align to the Welsh Government framework. The	30/06/2022	N/A	N/A	Not yet due	**-3**							31/03/22	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan	31/12/2022	N/A	N/A	Not yet due	**-9**			November 2021 Update: This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R7 At future projects:Contract documentation should be signed in a timely manner, prior to the commencement of works.	Agreed. The importance of a quick turnaround of contract documents has been relayed to the various project SCPs, PMs and ABUHB corporate services.	31/03/2023	N/A	N/A	Not yet due	**-12**							31/03/22	

ABUHB Ref. No.	Audit Type	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	No. of months past original agreed deadline	No. of months past Agreed Revised deadline	If closed and not complete, please provide justification and ensure	Progress being made to implement recommendation				Reporting Date	Date Added to Tracker
																Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?		
	External	Structured Assessment 2019	Not Rated	Board Secretary		Not rated	R2 There is scope to improve the quality of the corporate risks register (CRR). The Health Board should review the CRR by the end of March 2020 to ensure it clearly articulates cause and effect, reduces overlap between controls and mitigating actions, specifies controls such as policies and procedures, aligns assurances to controls, indicates whether mitigating action is effective and includes timescales to monitor progress.	The Health Board is in the process of reviewing our Risk Management Strategy, in readiness for approval by the Board in March 2020. 'Risk on a Page' has been introduced and is being further refined to ensure clear links with the IMTP priorities and	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021
	External	Structured Assessment 2019	Not Rated	Director of Planning, Performance, Digital & IT		Not rated	R3 Board updates on Clinical Futures do not include information on whether planned actions/mitigation are effective, and it is unclear whether risks no longer reported have been eliminated. The Health Board should include information on the effectiveness of risk mitigation in its board updates.	This will be added to future reports.	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021 - As the Health Board moves into the recovery phase of the pandemic, it should consider how progress on the Clinical
	External	Structured Assessment 2019	Not Rated			Not rated	R4 The recent report to the Finance and Performance (F&P) Committee on progress against the IMTP SCPs did not include progress against the relevant high-impact priorities aligned to them. The Health Board should ensure that committee reports on SCP progress clearly link relevant high-impact priorities with the achievements set out.	Reports have been made on SCPs to Finance and Performance Committee and the Board. This will be regularised in 2020 through the committee and Board forward work programme.	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021 - The Health Board is developing a monitoring and outcomes framework that will enable the Board to monitor, scrutinise and challenge
	External	Structured Assessment 2017	Not Rated	Director of Finance, Procuement and Value		High	R1 The Health Board should provide more detail to Executives and Independent Members in respect of progress against savings schemes. This should help them to provide sufficient scrutiny and challenge to schemes which are off target.	Current reporting to Board and Finance and Performance Committee (F&PC) provides a summary of savings plans, risk and deliverability. We will look at how to enhance the reporting to ensure that the level of delivery/financial risks is clearly understood both at Board level and where further scrutiny is required at F&PC. This is in addition to the detailed information which is already produced monthly to support Divisional financial assurance meetings	30/04/2018	N/A	N/A	Overdue	**47**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2021 - Finance reports provide an overview of Health Board savings progress to date and performance of its high level 'green' savings schemes.
	External	Structured Assessment 2017	Not Rated	Board Secretary	Head of Risk	High	R3 The Health Board should review risk management arrangements to ensure that corporate risks are appropriately escalated and managed by: a. developing upon its current risk reports to ensure that the context of the risk and progress in managing it are clearly set out; and b. revising the risk rating based on the mitigating actions.	The Health Board undertook a range of revision work to its approach to corporate risk management in 2017 prior to the conclusion of the Structured Assessment with additional training provided for the Board and Executive Team. New reporting formats adopted. The Board is in the process of further developing its approach and will introduce a documented risk and assurance framework following development work planned in line with the risk of non-delivery of the IMTP.	30/05/2018	N/A	N/A	Overdue	**46**							31/03/22	Identified as outstanding in Structured Assessment 2022 - The Health Board has reviewed its risk management arrangements and is currently introducing a new approach for escalating risks

	External	Structured Assessment 2017	Not Rated			High	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	N/A	N/A	Overdue	**44**							31/03/22	Identified as outstanding in Structured Assessment 2022 - With the merger of the communications and engagement functions, the Health Board, will review and refresh both the
	External	Structured Assessment 2017	Not Rated	Director of Planning, Performance, Digital & IT		High	R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Boards plans	A Strategic Outline Plan was developed for the Welsh Government in October 2016, which asked for a cost analysis to implement the Welsh Government E-Health and Care Strategy to assess the potential resource implications for Wales. The Health Board is currently revisiting the Strategic Outline Plan and Strategy in the light of the financial context and has also developed a new IMTP for Digital with ten priority areas linked to this Plan. The Health Board has undertaken a review and benchmarking exercise in order to	31/03/2019	N/A	N/A	Overdue	**36**							31/03/22	Identified as outstanding in Structured Assessment 2022 - There has continued to be increased investment in informatics both in terms of capital and revenue to help progress the
	Internal	IT Service Management, May 2018	Limited	Director of Planning, Digital & IT	Associate Director of Informatics	High	R3 Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	AcceptedWe recognise that this is a priority and that Service Point does not meet the needs of the service to develop the KCS (also identified by this audit) and therefore, Informatics will undertake a scoping and options appraisal exercise to define the requirements, including the resource needed.A business case has been developed for ICT only that seeks to address the concernswithin ICT; this work will inform the requirements of a similar review for Informatics.	31/10/2018	Feb-22	Jan-19	Overdue	**41**	2		November 2021 Update: Existing knowledge artefacts have been migrated to share point online and are fully searchable and available across Informatics teams. A review of information architecture is underway which will further consolidate knowledge and categorise by service facilitating a KCS approach. For Service Desk Knowledge, this will be complete by end of Feb 2022 in readiness for our Service Desk Institute Accreditation Audit.			Implement revised information architecture Define and Implement governance around permissions, review timescales and formats for new artefacts Establish links to service catalogue Ensure criteria for SDI Audit are met	31/03/22	
	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R4 The Health Board should address areas for improvement in relation to informatics, specifically updating ICT disaster recovery plans and test these to ensure they worked as intended.	key appointments have now been made against a number of positions relating to cyber security. Work is being completed on key personnel polices plans and underlying services. Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team.	31/03/2020	N/A	N/A	Overdue	**24**	#VALUE!						31/03/22	Identified as outstanding in Structured Assessment 2022 - progress made but not complete

	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R3 The Health Board should improve its information governance arrangements by: • improving compliance with the information governance training programme to reach the national rate of 95%;	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020	N/A	N/A	Overdue	**25**	#VALUE!		November 2021 Update: IGDG meetings will now include Cyber respresentation to ensure a comprehensive coverage of Governance across the organisation. The meetings have been sporadic due to COVID and winter pressures. IG have plans in place to target specific areas of non-compliance service areas. This work will commence at the beginning of 2022 due to winter pressures. Compliance has increased to 78% and the team are working towards achieving the 85% compliance which is mandated in the Information Governance Toolkit.		Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non-complance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		31/03/22	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress against achieving the national rate of 85% with compliance for the organisation currently reported at 74%
	External	Structured Assessment 2018	Not Rated	Board Secretary		High	R1 The Health Board should: • ensure board member induction and training meets the needs of Independent Members;	The Health Board has already introduced a new Induction and training programme for 2018/2019. Several elements of this have been completed. The programme will be completed during 2019. The Health Board is also participating in the redesign of the national NHS Wales Induction Programme.	31/12/2019	N/A	N/A	Overdue	**27**								31/03/22	Identified as outstanding in Structured Assessment 2022 - The Health Board does not have local induction arrangements for Independent Members.

	Internal	Job Planning, March 2020	Limited	Medical Director	Interim Director of Operations	High	R1 The Health Board should: · review the escalation process to ensure that it includes appropriate action following escalation to the Medical Director and holds medical staff to account for failure to have an in date job plan; · produce action plans to address poor compliance and review these as part of the monthly divisional meetings with the COO; · complete job plans on an annual basis, as opposed to a 15-month cycle. · consider the process for reviewing job plans and look at ways of increasing compliance, such as aligning job planning dates with other activities (i.e. IMTP /Corporate Planning cycle); and; · agree the job plan and implement an escalation / disciplinary process if there is not a legitimate reason for failure to agree a job plan.	Medical Director to formally write to all DDs with the outcome of this Internal Audit.Escalation Process will be refined giving timelines for response by DDs to Medical Director escalation.Tracker of escalations to be maintained by Medical Directors office.	01/03/2020	N/A	N/A	Overdue	**25**	#VALUE!		November 2021 Update: • Agreement by Executive Team to develop specification and instigate procurement process for E-Systems including job planning • Job planning procedure continue to be developed. • development of a standard operating procedure for Team Job Planning • Paper presented to Audit Committee October 2021 updating on action plan and achievement • Update provided to People & Culture Committee October 2021 • The Medical Director has written to Divisional Directors emphasising the need for their CDs to undertake job plan review meetings. He has also asked that a named member of the divisional				31/03/22	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager/ Service Lead / General Manager	Medium	R1 The Health Board should periodically review feedback from WAST / staff and patients, incidents, ongoing and expected future costs, overall performance and volume of patients etc. to ensure the expected benefits versus costs are still being achieved.	Agreed.The cost benefit analysis was reviewedagainst the original model and flagged as part of the Clinical Futures Readiness Assessment on 23rdJune. There will be ongoing monitoring of key KPIs.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Medium	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performancee.g. logging in times and periodically listening to callsand to feedback onperformance;•addressing any training needs that ariseand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. WAST incident numbers, GP surgery etc.;•providingregular refresher training;and•hosting team meetings to share case studies / best practiceand address any issues / concerns that arise.	30/09/2021	N/A	N/A	Overdue	**6**	#VALUE!						31/03/22	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021	N/A	N/A	Overdue	**6**	#VALUE!						31/03/22	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R4 We recommend the Flow Centre Team undertake periodic test runs of the business continuity plan against different continuity events. Any learnings or improvements should be detailed specifically in the plan.	Agreed. We will finalise the business continuity plan(BCP)and undertake a test run, including a relocation planto the Grange University Hospital, if required. Any learning or improvements will be incorporated into the BCP.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	

	Internal	Mass Vaccination Programme, April 2021	Substantial	Director of Public Health and Strategic Partnerships	Deputy Director of Public Health	Medium	R1 The Health Board should review:•how it engages with members of the public who do not have access to the internet; and•advertising the telephone number for the appropriate appointment booking team.	The need to review how the Health Board engages with members of the public who do not have access to the internet is accepted. As part of that review, the Health Board will consider advertising the telephone number and whether the significant operational implications of doing so can be overcome. If advertising the number continues to be too big a risk to the pace of delivery of the programme, alternative options will be provided.	30/06/2021	N/A	N/A	Overdue	**9**	#VALUE!						31/03/22	
	Internal	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Director of Primary, Community Care and Mental Health	SISU - Strategic Capital and Estates Programme Director and WPWS Programme Manager	Low	R3 We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:•the collection of baseline data;•targets or success measures with which to compare what is actually achieved;•the measurement and recording of the benefit metrics;•responsible managers; and•the oversight body of the benefits, to ensure these are achieved.	Agreed. We acknowledge that a robust benefits realisation plan needs to be developed and we are looking to commission external support to assist with this process for the SISU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.WPWS –to review benefits realisation plans for supporting projects	30/09/2021	N/A	N/A	Overdue	**6**	#VALUE!		November 2021 Update: Further work has been undertaken through the clinical workshops on developing the benefits register and this is still work in progress. Benefits realisation plan will be developed once the consultants have been engaged to inform the OBC prior to submission to the Board in March 2022. New Programme support for WPWS workstream has strengthened benefits management. Baseline data is/will be collected to support benefits realisation.				31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R1 The Health Board should ensure it clearly documents roles and responsibilities in its governance structures and plans.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R2 Where possible, the Health Board should endeavour to incorporate accountability,reportingand assurance into existing structures, rather than as additional processes which are not sustainable in the longer term.Using the example of the CIP, going forward this could include:i.accountability,reportingand assurancethrough the existing quality and patient safety governance mechanisms;ii.reporting integrated into existing divisional/site-based reports; andiii.CIP compliance assurance integrated into the divisional/site-based clinical audit plans.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R3 The Health Board should clearly document reporting requirements within its governance structures and plans, at each level of the organisation. This should include:i.expected frequency of reporting;ii.level of detail / assurances expected;iii.type of reporting expected, for example, tracking progress, reporting by exception, monitoring key metrics or performance indicators (KPIs), etc;iv.nature of the reports expected, for example, verbal, formal, set template, etc;	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R4 Where KPIs or data-driven reporting is used, the Health Board should ensure:i.the data is accurateand can be efficiently accessed; andii.KPIs are presented consistently between the divisions, for example, by clearly defining how KPIs are calculated.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	

	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R5 The Health Boardshould consider developinga protocol pack for any future surges of the pandemic.This could be implicit within the Health Board's pandemic framework and include, for example:i.Formally identifying governance structures for different surge levels;ii.For each governance structure, identifyinggroups that are required to meet, with clearly documented terms of reference identifying:a.roles and responsibilities;b.anticipated membership, including leadership of the group;c.frequency of meetings;d.reporting requirements (see recommendation6below);ande.records required to demonstrate monitoring, scrutiny and decision-making, for example, minutes, action log, decision log, etc(see recommendation4below).This should take into accountrecommendation 2 above.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R6 The Health Board should ensure meetingminutes appropriately demonstrate monitoring, scrutiny,decision-makingand assurance, particularlyif reporting isinformal /verbal.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R7 When developing action plans, the Health Board should ensure:iii.the plans contain clear timescales and milestones;iv.clarity is provided on demonstrating progress, for example, RAG rating definitions and requirements for validating progress; andv.benefits and key metrics are defined within the plan.	Not included within advisory report	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R1 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	A review of categories of well-being support will be undertaken to ensure staff can readily locate the support that best fits their need.	31/03/2022	N/A	N/A	Overdue	**0**	#VALUE!		November 2021 Update: This will be supported by the development of our internet and intranet resources and also the creation of a single point of access (phone and email). We are following and evidence based approach which advocates that the simplest route to seeking support is considered the most effective.				31/03/22	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R2 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same).However, the team will review a system of describing what others found helpful. This will enhance the current offer of feedback and satisfaction questionnaires completed by staff following an intervention. The development of an evaluation framework that has commenced with Cardiff Metropolitan University to evaluate the implementation of the Well-being Centre of Excellence will also support this recommendation.	31/03/2022	N/A	N/A	Overdue	**0**	#VALUE!		November 2021 Update: This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same). However clinical outcome data is collected by all clinicians in the service as part of good (standard) practice. More specifically the recently developed Trauma Pathway (within the Psychological Therapy Service) has now been evaluated				31/03/22	

	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R3 RecommendationThe Health Board should:•Review each initiative versus the time and financial cost to provide the service against the staff uptake and value / benefit of the initiative. •Consider additional analysis to help assess and target wellbeing initiatives to staff requirements.•Consider establishing wellbeing KPIs or other performance metrics to measure the success of the strategy and specific initiatives.	Calculating the relationship between financial investment and value is a complex process due to the range of clinical and individual variables. Outcome data is regularly collected and evidence based practice followed, the evidence base is evolving and ABUHB is at the forefront of developing this evidence and outcome data.The additional analysis recommended will be provided via the quarterly well-being surveys and deep dive work within divisions. The next well-being survey has enhanced questions that link back to the 6 pillars of the Employee Experience Framework.•The Employee Well-being team will take the recommendation around KPI'sunder consideration and further explore the additional functionality of the new version of the clinical recording system(CORE)now in use.	31/03/2022	N/A	N/A	Overdue	**0**	#VALUE!						31/03/22	
2021.11	Internal	GUH – Equipment Procurement Assurance - Follow up	Reasonable	Director of Planning, Digital & IT	Project Director	Medium	Management should ensure the ability to utilise "as fitted" water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Lessons learnt from equipment has been picked up as part of the broader lessons learnt report but a review by procurement alongside other projects would be beneficial.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.11	Internal	GUH – Equipment Procurement Assurance follow - up	Reasonable	Director of Planning, Digital & IT	Project Director	Low	R7 Single Tender / Single Quotation Actions should be reported to the Audit Committee in a timely manner, in line with SFIs, to enable effective scrutiny (O).	Agreed, all outstanding STAs will be taken to the next Audit Committee.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	MCA Lead/Head of DOLS	Low	R1 We recommend that procedural documents that have passed their stated review date are updated where required to reflect current legislation.	Agreed This procedure will be reviewed and updated with pace.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R2 We recommend that the 'best interests' discussion for patients assessed as lacking capacity is documented in the designated pages of the capacity assessment document in all cases.	Agreed A reminder will be issued across the organisation regarding robust completion of documentation.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	HIgh	R3 We recommend that, excepting where there is no reason to doubt that the patient has capacity, DNACPR decisions forms are accompanied by completed Health Board patient capacity assessment forms in all cases.	Agreed A reminder will be issued across the organisation regarding completion of DNACPR and Capacity Assessment forms.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Clinical Executives	Low	R4 The All Wales DNACPR policy must be complied with in full without exception. We recommend that succinct but sufficient details of patient or relatives' discussions are recorded on the All Wales DNACPR forms in all casesin order to ensure that the policy is complied with.	Agreed Correspondence will be sent to clinicians outlining the importance of detailing discussions with relatives.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R5 We recommend thatmanagement remind ward staff conducting capacity assessments of the need for competency in this area and that theyseek competency status from each relevant member of staff and if necessary ensure that relevant training is accessed and completed.	Agreed Correspondence will be issued to Divisions, for cascade, highlighting the training available.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!						31/03/22	25/03/2022
2021.02	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent	31/10/2021	N/A	N/A	Overdue	**5**	#VALUE!						31/03/22	25/03/2022

2021.01	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	N/A	N/A	Overdue	**5**	#VALUE!						31/03/22	25/03/2022
2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Head of Legal Services	Low	R1 Management should update the policies and procedures available to staff on the intranet and ensure only those that are in date and reflect current practice are maintained.	Agreed.Outdated Policies will be removed & existing policies will be updated to reflect changes to WRP and portfolios.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Director of Nursing	Medium	R2 Before payment is processed,clinical negligence cases which have damages in excess of £100k,mustprovide evidenceas having been approved by the LitigationGroup. Where payment needs to be made before the next Group meeting and the Group is unable to reconvene before this date, the Legal Services Team should issue an email to the members of the Group informing them payment will be made before the next meeting and any objections to this payment should be identified immediately. Additionally, the BACs payment sheet should be updated to include the date the case will be brought to the Litigation Group for retrospective approval. This should serve as one of the final checks prior to payment.	Agreed for immediate action	15/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R1 Divisions should provide assurance that actions arising from a complaint investigation areaddressed,with ongoing monitoring, depending on the significance of the action. Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The Assistant Director of Nursing will confirm this requirement with all Divisions and a process of audit will be introduced, led by the Corporate PTR Team, for assurance.	31/10/2021	N/A	N/A	Overdue	**5**	#VALUE!						31/03/22	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R2 Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The functionality of the new Datix system will be confirmed for all Divisions prior to implementation, together with the expectation that reports generated from Datix will be formally discussed in Divisional QPS meetings to monitor performance and learning.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.04	Internal	Charitable Funds	Substantial	Director of Finance	Charitable Funds Manager	Medium	R1 The Health Board should:a)Engage with ward staff via alternative mediums, e.g.,Teams presentations, presentations to Divisional Management Team meetings.b)Establish a timeframe for restarting ward visits and training sessions.c)Continue to promote the Charitable Funds Financial Control Procedure.	a.Agreed. Presentations to be prepared by December 2021 with roll out to commence in the new year with a view to completing by March 2022, confirming suitable dates with the divisions. b.Agreed. Face to face meetings will be dependent on advice from Infection Prevention and Controlbut meetings will be arranged by Teams liaising with relevant ward staff to arrange meetings prior to March 2022.c.Agreed. There will be follow up e-mails by the Charitable Funds Team to a and b above providingthis information.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R1 Clarity should be sought over the rolesandresponsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner.ABUHB Radiologyinternallyrequest on service point if the department knows the server team need to undertake work. We will continue to do this.				Complete								31/03/22	25/03/2022

2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMBfor an integrated electronic process cannot be delivered.The Health Boardshouldcarryout an analysis to fully identifyits needsfor a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	N/A	N/A	Not yet due	0	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	High	R3 Whilst we understand the Health Board isin the process of planning to upgrade to the 2016 version we highly recommend that the Health Board expeditesthe upgrade.	This upgrade took place on 14thNovember however only application server was upgraded. DHCW and ABUHB are working closely to plan the rest of the upgrade. However DHCW will not touch the RadIS local database which stores all of our crystal reports and letters. This is a risk and we havegone to our server team internally to plan anbackupsolutionfor the RadIS local database.	30/04/2022	N/A	N/A	Not yet due	-1	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R4 The Health Board should seek clarity over what maintenance tasksare expected and establish a process to ensure that these are completed.	There is a backupregimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	N/A	N/A	Not yet due	0	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R5 a.The Board should investigate an electronic solution to uploading requestsinto WRIS.b.The Board should introduce a completeness check to ensure that all requestsreceived have been entered into WRIS.	a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	31/03/2022	N/A	N/A	Not yet due	0	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R6 a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have5attempts.				Complete								31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	N/A	N/A	Not yet due	-1	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R8 The Health Boardshould request that this logging function be developed.The Health Board shouldconsider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	N/A	N/A	Not yet due	0	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	N/A	N/A	Not yet due	-1	#VALUE!						31/03/22	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022	N/A	N/A	Not yet due	-1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations		Low	R1 The Pathology Team should consider updating the External inspection Policy to include one centralised repository for all external reportsthat incorporatetimescales for a responseand provides a clear overviewof progressacross all areas.	Will ensure reportsare maintained in a centralised repositoryand ensure the policyis updated accordingly	24/02/2022	N/A	N/A	Overdue	1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 a.All instances of non-conformance identified in the reports should be recorded centrally to support periodic trend analysisand in particular theCAPA module within QPulse.	a.Log UKAS inspection as one single CAPA within QPulse and update progress as per any other non-conformity	24/02/2022	N/A	N/A	Overdue	1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 b Periodic trend analysis / pattern identification should be completed across all instances of non-conformanceand used to identify common areas of concern for corrective/preventiveaction.	.Try to identify themes and trends across Pathology, though inspections are held at different times of the year for each discipline so not as straightforward.	Ongoing	N/A	N/A	Not yet due	#VALUE!	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R3 Liaise with the ABUHB emergency planning team to go through their process for completion of all business continuity planningdocumentation.	Discipline Managers have been liaising with emergency planning team and will continue to do so.	24/02/2022	N/A	N/A	Overdue	1	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R4 Establish aschedule for testing BCPsat all locationsand across a range of likely continuity events.	Will establish a schedule for testing across Pathology	24/12/2021	N/A	N/A	Overdue	3	#VALUE!						31/03/22	25/03/2022

2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R5 The Pathology Team should seek to automate as much of the performance reporting as possibleand includeall test results within the KPIs.	Will horizon scan for new technologies to deliver automated TATs	24/02/2022	N/A	N/A	Overdue	**1**	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R6 If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis appropriate.	If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis appropriate.	24/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R7 A scorecard/ dashboard reportshould be developedto provide an overview of performance against the key measures/ risks withinPathology.	Scorecard currently in progress and being populated	24/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Assistant Directorate Manager	Low	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2021	N/A	N/A	Overdue	**13**	#VALUE!						31/03/22	25/03/2022
2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R1 The Health Board should:a)Remind clinical staff of the need to promptly update the administration section of a patient's file.b)Consider the value and benefit derived from using the administration section versus the effort required to maintain the latest position.	a.Issue included on the agenda(item 11a) of the Occupational Health Senior Clinical and Administration team meeting held on the 20thOctober 2021.b.All membersof the occupational health team involved in the process have been communicated with on the 8thNovember 2021to improve management of this data set.c.A monthly report query will be introduced from the 1stDecember 2021 to capture any outstanding issues as an additional assurance layer.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022
2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R2 The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately.b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1stNovember and is planned to conclude on March 31st2022. Health function. A detailed service review is	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with external Project Manager	Medium	R1 The Project Execution Plan should be updated to reflect the current stage of the project / programme.	Agreed. Will liaise with the external Project Manager to issue an updated version.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!						31/03/22	25/03/2022

2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R2 To enhance current arrangements, the terms of reference for the Project Team and Project Board should be reviewed and updated accordingly to include: • Coverage of frequency of meetings; • Quoracy for decision making; • Requirement for delegated deputies to be in attendance when there are periods of absence; and • The correct membership (named as generic roles / departments) reflective of both the project named management and current stage of the project.	Agreed. The terms of reference are currently being reviewed and updated for the recommended points including reference to the current stage of the project and the expectations of ownership by the members of the Project Team / Project Board.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with the Cost Adviser.	Medium	R3 The Cost Adviser reports should be updated to incorporate a summary cumulative position to better visualise the current financial position of the project	Agreed. Whilst there is additional information available to the project team to understand the current financial position, it would be helpful to have the 'snapshot' in the Cost Adviser report. Will liaise with the Cost Adviser to include within the reports.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R4 Welsh Government dashboard returns should be shared with an appropriate forum.	Agreed. The latest dashboard was shared with Project Board on 19 October 2021.				Complete									31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R5 Confirmation notice 1 should be finalised as soon as possible for both the Cost Adviser and Project Manager..	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R6 Recognising that main construction works have commenced on site, Confirmation Notice 2 should be executed as soon as possible.	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R7 Agreed. Both recommendations are being addressed as a matter of urgency.	Agreed. Discussions will be held with all relevant parties to confirm the delay damages calculation, and agreed amount, to be included in Confirmation Notice 2.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R8 Noting that no action can be taken at this project, management should ensure that the requirements of the NHS Wales Investment Infrastructure Guidance are applied at all future projects with regard to Enabling Works and Advanced Works.	Agreed. NHS Wales Investment Infrastructure Guidance will be followed on all future projects.	At future projects	N/A	N/A	Not yet due	**#VALUE!**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R9 The Project Director should advise the UHB Board of the actions taken to award the Enabling Works element of the contract and the non-compliance with the NHS Wales Investment Infrastructure Guidance.	Agreed. The issue was raised at Project Board and will be raised / discussed further in the first instance at the Strategic Capital and Estates Workstream. It should be noted that the demolition process was conducted via a separate contract and the provision of compensation event for the subsequent grouting was, and is considered, to be the correct approach. It is accepted that the Advance Works should have had a separate contract.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R10 Post submission of KPIs, the Project Board should discuss the collective output [and trend of previous submissions] to ensure issues with performance are reviewed and addressed in an appropriate and timely manner.	Agreed. Collective discussions are now being held for the returns on all current projects. It would be preferred if these discussions were held prior to submission of returns to NWSSP:SES, but it is acknowledged this is not the expectation for collation of DfL data	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R11 The risk register should be reviewed to incorporate applicable costs; with the costs regularly reviewed to facilitate monitoring of the project.	Agreed. The initial project risk register informed the FBC contingency pot [September 2020]. Work is underway to complete a reconciliation for the current financial position to review how much of the contingency sum will be consumed with the correct projected overspend for the project. This will then be further analysed to cost the risks, as applicable, on a line-by-line basis.	31/12/2021	N/A	N/A	Overdue	**3**	#VALUE!							31/03/22	25/03/2022
2021.1o	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R12 The risk register should be updated to reflect the current risk regarding the financial position of the project, and the proposed mitigating actions / countermeasures.	Agreed. This risk, and any other new ones identified, will be included in the next risk register review scheduled with the external Project Manager.	30/11/2021	N/A	N/A	Overdue	**4**	#VALUE!							31/03/22	25/03/2022

2021.09	Internal	GUH: Technical Assurance	Substantial	Director of Planning, Digital & IT	Estates Manager	Low	Management should ensure the ability to utilise “as fitted” water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Agreed. A capital bid has been submitted by the division to (a) employ full time CAD staff to keep records up to date and (b) to have access to the third-party software.	31/03/2022	N/A	N/A	Not yet due	**0**	#VALUE!						31/03/22	25/03/2022
202102	External	Radiology services: follow-up of 2017 recommendations	Not Rated	Director of Operations	Radiology Directorate Manager	Not rated	R4 The Health Board should look to further develop its collection of patient experience information across its sites and seek to identify any common trends that can be actioned to improve the service. Follow up 2021 - Whilst the Health Board has made positive progress against this recommendation, we feel unable to close this recommendation until the Health Board has implemented the site-specific PREM and reintroduced the comments box. In terms of learning, it would be helpful for the Health Board to identify how learning from patient feedback has made a difference and led to improvements.	TBC	31/03/2018	N/A	N/A	Overdue	**48**							31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD		High	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	N/A	N/A	Not yet due	**-1**							31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		High	The HealthBoard should hold workshops with Audit Wales to discuss what information is required to provide assurance for the audit, and what are the best ways of obtaining this.	A workshop will be arranged with Audit Wales in January 2022 to ascertain the information required in order to substantively test payroll transactions. Relevant Health Board employees will be invited to attend this workshop to ensure that going forward information is provided in the format required and on a timely basis.	31/01/2022	N/A	N/A	Overdue	**2**							31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Planning, Performance, Digital & IT		Medium	The HealthBoard should consider strengtheningtheirIT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Wellsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the	31/12/2021	N/A	N/A	Overdue	**3**							31/03/22	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Board Secretary	Head of Corporate Governance	Medium	The draft Annual Reportand Annual Governance Statement should be subject to a Quality Assurance review to ensure compliance with the Manual for Accounts, with evidence of this review submittedfor auditas part of the supporting working papers.	A checklist will be prepared to identify each area within the Manual for Accounts and link to the relevant part of the Annual Report and Annual Governance Statement. This checklist will be submitted to Audit Wales with the draft documents to facilitate review.	31/05/2022	N/A	N/A	Not yet due	**-2**							31/03/22	25/03/2022

202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		Low	The new asset tagging system should be implemented as soon as possible, and in readiness for the audit of the 2021-22 financial statements.	The interface between the Fixed Asset Register (Asset 4000) and the new RFID system is complete. The team are working through final issues identified on the user testing of the interface between the EBME equipment register and the RFID system during November 2021, with a view to going live with the system by the end of the month. The user training sessions have taken place. The tagging of new and existing equipment assets has commenced with around 1400 assets tagged to date. The programme of tagging of existing assets will run into the 2022/23 financial year due to the volume of assets and current capacity of staff. However, the finance team are progressing a fixed term appointment to support the delivery of this work over the next year.	31/03/2023	N/A	N/A	Not yet due	**-12**							31/03/22	25/03/2022
202103	External	Audit of Accounts Report – ABUHB Charitable Fund and Other Related Charities (Dec 2021)	Not Rated	Director of Finance, Procurement & Value		Medium	FCPs not being updated to reflect the changing profile of the investment portfolio. In addition, the Charitable Fund should consider having clearer procedures regarding the classification of income.	The Charitable Funds financial control procedure is reviewed on a 3-year rolling basis and is due for review in July 2022. Going forward, additional reviews will be carried out on an annual basis to ensure that the procedure remains relevant and that no significant changes have occurred since the last review.For clarity, the income section (section 9 of the current financial control procedure) will be enhanced to include a more detailed section on the types of income received by the Charity and how the classification is determined, eg grant, donation, legacy etc. and the documentation required to be obtained/retained to verify this classification.	31/07/2022	N/A	N/A	Not yet due	**-4**							31/03/22	25/03/2022
202104	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		Not rated	R1 NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	Occupational Health are piloting an Occupational Therapy Service until the end of March 2022 to support staff with post covid syndrome. The work has been supported and funded by the Post COVID Recovery Service and work is ongoing to formalise the service pathway to ensure equitable provision for the whole workforce. A review of this pilot will be conducted in March to identify whether there is scope to expand this service to support our workforce with other underlying ill health conditions.	31/03/2022	N/A	N/A	Not yet due	**0**							31/03/22	25/03/2022
202104	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		Not rated	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called “#PeopleFirst, #CynnalCynefin, reconnecting our workforce”. The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-executive support.	31/12/2022	N/A	N/A	Not yet due	**-9**							31/03/22	25/03/2022

202105	External	Structured Assessment 2021	Not Rated	Director of Planning, Performance, Digital & IT	Associate Director of Communications and Engagement	Not rated	R1 The Health Board's website contains some outdated information relating to its governance arrangements and incomplete performance data which is not supported by appropriate explanatory information. The Health Board, therefore, should take immediate action to ensure: • Content is well organised, easy to navigate, clear and concise, and • Key information / data is up-to-date and in a format that the public and stakeholders can interpret and understand.	The Health Board accepts this recommendation. The website is in the process of being reviewed and updated to reflect suggestions made including, ensuring all fundamental Health Board information (related to Board, Committees, and governance arrangements) is accurate and up to date for the public and stakeholders. Further developmental work will be required to ensure Divisional engagement around local pages on the website are kept up to date with useful and meaningful information. However, it should be acknowledged that the resource required in order to conduct such a substantial review is not inconsequential.	31/03/2023	N/A	N/A	Not yet due	**-12**							31/03/22	25/03/2022
202105	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R2 Some Board members have expressed concerns about the volume of work now undertaken by some of the committees and the robustness of the arrangements for ensuring flows of assurance. The Health Board, therefore, should complete its review of the new governance structure by its intended deadline of April 2022 to be assured that it is operating as intended.	The Health Board accepts this recommendation. A complete and robust Committee and Board effectiveness exercise will be undertaken by April 2022. The Health Board accepts this recommendation. A complete and robust Committee and Board effectiveness exercise will be undertaken by April 2022.	30/04/2022	N/A	N/A	Not yet due	**-1**							31/03/22	25/03/2022
202105	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R3 Recent staff turnover within the Corporate Governance Support Team has impacted on the quality of service it is able to provide to the Board and its Committees. The Health Board, therefore, should review the effectiveness of its Corporate Governance Support Team as soon as possible to ensure that it has sufficient resilience and capacity to support all governance functions. Arrangements should also be put in place to ensure staff are able to access suitable training / learning opportunities to develop their knowledge and skills within their respective roles.	The Health Board accepts this recommendation. The Health Board will undertake a review and endeavour to ensure adequate and appropriate corporate governance capacity to fulfil the statutory functions of the Board and the Committees, enabling it to discharge its functions. It should be noted that external training in specific corporate governance, information governance and accredited risk management has been undertaken over the last two years, despite the pressures of the pandemic. This demonstrates the Health Board's commitment to develop and enhance skills within its governance team. However, it is also recognised that further mentorship and training programmes could be developed in order to 'future proof' the department and provide a robust corporate governance function.	30/09/2022	N/A	N/A	Not yet due	**-6**							31/03/22	25/03/2022

202105	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R4 The Health Board has experienced significant changes in its Executive Team and cadre of Independent Members resulting in several interim Executive Director appointments and is currently recruiting to two independent member vacancies. However, maintaining these temporary arrangements indefinitely alongside the turnover of Independent Members present risks at a time of significant operational pressures. The Health Board, therefore, should seek to make permanent appointments to these key Executive Director roles at the earliest possible opportunity. In addition, there remains a need for the Health Board to strengthen its induction and training for new Independent Members in line with our recommendation in 2019	The Health Board accepts this recommendation. Independent Members Interviews have now been undertaken for Independent Members for Finance and Digital and the recruitment process for this continues to progress. Continued liaison with the Public Appointments Team to progress the substantive recruitment of the Vice Chair and an Independent Member for Community is anticipated to progress from February 2022. Executive Team: Chief Executive Officer (CEO) – interim arrangement to be continued during 2022. Director of Primary Care, Community & Mental Health – recruitment in process. Director of Finance & Procurement – interim appointment to be extended in line with Interim CEO arrangement. Deputy CEO – interim appointment to be continued in line with Interim CEO arrangement. Interim Director of Operations – current interim appointment until April 2022. Recruitment	30/04/2022	N/A	N/A	Not yet due	-1							31/03/22	25/03/2022
202105	External	Structured Assessment 2021	Not Rated			High	R5 The Health Board has not finalised its monitoring framework due to the pandemic, subsequently there continues to be limited oversight and scrutiny at Board-level on overall delivery against priorities outlined in the 2021/22 Annual Plan. The Health Board, therefore, should complete the development of its monitoring framework as soon as possible to allow the Board to review and if necessary, challenge delivery of its strategic priorities and progress against the Annual Plan and future Integrated Medium-Term Plans.	The Health Board accepts this recommendation. The delivery framework of the 3 year IMTP process did include a quarterly monitoring report structure which has not been completed this year against the annual plan due to the challenges of the Health Board's response to the pandemic and other priorities. The shared objective of developing a comprehensive outcomes based framework for the organisation is a developmental one and progress has been limited in this area due to the challenges associated with the pandemic, a change in leadership of the performance function (due to the Exec team changes referenced in the report) and due to Welsh Government developing an All Wales outcomes framework that would enable the Health Board to align a local framework to. The Health Board will therefore develop the first iteration of an outcomes framework for 2022/23 to support the 3 year IMTP and align to the Welsh Government framework. The	30/06/2022	N/A	N/A	Not yet due	-3							31/03/22	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	N/A	N/A	Overdue	9			November 2021 Update: Digital Delivery Board is now in place and divisional representation required. It will form part of the formal governance process. Updates will be provided from this Board to Exec Team.				31/03/22	25/03/2022

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R2 A register of compliance requirements for all IM&T related legislation and standards across the whole organisation should be developed for the IGC along with a process for assessing status and reporting upwards to Committee.	Agreed. Currently the establishment, processes and mandate of informatics in ABUHB does not extend (with the exception of IG) beyond the directorate. In terms of accountability where devolved responsibility exists for information assets the same level of scrutiny and compliance should be applied. A corporate risk will be submitted with the recommendation of a strategic options appraisal for Board consideration and within this the role of Informatics as a Directorate will be considered along with other corporate and clinical divisions.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: The Health Board has engaged Templar to review the Information Asset owners, compliance and current risk and this work will be taken forward with the Office of the SIRO to be established as part of the overarching objectives.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R3 Management should consider enhancing the risk management process in place within the Health Board by providing an annual report that identifies risks that have a low likelihood, have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.	Accepted. Part of the new governance will focus on the objectives of the CDO as SIRO for the Health Board. Following the review and adoption of the Target Operating Framework and HB exec oversight a programme will commence to adopt new policies, training and performance management of ICT and Information Asset including training for Information Asset Owners.	31/03/2022	N/A	N/A	Overdue	**0**			November 2021 Update: The Templar Cyber risk report has been presented to the Digital Oversight Board and scheduled to go to Exec team and future board briefing and the to consider the implementation of the Office of the SIRO which will ensure that the strategic aims are				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	ADI Governance and Assurance	N/A	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: The release of the Corporate Risk Management Strategy will inform the final updated of the Informatics Directorate processes. The approach to the Clinical Assurance, including the risk approach, of the development and implementation of Informatics Services will be ratified at the January Digital Delivery Oversight Board (strategy and process). Risk categories pertinent to the work of the directorate have been agreed; the local risk management processes, aligned to the organisation strategy will be taken to the oversight board in January as well for approval. A directorate risk register has been				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics	31/03/2021	N/A	N/A	Overdue	**12**							31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan	31/12/2022	N/A	N/A	Not yet due	**-9**			November 2021 Update: This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				31/03/22	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of “Once for ABUHB” which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Exec Team Q1 and Board Q2 2021.	30/09/2021	N/A	N/A	Overdue	**6**			November 2021 Update: A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	N/A	N/A	Overdue	**9**			November 2021 Update: The establishment of a small PMO within Informatics, aligned to P3O Portfolio Management, has progressed in recent months with the permanent appointment of both a PMO Portfolio Analyst and PMO Support Officer. The appointment of an interim Head of PMO will further support the work being undertaken over the coming quarter to carry out a structured maturity assessment of current PPM capabilities within Informatics, to enable the development of a comprehensive roadmap and as a means of measuring the success of capability over time.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	N/A	N/A	Overdue	**6**			November 2021 Update: A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs. This includes the recommendation for Business partner roles to propogate a network of champions.				31/03/22	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R10 The Informatics Directorate budget should be set to reflect the actual need of the organisation. Where funding cannot be fully granted, the impact on the underfunded position of Informatics work and Digital Strategy delivery should be clearly stated and agreed with Executives.	Agreed. The Portfolio approach and executive oversight governance will provide the framework in which difficult prioritisation decisions must be taken to avoid historical best endevours approaches. Part of the recommendations from the review of informatics in ABUHB is to establish a dedicated Digital Investment Panel which will provide performance management and oversight to investments in digital. The Health Board recognises the need to prioritise and invest in order to deliver benefits and supports the principle of a benefits management realisation framework and strategy. Budget setting is taking place for next financial year with the aim to agree a growth commensurate with strategic objectives. The Target Operating model is designed to ensure capacity and capability of Informatics is fit for purpose and is currently being costed to inform a case for consideration.	01/10/2021	N/A	N/A	Overdue	**6**			November 2021 Update: A final internal challenge session is scheduled for December within the Division to ensure capacity and capability meets the Health Board requirements and will be presented in January 22 to the Digital Delivery Oversight Board before returning to Exec Team.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021	N/A	N/A	Overdue	**6**			November 2021 Update: The Informatics service is engaging iwith Health Education and Improvement Wales to further develop Health Informatics apprenticeship pathways from entry level. The service is actively engaged with HR &OD, Finance colleages to ensure the best route to recruitment and retention of staff. The TOF provides the resoure/skills gap that currently exists and the resource requirement to support it.				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R12 Once the team has been re-established, the key security tasks should be in place:•regular review of firewall rules;•regular vulnerability testing; and•development of a security incident response plan.	Accepted. Active recruitment has been taking place with a Cyber Security Team leader successfully recruited. Emergency Planning colleagues have been collaborating with the cyber teamand the Health Board has contracted with specialist consultancy to accelerate the development of a Information Risk and Cyber Security operating model. Work will commence Q1 including cyber resilience and response plans.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: The Informatics service has engaged a specialist company, Templar to review the current Cyber arrangements and the specific Information Security requirements that need to be addressed. This report has been provided to the Exec Team and there will now be further engagement to ensure that the recommendations are addressed and the Target Operating Model with the Office of the SIRO established.				31/03/22	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system				31/03/22	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021	N/A	N/A	Overdue	**3**			November 2021 Update: A report commissioned by the Health Board has been presented at the Digital Delivery Oversight Board and accepted. A proposal on next steps will be presented with associated costs to Executive Team in Q3 2021.				31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R1 The function and membershipsof the Statutory Compliance Group and Electrical Safety Sub-Group should be reviewed to ensure:a)Both groups meet with the required frequencies set out in their Terms of Reference; b)Responsibilities and memberships across the two groups meet the recommendations of WHTM 06-01;c)Anelectrical-specific Terms of Reference, or as a minimum, a standard agenda, is developed for the Electrical Safety Sub-Group and approved by the SCG;d)Awritten report be submittedby the ESSG to each SCG meeting, providing assurance on thekey areas of compliance required byHTM 03; ande)Minutes from all meetings should be retained for future reference, in line with the UHB's agreed document retention policy and WHTM/HTM requirements (O).	Agreed. The next meeting of the ESG has now been scheduled for 24th March 2021.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R3 a)An audit / recommendation tracker should be put in place, to monitor the status of compliance-related recommendations received.b)Progress should be monitored at the Electrical Safety Sub-Group (and other sub-groups as appropriate),and reported to the Statutory Compliance Group(O).	Agreed, an action tracker will be implemented. We recognise this may also facilitate funding allocations.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R6 Limitation of Access forms should be used where appropriate for work undertaken by the maintenance contractor (e.g. circuit breaker protection trip testing) (O).	Agreed. Appropriate documents will be in place from now onfor relevant works.	30/04/2021	N/A	N/A	Overdue	**11**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R2 The NWSSP: SES website should be periodically checked to ensure Works & Estates are in receipt of all relevant hazard notices(O).	Agreed, the website will be periodically checked from now on. The omission was not the fault of the UHB, and further we would normally expect input from NWSSP:SES to provide additional assurance in this area. Under normal circumstances, we would also monitor alerts for reporting to the Statutory Compliance Group / ESG (as discussed above).	30/04/2021	N/A	N/A	Overdue	**11**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R4 a)Operational Procedure and Operations & Maintenance files should be reviewed, with out of date documents archived and current documents filed, as required by HTM 06-03.b)Site/substation log books should be maintained in the format required by HTM 06-01 (section 8).c)Records of inspections / replacement of equipment for which the UHB is responsible for should be maintained in the HV files(O).	Agreed, we recognise the benefits of improved record keeping, to make current documents more accessible.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R5 The UHB's HV policy requirement for inclusion of specific wording on the Limitation of Access forms should be reviewed, and removed if no longer considered feasible / necessary (D).	Agreed. We have reviewed the policy and agree the reference will be removed.	30/06/2021	N/A	N/A	Overdue	**9**							31/03/22	

	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R1 The UHB should have appropriate procedures in place to ensure that when determining the preferred supplier to inform the design, confirmation is received of willingness to participate in the subsequent procurement/market testingexercise (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Overdue	**10**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R2 Lessons learnt from the development of the design and equipment procurement exercise should be captured, either separately or as part of the formal post project evaluation (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Overdue	**10**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R3 For accuracy of reporting, the Cost Adviser cash-flows should be reconciled to UHB payments made. (O)	Agreed; and has already been addressed.	N/A	N/A	N/A	Complete	**#VALUE!**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R5 The monthly Welsh Government dashboard reports should be submitted in accordance with expectation (O).	Agreed. The Welsh Government reports will continue to be submitted.	31/03/2021	N/A	N/A	Overdue	**12**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R6 An HDSU Project Board should be established to take through to completion / handover (as a minimum) (O)	Agreed. The GUH Project Board currently fulfils this function and alternative arrangements will be made after the April 2021 meeting.	30/04/2021	N/A	N/A	Overdue	**11**							31/03/22	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R7 At future projects:Contract documentation should be signed in a timely manner, prior to the commencement of works.	Agreed. The importance of a quick turnaround of contract documents has been relayed to the various project SCPs, PMs and ABUHB corporate services.	31/03/2023	N/A	N/A	Not yet due	**-12**							31/03/22	
	Internal	Clinical Futures - Workforce (2020/21)	Substantial	Director of Workforce & OD		Medium	R1 The Health Board should reinstate the completion of the Action and Delivery Frameworks to assist in the delivery of the IMTP objectives.	It is acknowledged that the monitoring of the WOD IMTP Objectives and milestones changed during the pandemic. The WOD function is planning on introducing a revised internal monitoring process in line with the 2021 People Plan which will be aligned to the Health Board's approved Annual Plan.	31/01/2022	N/A	N/A	Overdue	**2**							31/03/22	
	Internal	Management of Balance Sheet Assets (2018/19)	Reasonable	Director of Finance, Procurement & Value	Head of Capital Finance	High	R1 The Health Board should introduce tagging / identity marking of all relevant assets.	Agree the Recommendation.For clarification, whilst capital assets are not tagged with the individual Fixed Asset Register number, a significant proportion of assets are tagged by other departments such as Medical Electronics and IT. Current processes involve the asset register being updated with serial numbers and the appropriate Medical Electronics reference, however, this information is not available for all historic assets.To improve the security of assets, and identification as part of the annual verification process, the Capital Team will, in consultation: Develop a policy for asset tagging which defines where tagging is appropriate; Investigate options for the purchase of an asset tagging system, considering existing systems in use in ABUHB and potential for linking to the Medical Electronics database and research the systems employed at other health boardsand trusts; Develop a business case and plan for the implementation of a preferred option in 2019/20 including outline specification, cost/benefits analysis, procurement options, funding requirements and resource implications.	31/03/2020	N/A	N/A	Overdue	**24**			November 2021 Update: Training sessions held, software integration issues remain - meeting to resolve to be held on 29th October 2021. Tagging on-going and full live roll out will be implemented once integration resolved.				31/03/22	

	Internal	Clinical Audit Follow-up (2018/19)	Limited	Medical Director		High	R1 1.1The Health Board should develop a Quality & Patient Safety Improvement Strategy and Assurance Framework, based upon a reviewofits approach to clinical audit and other QPS assurance mechanisms. This should incorporate an assurance mapping exercise against the organisation's quality and patient safety risk registers, focusing on major clinical risks.Such a Strategy and Framework should bring together the quality and patient safety improvement work undertaken throughout the Health Board, including clinical audit, ABCi, Value Based Healthcare, etc, and explicitly cover: the Health Board's approach to quality and patient safety improvement; how this work addresses the Health Board's major QPS risks; the governance and accountability structures within the organisation that support the delivery of the work; and the reporting mechanisms to bring this work together to form an overview of QPS improvement work and the assurance it provides to the organisation; how quality improvement activities comply with information governance legislation; and howservice users are involved and engaged in quality improvement activity.The Strategy and Framework should either make reference to, or incorporate, the existing strategies for individual elements of quality and patient safety improvement work ongoing throughout the Health	A Quality Improvement Leaders Group will be set up, with the leaders of ABCi, Value based healthcare, clinical audit and R and D and innovation,toseek todevelop a new way of usingclinical information for improvement and from this, a Quality and Patient Safety Improvement Strategy and Assurance Framework. It will incoprporate a review of known clinical risks and those on the patient safety risk registers, focussing on major clinical risks.From this, the Executive Team will assess the level of clinical audit required by the organisation and the resource needed to support this,in order to undertake the Health Board wide audit above and beyond the NCAORP,ensuring that the clinical audit activity is effective in bringing about improvement.The Medical Education Team will be charged with randomly selecting 100 non-identifiable Consultant re-validationquality improvement domains, to identify the volume and subject of the audit activity in a year. This will be mapped against the broad areas where clinical risk has been identified, not withstanding large scale work undertaken via other QPS improvement mechanisms.	31/03/2020	N/A	N/A	Overdue	**24**			November 2021 Update: The clincal audit policy and strategy are currently being reviewed and updated to reflect a more targeted approach to local and corporate audit designed to provide assurance around quality and safety priorities.				31/03/22	
	Internal	Clinical Audit Follow-up (2018/19)	Limited	Medical Director		High	R2 The Health Board is required to participate in a certain level of clinical audit, as noted in section 6. Therefore, it is necessary to have appropriate governance and reporting structures in place to support this. We have set out our recommendations to improve the current structuresfor national and Health Board wide clinical auditbelow.2.1The Clinical Audit Strategy and Policy should be updated to incorporate the recommendations of this review. The QPSC should formally approve the Clinical Audit Strategy and Policy. 2.2The MDST should ensure that relevantstaff are aware of, and adhere to, the requirements of the Strategy and Policy.2.3The MDST should bring together the top twotiers of the clinical audit plan (nationalandHealth Board wide) into one document, 'the Clinical Audit Programme'. TheClinicalAudit Programme should explicitly state which QPS risks it addresses and should be formally approved by the QPSC.2.4Governance mechanisms should be sufficient for the QPSC to regularly monitor delivery of the Clinical Audit Programme. This could be in the form of anoverall summary within the QPSreport that is currently written and presented by the Assistant Director of QPS. The summarycould be in a narrative or dashboard style. .2.5There should be a clearly defined and documented mechanism for the dissemination of results and recommendations throughout the Health Board and the escalation of significant findings to the appropriate forums. Escalation of results could be done via the	2.1-2.6.The Clinical Audit Strategy and Policy will be updated to include the outputs from the recommendations from this review once the process has been completed. This will be approved at Exec Board and QPSC and communicated across the organisation, through dissemination to the Clinical Directors.The MDST will bring together the NCA and health board wide audit into a clinical auditforimprovement programme, through discussion at QPS Operational Group. It will be approved at QPSC.Set up a Clinical Effectiveness and Standards Group('CESG'), chaired by the AMD for Clinical Effectiveness and with ADD representation from all Divisions, which will monitor the delivery of the Clinical Audit for Improvement Programme and monitor the implementation of recommendations. It will receive the results of the NCAs and Health Board Audits and determine which require escalation and reporting to QPSC.2.7. The MDST wil develop over a number of meetings, a report on participation in NCAs within the Quality Performance Report for QPSC.2.8.One to one supporton clinical auditis always available to staffthrough the MDST. The training resources available will be clarified on the Clinical Audit Intranet	31/03/2020	N/A	N/A	Overdue	**24**			November 2021: The Health Board participates in the National clincal audit and outcome review programme and is currently reviewing resources and registration arrangements to ensure participation in all audits.				31/03/22	
	Internal		Limited	Medical Director		High	R3 The Clinical Audit Policy states that the Divisional Directors"are responsible for maintaining the overview of local clinical audits within the Directorates, to ensure they complywith the Policy". However, there is no mechanism for holding the divisions to account in this process. We have set out our recommendations to ensure appropriate accountability in the divisional clinical audit process below.3.1The divisions should produce anannual workplan of assurance against their major clinical risks, including, but not limited to, clinical audit.3.2The divisions should provide a clinicalassurance report to each QPSOG meeting, detailing the assurance work undertaken against the annual workplan. The reports should also highlight any significant issues arising from the assurance workand detail the action being taken to address these	3.1-3.3.Whilst the Divisions willproduce andpresent annual workplans of assurance against their major clinical risks, and significant issues arising from the work plan,alignment of these risks to clinical audit for improvement will be highlighted within the work plans.These will be presented to the CESG, and this will be summarised in an annual over view of Clinical audit to QPSC every Septemberfrom 2020.3.4 The clinical audit registration form and checklist will be updated and be available on the Clinical Audit intranet site.	31/03/2020	N/A	N/A	Overdue	**24**			November 2021: A procurement exercise has commenced to purchase a digitial platform to manage clincal audits and actions plans.this will provide oversight of all audits at directorate divisional and health board level and dashboards to support monitoring of perfromance and actions				31/03/22	

	Internal	Well-being of Future Generations (Wales) Act 2015 (2018/19)	Reasonable	Medical Director		High	R1 The Wellbeing of Future Generations Act Programme Boardshould include a review of the objectives and the progress against them as part of itsagenda, to ensure objectives are fit for purpose and the activities required to meet them are identified and monitored. 2) EachProgramme Board should be chaired by the Executive Lead in order to provide leadership, monitor effectivenessand highlight the importance of attendance. 3) Poor attendance at the Programme Board should be taken forward by the Executive Lead in order to ensure that it is rectified.	Agreed1.Thereview of the Wellbeing Objectiveswill be undertaken in conjunction with a broader review of where these objectives sit in the context of other Organisational priorities and ambitions. A landscape review/mapping of these various aspects will need to be undertaken in conjunction with the ABUHB Planning Teamtoinform the review of Well-being Objectivesas part of the IMTP process.The Programme board will include a review of progress against objectives as part of its agenda. 2.Programme Board meetings will be moved from a monthly to a quarterly basis and will be chaired by the Executive Director of Public Health and Strategic Partnerships. This will be supported bysub-Board meetings.3.The Executive Director of Public Health and Strategic	31/12/2019	N/A	N/A	Overdue	**27**			November 2021 Update: the review of the Wellbeing objectives has been put on hold due to the prioritisation of the response to the Covid-19 pandemic'				31/03/22	
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: how service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	N/A	N/A	Overdue	**47**			November 2021 Update: the position has not changed since the last update in August 2021, however, a meeting is planned with colleagues in the Facilities Division this month to work collaboratively to develop a health and safety monitoring programme. The programme will include H&S management audits, thematic audits and 'walk the ward' inspections. The roll out of the new programme is planned for April 2022. In addition to this we are also planning the development of self-assessment inspection tools for wards and departments to be conducting their own health and safety monitoring. Finally, there is evidence that				31/03/22	
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	N/A	N/A	Overdue	**47**			August 2021: Due continued demands and impact from the pandemic within the Corporate Health and Safety Department the programme of health and safety monitoring has not re-started. However, monitoring has been conducted relating to COVID Safety				31/03/22	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	N/A	N/A	Overdue	**48**			November 2021 Update: Radio frequency ID tagging has commenced for all medical devices and will progress over the next 12 months. This will support the management and localtion of all devices including servicing history. Thetares are developing a register of all medical devices.				31/03/22	

	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	N/A	N/A	Overdue	**48**			November 2021 Update: Options are being explored to record compliance on ESR. A more sustainable approach to infusion device training is being explored with the practice educators currently taking a lead and a more measured approach to reassessment for regular users being				31/03/22	
	Internal	Pay Incentives (2019/20)	Limited	Director of Workforce & OD		High	R1 The Health Board should restrict additional session payments to standard levels, but where this is not possible; maintain an approved schedule of enhanced rates ratified by the Executive Team with appropriate justification / reasoning included. The schedule of enhanced rates should be reviewed frequently e.g. every three months.	Approval to continue paying WLI rates from Executive Team – taken forward to RATS Committee. Review as part of IMTP demand and capacity discussions each year.	30/09/2019	N/A	N/A	Overdue	**30**			November 2021 Update: Rate card has been revised and drafted across all divisions and will be shared and signed off by the Divisonal Director's with a view to sign of at Execs for the end of November, with the agreement of the MD				31/03/22	
	Internal	Pay Incentives (2019/20)	Limited	Director of Workforce & OD		High	R2 In relation to the non-automated process only, consultants should submit signed claim forms for all additional sessions they are claiming payment for, listing appropriate details in respect of session dates, start/ finish times etc. and including a declaration that all sessions claimed are in addition to contracted work. The submitted claim form should be reviewed, validated and checked for accuracy before any payment is made.	Agreed. Executive Team will agree the approved system for claiming for all additional sessions and communicate with the Health Board. This must simplify the process for claiming to maximise compliance.	30/09/2019	N/A	N/A	Overdue	**30**			November 2021 Update: General Managers for Family & Therapies, Medicine and Scheduled Care have all confirmed this process is in place. Scheduled Care noted Radiology email once additional sessions are completed and is checked against activity before being signed off by the DM.				31/03/22	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk and Assurance Committee 7th April 2022 Agenda Item: 6.2

Aneurin Bevan University Health Board

Audit, Risk and Assurance Committee – Risk Management Strategy Realisation Plan

Executive Summary

This report outlines the draft plan to embed the objectives agreed within the revised Risk Management Strategy (August 2021); the actions needed to be completed, responsible officer(s), deadlines and governance oversight/scrutiny, the benefits realisation and a proposal as to how we could measure the efficacy of each action.

Audit, Risk and Assurance Committee is requested to approve and endorse the proposed and acknowledge the continued developed of the OfWRLDatix Risk Management Module and suggested deferment of implementation until the end of the calendar year.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Director of Corporate Governance
Report Author:	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**N/A**	**Committee of the Board:**	• **Audit, Risk and Assurance Committee**

Date of the Report: 28th March 2022

Supplementary Papers Attached:
Appendix 1 – Risk Management Realisation Plan March 2022
Appendix 2 – Risk Management Strategy (2021)

Purpose of the Report

The purpose of this report is to provide the Audit, Risk and Assurance Committee with the plan to fully realise and subsequently embed the objectives outlined within the Health Board risk management strategy. It also provides context in relation to the deferment of the RLDatix Once for Wales risk management module, until the end of the calendar year.

Background and Context

In February 2021 a Head of Risk and Assurance was appointed to join the Corporate Services Team at Headquarters. This was a new post and as such, an initial set of

objectives were developed for the role one of which included a review of the Risk Management Strategy.

A review was undertaken alongside a complete revision of the Board Assurance Framework in Summer 2021 and the Board approved and endorsed a revised Strategy at its meeting in September 2021.

Organisational awareness raising and close liaison with Divisions has taken place. Work is now required to develop the mechanisms and infrastructure for the Health Board to fully realise the benefits associated with the revised Strategy and establish a baseline to build a new culture of risk management throughout the organisation.

In addition to the revision of the Risk Management Strategy, the Health Board is also part of a wider National programme of work known as Once for Wales (OfW). This programme of work was agreed as part of the Welsh Government report '***The Gift of Complaints'.*** The Welsh Government 'statement of intent' for the OfW Programme states:

> ***"By making better use of available data we can improve decision making, plan change and drive improvements in quality and performance. Beyond supporting the immediate care of individuals, the sharing and use of data is essential as the basis for creating information and intelligence to help those commissioning and delivering health and care services to learn from what has happened in the past, understand what is happening today, and to plan for the future."***

Phase one implementation of this programme, incorporating complaints, claims and incidents modules on DATIX has recently been implemented with the incidents module implemented in December 2021. Phase 2 of this programme of work is now underway and includes a specific Risk Management module.

The capacity to implement the Risk Management module cannot be understated. There are currently more than 3,000 risks on the current DATIX system. A comprehensive review, moderation and potential closure of the risks needs to be undertaken by local risk owners. Given the ongoing operational pressures and continued and sustained pandemic response alongside restart and recovery plans, this places significant additional pressure on Divisions and Directorates. However, it is important that the Health Board undertakes these actions once and comprehensively in order to maximise the potential benefits associated with the new system.

The implementation of the new RLDatix Risk Management module features as one mechanism to fully implement the revised Risk Management Strategy; however, it should be noted that a more detailed plan will be developed to ensure a clear understanding of the stepped approach that needs to be undertaken for successful implementation. It is anticipated that a fully detailed plan for implementation of the OfW Risk Management Module will be presented to the July 2022 Audit, Risk and Assurance Committee.

Assessment & Overview of Current Status

The table below provides a high-level view of the more detailed plan appended to this report:

Objective	Deadline
❖ (1) Develop a suite of documentation including protocols and procedures to underpin and support the embedding of the strategy and associated risk management approach within the organisation.	**May 2022** – Executive Team for endorsement and then wider cascade organisationally.
❖ (2) Understand the risk environment and adapt and remain resilient to changing circumstances or events.	Timelines for risk management training outlined within **objective 4**. **September 2022** – Board review as part of the 1 year review of the Risk Management Strategy.
❖ (3) Use performance data and business intelligence around risks to underpin strategy, business planning, decision making and allocation of resources and to assess whether or not objectives are being met.	**May 2022** – Board, as part of the revised BAF to reflect the revised IMTP an assessment on risks to delivery, internal controls and levels of assurance will be undertaken. Committee agenda setting meetings will continue to be influenced and informed by the BAF. This means that whilst the Committee strategic risk reports will highlight the overall risk position, items on Committee and Board agendas should draw out the assurances required to demonstrate risks are being managed appropriately.
❖ (4) Develop an electronic training programme incorporated into the induction of all employees, more in depth training for managers and specialised training for Board members. [1]	**March 2022 –** identify risk champion roles within each Division and encourage their attendance at the Risk Managers Community of Practice Meetings. **May 2022 –** Basic training for all staff to be made available and will incorporate some of the suite of documentation developed as part of objective 1. **June 2022** – Management level training packages to be developed and shared through DMTs/HSLG/Divisional QPS meetings **July 2022 –** Board level risk management training to be delivered. **Board May 2022** – the Health Board will request an extension on the implementation of the revised risk management module to

[1] The Committee is asked to note there is also significant work being undertaken at a National level in relation to the development of electronic risk management training however this has been paused whilst development of the OfW module remains ongoing.

	facilitate full engagement and allow training packages to be developed.
❖ (5) Develop a culture where active risk management is integrated into all Health Board and Partnership business.	**Executive Team/Strategic Group/DMTs/HSLG/QPS meetings/Board** – 2-3 years to fully embed. **March 2022** - Executive Team
❖ (6) Clear definitions and clarity on the organisational risk appetite.	**Board Development Session May 2022** – as part of development of revised BAF and following Board receipt of revised IMTP. Executive Team/Healthcare Systems Leadership Group/DMTs – **June/July 2022**
❖ (7) Ensure appropriate structures, capabilities and capacity are in place to manage risks with clear escalation levels and processes.	**March 2022** – Ensure adequate timings for risk discussions on Committee and Board agendas. Encourage Divisional Assurance meetings to include a specific risk item to ensure respective Executive Directors are made aware of most significant Divisional risks. Cultural change to risk management – **2-3years** **April/May 2022 –** Development and communication of risk escalation framework to dovetail with baseline risk management training.
❖ (8) Create an electronic risk management system which is user friendly and allows prompt assessment, mitigation and escalation of risk.	**December 2022 –** an implementation plan for RLDatix Risk Management module to be presented to the July 2022 Audit, Finance and Risk Committee.
❖ (9) Ensure the risk management system is supported by robust and clear monitoring and reporting processes at all levels in the organisation.	**March 2022 –** Ensure adequate timings for risk discussions on Committee and Board agendas. Encourage Divisional Assurance meetings to include a specific risk item to ensure respective Executive Directors are made aware of most significant Divisional risks. Cultural change to risk management – **2-3years** **April/May 2022 –** Development and communication of risk escalation framework to dovetail with baseline risk management training.

Audit, Risk and Assurance Committee will note that a number of actions need to be undertaken in parallel to each other in order to ensure pace, traction and cohesion with other National work currently being progressed as part of the Once For Wales (OfW) Programme and the revised RLDATIX risk management module.

A separate implementation plan for this is being developed through the Health Board OfW Project Management Team. National learning will also contribute to the

development of this plan as Betsi Cadwalader University Health Board (BCUHB) alongside Shared Services have agreed to be early adopters of the RLDATIX risk management module. Engagement between counterparts across Wales is operational on a weekly basis currently and discussions held will underpin the development of the internal Health Board plan.
Recommendation & Conclusion
Audit, Risk and Assurance Committee is requested to endorse the proposed plan and acknowledge the significant training requirement and commitment required from the Board to maximise the benefits associated with the cultural shift in relation to risk management. Audit, Risk and Assurance Committee is also requested to support the proposal to defer the implementation of the OfW RLDATIX risk management module until the end of the calendar year (2022) to enable data cleansing, National learning and a robust readiness assessment to be undertaken.

Supporting Assessment & Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP
The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None

Public Interest	Report to be published

Appendix 1
Risk Management Strategy Realisation Plan 2022

Strategic Objective Stated within the Risk Management Strategy (2021)	Action(s)	Responsible Officer	Deadline/Governance Oversight	What are the Benefits?	How will we measure?
❖ (1) Develop a suite of documentation including protocols and procedures to underpin and support the embedding of the strategy and associated risk management approach within the organisation.	Development of a toolkit to include agreed definitions relating to risk e.g. risk vs issues, examples of good practice. Provide organisational clarity on the risk management escalation process. Develop a quarterly newsletter on risk management to be shared will all staff including useful shared learning links.	Head of Corporate Services, Risk and Assurance	**May 2022** – Executive Team for endorsement and then wider cascade organisationally.	Provide staff with the tools to enable the strategy to be optimally realised and implemented and equip the Health Board with the appropriate infrastructure to become a risk intelligent organisation, with enhanced focus on most appropriate areas.	This will be evidenced by having the toolkit available and communicated across the organisation. The toolkit will also be regularly reviewed to ensure compliance with changing legislation and evidenced based best practice.
❖ (2) Understand the risk environment and adapt and remain resilient to changing circumstances or events.	This objective will be addressed via the internal training package as outlined in **objective 4**. Internal Audit will always undertake reviews in relation to risk management, the results of which would then be used to track and monitor compliance and uptake rates in relation to risk management training.	Head of Corporate Services, Risk and Assurance	Timelines for risk management training outlined within **objective 4**. **September 2022** – Board review as part of the 1-year review of the Risk Management Strategy.	By understanding the environment and context of the risk, the action plan, mitigations and monitoring of the risk becomes clearer. Only by understanding our risk environment and the potential impacts can the Health Board really determine how we manage the risk going forward. By achieving this objective, the Health Board will become more risk focussed and will further support alignment to the BAF and cultivate stronger risk management practices throughout Divisions.	Enhanced understanding at a management and Board level could be undertaken via an internal questionnaire to a random cross section of staff to check their understanding. The results of this would be reported back to the **September 2022 Board** meeting as part of 1 year review of Risk Management Strategy. A Board level risk based maturity matrix self-assessment exercise. We would also seek to introduce horizon scanning sessions for 2022/23 with the Board on the Risk Management, Board Assurance Framework and IMTP cycle. Uptake rates on internal training compliance to measure maturity of risk management training packages.

❖ (3) Use performance data and business intelligence around risks to underpin strategy, business planning, decision making and allocation of resources and to assess whether or not objectives are being met.	At a Corporate/Strategic level, reporting on key deliverables associated with key programmes of work as outlined in the IMTP will be risk stratified and monitored at Executive Team, HSLG, Committees and the Board. Risks identified as threats to successful achievement of Health Board objectives will also be highlighted, monitored and managed via the BAF. An assessment against levels of assurance (internal and external) will also be undertaken as part of the review of the BAF 2022/23. At a Divisional/Operational level, Divisions will be encouraged and supported to consistently map their performance data to their respective risk areas to measure and demonstrate efficacy of internal controls and to use these metrics when reporting at Divisional assurance meetings for example.	Head of Corporate Services, Risk and Assurance	**May 2022** – Board, as part of the revised BAF to reflect the revised IMTP an assessment on risks to delivery, internal controls and levels of assurance will be undertaken. Committee agenda setting meetings will continue to be influenced and informed by the BAF. This means that whilst the Committee strategic risk reports will highlight the overall risk position, items on Committee and Board agendas should draw out the assurances required to demonstrate risks are being managed appropriately.	Using performance data in relation to management of risks will provide a level of assurance to the organisation and the Board and will enable clear understanding of which controls are working and importantly, which controls are not. Using data can also support risk management exit strategies and helps to predict future potential risks and promotes 'one version of the truth' reporting.	Any Health Board plans should include key risks to delivery and these should then be reflected back in to the BAF. There should be cohesion across all strategic documentation. Divisional risk reporting should be clearer and decisions related to risk management should be well evidenced and based on best practice.
❖ (4) Develop an electronic training programme incorporated into the induction of all employees, more in depth training for managers and specialised training for Board members.	Develop an internal risk management training package for staff at all levels including: • Revised template CRR with examples of good practice and notes • Clarity on what is a risk and what is an issue • Clarity on internal controls and action plans • Clarity on examples of good assurance • Ensure consistency of language when populating DATIX	Head of Corporate Services, Risk and Assurance	**March 2022 –** identify risk champion roles within each Division and encourage their attendance at the Risk Managers Community of Practice Meetings. **May 2022 –** Basic training for all staff to be made available and will incorporate some of the suite of documentation developed as part of objective 1. **June 2022** – Management level training packages to be developed and shared through DMTs/HSLG/Divisional QPS meetings	Relieve pressure on operational colleagues when populating and reporting Directorate and Divisional risks	A review at mid-year point **(November 2022)** to be undertaken with Divisions and the Board to demine the success level of training delivered and identify any training gaps or needs. Uptake rates for risk management training, building in refresher training every 3 years for senior managers/risk leads.

	fields to enable consistent reporting • Exit strategies for risks • Positive/opportunity risk management		**July 2022 –** Board level risk management training to be delivered. **Board May 2022** – the Health Board will request an extension on the implementation of the revised risk management module to facilitate full engagement and allow training packages to be developed.		
❖ (5) Develop a culture where active risk management is integrated into all Health Board and Partnership business.	Ensure risk item remains on all Executive Team and Strategic Group meetings and encourage DMTs and Divisional Assurance Meetings to follow example. A monthly specific risk report to be developed for Executive Team which requests active participation from Exec Team members to be introduced and predicates discussions on risk management at Committee and Board meetings.	Head of Corporate Services, Risk and Assurance	**Executive Team/Strategic Group/DMTs/HSLG/QPS meetings/Board** – 2-3 years to fully embed. **March 2022** - Executive Team	Promote a culture whereby risk management is seen as a positive performance management tool and not a bureaucratic exercise.	Will be evidenced via agendas and minutes of meetings. A cultural change will take time to embed and this should be acknowledged. Some of the progress in this area will be measured via a qualitative method rather than quantitative. The Board risk management maturity matrix would also be used as a measure of a changing risk culture.
❖ (6) Clear definitions and clarity on the organisational risk appetite.	Re-set the Health Board Risk Appetite Statement (to include risk tolerance and capacity levels),definition areas and escalation routes in line with Health Board agreed Emergency Pressures and Escalation Policy (2021)	Head of Corporate Services, Risk and Assurance	**Board Development Session May 2022** – as part of development of revised BAF and following Board receipt of revised IMTP.	Provide absolute clarity and consistency on organisational risk appetite, how it links to risk treatment and if we are operating within it.	Internal questionnaires to a random cross section of staff to check their understanding and reported back to the **September 2022 Board** meeting as part of 1 year review of Risk Management Strategy. Regular reporting and focussed Board/Committee attention on management of risks outside of target appetite levels. This would be quantified by the number of risk targets above the appetite level without an agreed level of tolerance.

	Communicate and embed the agreed risk appetite developed by the Health Board and informed by Nationally using agreed risk definitions from OfW	Head of Corporate Services, Risk and Assurance	Executive Team/Healthcare Systems Leadership Group/DMTs – **June/July 2022**	Promote consistency of approach across the organisation, empower staff to locally manage an down their respective risks and support in the realisation of the aspirations of the Risk Management Strategy.	Should see less escalation of operational risk and more innovative, localised management, reporting to Board and Committees by exception. Increased staff empowerment should also lead to greater staff well-being/morale (via staff satisfaction surveys). This should also be evidenced through regular performance reporting.
❖ (7) Ensure appropriate structures, capabilities and capacity are in place to manage risks with clear escalation levels and processes.	Further strengthen current governance structures to ensure risk informs agendas and is allocated adequate time at Divisional and Strategic meetings. Cultivate a culture where the 'Ward to Board' approach is adopted and enacted. A clear risk escalation framework with agreed definitions and triggers to be developed (in conjunction with the Board and Senior Divisional leaders) and communicated throughout the Health Board. A clear role for the Risk Management Community of Practice in championing risk management across the organisation.	Head of Corporate Services, Risk and Assurance	**March 2022** – Ensure adequate timings for risk discussions on Committee and Board agendas. Encourage Divisional Assurance meetings to include a specific risk item to ensure respective. Executive Director led risk management to be deployed through Divisions and Directorates which is aligned to agreed escalations. Cultural change to risk management – **2- 3years** **April/May 2022 – Development and communication of risk escalation framework to dovetail with baseline risk management training.**	Clear escalation frameworks for risk empowers local staff to own their risks and provides them with assurance that mechanisms are in place to support them through an escalation process. This also provides enhanced assurance to the Board in respect of accountability at the various levels throughout the organisation. In the interests of openness and transparency, a clear governance framework for risk will ultimately enhance patient experience and public confidence.	This can be evidenced through governance and decision making frameworks, the development and communication of the risk escalation framework and through agendas and minutes of relevant meetings. The Health Board will also test the efficacy of the mechanisms as part of the 1 year review of the risk management strategy in **September 2022.** This will be undertaken through an evaluation of the capacity to support the facilitation of risk management i.e. training, guidance, support and corporate reporting. Continued Board level training and ownership of risk.
❖ (8) Create an electronic risk management system which is user friendly and allows prompt assessment, mitigation and escalation of risk.	Implement the OfW risk management module across the Health Board ***requires separate implementation plan, developed and owned by the ABUHB OFW project group*** ***NB: BCUHB are early adopters of this module and are developing their own implementation plan***	Head of Corporate Services, Risk and Assurance	**December 2022 –** an implementation for RLDatix Risk Management Module plan to be presented to the **July 2022** Audit, Risk and Assurance Committee.	Enable consistent reporting, increase understanding of risk management at all levels and enable to Health Board to achieve its objectives.	Regular monitoring of implementation via the Health Board internal OfW Project Group will be enabled and learning will be shared from other modules which have already been implemented (incidents/claims etc.) reporting by exception to

	which could then be used across other Health Board in Wales.				**Executive Team/AFR Committee** and the **Board.**
❖ (9) Ensure the risk management system is supported by robust and clear monitoring and reporting processes at all levels in the organisation.	Review current QPS and risk management arrangements and ensure that gaps are addressed for example, provide a mechanism for Divisional Directors and respective Executive Directors to discuss most significant risks. Ensure escalation routes and accountability for mitigating actions is clear for risks. Encourage consistent reporting using agreed themes and reporting trends to be used to inform strategic risk profiles and the Board Assurance Framework,	Head of Corporate Services, Risk and Assurance	**March 2022** – Ensure adequate timings for risk discussions on Committee and Board agendas. Encourage Divisional Assurance meetings to include a specific risk item to ensure respective Executive Directors are made aware of most significant Divisional risks. Cultural change to risk management – **2- 3years** **April/May 2022 – Development and communication of risk escalation framework to dovetail with baseline risk management training.**	Clear escalation frameworks for risk empowers local staff to own their risks and provides them with assurance that mechanisms are in place to support them through an escalation process. This also provide enhanced assurance to the Board in respect of accountability at the various levels throughout the organisation. In the interests of openness and transparency, a clear governance framework for risk will ultimately enhance patient experience and public confidence.	This can be evidenced through governance and decision making frameworks, the development and communication of the risk escalation framework and through agendas and minutes of relevant meetings. The Health Board will also test the efficacy of the mechanisms as part of the 1 year review of the risk management strategy in **September 2022.**

Aneurin Bevan University Health Board

Risk Management Strategy and Framework

Version: Revised – August 2021

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

Contents

1. Introduction

Within an organisation, Risk Management is a normal continuing process and one based upon good governance practice. As such, it forms an integral part of Aneurin Bevan University Health Board's (Health Board) approach to achieving our strategic objectives, annual priorities and in providing safe and effective care to the population which we serve (as expressed in our Integrated Medium Term Plan and Annual Plans).

Effective risk management will attempt to control, as far as possible, future outcomes by being proactive in managing the threats to strategic objectives. This will offer the possibility to reduce the potential of threats to be realised (when it then becomes an issue) and the potential impact if it is realised.

The Health Board will do this by identifying potential risks to the successful achievement and delivery of our objectives and by forming an opinion of how the threats are managed.

2. Aim

Whilst recognising that some risk is inherent in all that we do, this strategy aims to provide a connected risk management system throughout the Health Board and provide clarity on how risk to achievement of objectives are identified, escalated, reported, managed and monitored through the organisation, the Board and its Committees.

3. Objectives

We will achieve the aim of this strategy by:

- Developing a suite of documentation including protocols and procedures to underpin and support the embedding of this Strategy and associated risk management approach within the organisation;
- Understanding our risk environment and adapting and remaining resilient to changing circumstances or events;
- Using performance data and business intelligence around risks to underpin strategy, business planning, decision-making and the allocation of resources and to assess whether or not objectives are being met;
- Developing an electronic training programme incorporated into the induction of all employees, more in depth training for managers and specialised training for Board members;
- Developing a culture where active risk management is integrated into all Health Board and partnership business;
- Clearly describing the risk appetite of the organisation;

- Actively using our view of risk to inform our approaches and decision making;
- Ensuring appropriate structures, capabilities and capacity are in place to manage risks with clear escalation levels and processes;
- Creating an electronic risk management system which is user friendly and allows the prompt assessment, mitigation and escalation of risk;
- Ensuring the risk management system is supported by robust and clear monitoring and reporting processes at all levels in the organisation;

4. Scope – To whom does this Strategy apply?

This Strategy applies to all employees of the Health Board, irrespective of grade or role. This includes those that we contract with, those seconded to work in the organisation and any volunteers that work in partnership with the organisation. Therefore, accountability and responsibility for active risk management sits at all levels within the organisation and across our partnerships to ensure that risk management is a fundamental part of the total approach to health, partnership governance and service delivery.

5. Links to the Board Assurance Framework (BAF)

The purpose of the Board Assurance Framework is to provide clarity on the internal assurances that the Board requires and whether or not the Board can be satisfied that risks are being managed appropriately and that the organisation is on track to achieve its stated objectives.

The Board Assurance Framework links with the Health Board's Risk Management Framework and Quality Assurance Framework to provide a robust structure that enables the Health Board to focus on threats to its most important objectives.

6. Delivery Framework

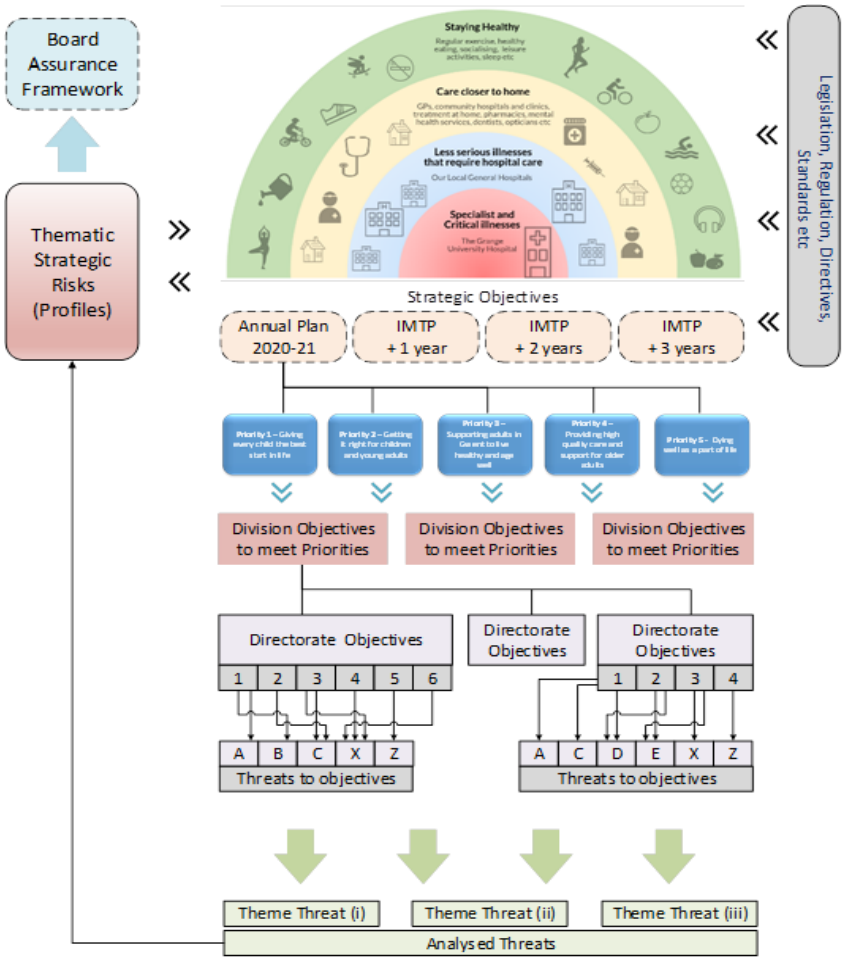
The Health Board has endorsed a revised approach to Risk Management and an associated Delivery Framework to embed the approach throughout the organisation. The premise of the revised approach is that it will form part of the process to deliver the Health Boards agreed strategic priorities and objectives (through its strategy, IMTP and Annual Plan).

Operational application is expected to include identifying the threats to the successful delivery of objectives and an assessment of the management of the threats. These will then be aggregated and amalgamated to create sets of threats which can then be escalated as

strategic risk themes. This is integral to the success of the risk management delivery framework.

Strategic application will include the opportunity to include organisational risk profiles informed by the Executive Team and horizon scanning for potential risks to the organisation based on expertise and significant knowledge in respective areas.

The Delivery Framework for the revised Risk Management Approach is depicted below:



Risks will be identified and scored using a Risk Matrix.
The Health Board will adopt the NHS Wales Risk Matrix.

7. How will the Risk Management Approach Work?

The Health Board will develop organisational risk profiles which will focus on the operational risks to the Health Board of achieving its strategic objectives and priorities. Risk profiles which score 15 or above

will be reported to the Audit, Finance and Risk Committee at each of its meetings via a dashboard approach. The Committees of the Board will receive a report at each of its meetings encompassing all threats that are overseen by the respective Committee. The Committee will then be able to determine assurance, or not, as to the effectiveness of the Health Board's internal controls in relation to the management of its risk profiles.

All levels of the organisation, each Directorate, Department and Division will maintain its own risk register. These risks will be recorded using the electronic risk management system.

The Health Board's organisational risk profiles (which will be actively monitored by the Board, Committees and Executive Team) will be aligned to the risks recorded. This will enable the organisation to have a clear understanding of the profile and management of risks.

8. Risk Controls

The assessment of each risk will determine how that risk is managed i.e. it will be Terminated, Transferred, Treated or Tolerated.

TYPES OF RISK CONTROL	
Terminate	Eliminates the risk completely
Transfer	Passes the risk to a third party, who bears or shares the impact
Treat	***Containment***: Reduces the likelihood and/or the impact
	Contingent: Establishes a contingency to be enacted should the risk happen
Tolerate	Accepts the risk, subject to monitoring

9. Risk Appetite General Statement

The Health Board is clear that:

- The organisation must take risks in order to achieve its aims and deliver beneficial outcomes to patients and the general population.
- Any risks will be considered and managed in a controlled manner.
- Exposure to risks will be kept to a level deemed acceptable by the organisation.
- The acceptable level(s) may vary from time to time.

- Where rewards or benefits of tolerating a risk are high, the cost of controlling them prohibitive or the period of exposure prolonged then higher tolerance levels may be accepted

The risk appetite will vary for different risks dependent upon the service provided to whom.

The Health Board will review its general risk appetite statement every year and will develop a risk appetite process to enable and empower different parts of the organisation to contribute to the discussion on risk appetite.

10. Risk Appetite, Attitude, Tolerance and Capacity

Before considering how to manage a risk, the organisational appetite for the risk should be considered. This helps to empower staff to manage the risk by understanding the parameters within which they are expected to operate and encourages some autonomy in respect of risk management.

A risk ***appetite*** is defined as the degree of uncertainty an organisation, service or individual is willing to accept (it is a short–term approach to the treatment of a threat), whereas risk ***attitude*** is defined as a longer term culture or behaviour towards a risk. It is important to recognise and describe these differences when evaluating and assessing risks or threats.

The appetite towards a risk defines what the initial management considerations. A ***tolerance*** level i.e. a set of parameters that specifies a range of acceptable levels of deviation that will be applied to the management of that risk.

A ***capacity*** level which determines the maximum application will be applied in extremis. The appetite towards a risk defines the initial management considerations concluded in its assessment of the risk.

A risk ***capacity*** level is the maximum amount and type of risk that the organisation is able to support. It sets the maximum risk levels that will be applied in extremis.

As risk tolerance is defined within the context of objectives and risk appetite, it will be communicated using the metrics in place to measure performance and will embed within our cyclical planning processes. Risk tolerances guide services and operational areas as they implement risk appetite within their sphere of activity and will need to be specifically identified and agreed for each identified area of risk. A table detailing the service areas and a general risk appetite level will form part of the suite of documentation that supports the implementation of this Strategy.

11. Escalation Routes and Reporting Mechanisms:

11.1. Organisational Oversight and Scrutiny

The Board will be advised of the Risk Profiles twice per year. It will also be made aware of new risk profiles, risks that might have changed in the preceding period and risks that have been mitigated and reduced in assessed level or removed from the profiles.

The Audit, Finance and Risk Committee will receive the full organisational risk profiles to provide challenge, support and scrutiny twice a year (February and October). This will align with a review of the Board Assurance Framework to be presented to the Board at its March meeting.

Where a risk profile receives oversight from a specific Committee of the Board, this will be reported to each meeting of that Committee.

The Executive Team will undertake a review of the principal risks to the organisation on a monthly basis. A dedicated risk development session will also take place on a quarterly basis where Executive Team will have the opportunity to inform the Organisational Risk Profiles of any new developments and horizon scan for potential risks.

Twice a year all Divisional and Directorate Risk Registers will be submitted to the Head of Corporate Services, Risk and Assurance to enable a full organisational review to be undertaken. This will allow the Health Board to measure itself against the aspirations of this Strategy and ensure consistent reporting is taking place. The review will assist with the completion of the Health Board's Annual Governance Statement.

Risks will be reported using a Risk Dashboard, which will track risks and outline issues of impact, risk appetite and sources of assurance. The dashboard will provide an overview of actions being implemented where mitigation is considered the appropriate way to deal with the risk.

11.2. Operational Oversight and Scrutiny

All Divisions and Departments will be expected to record risks using the internal risk management system. The Quality Patient Safety Operational Group (QPSOG) and other forums outlined within the Health Board's Quality Patient Safety Governance Framework will be used to monitor any concerns and changes to risk management.

12. Network of Risk Management Champions & Competent Person

Risk identification and management is part of every staff member's role. To support this, the Health Board will develop a risk management community of practice. A network of individuals will be identified in each Division and/or Department to ensure that the Health Board's approach to risk management is communicated, awareness is raised at local levels, local approaches are well co-ordinated and reporting is undertaken as expected. The role of the risk managers will be to ensure that training and awareness raising is undertaken to promote good risk management through making sure that staff in their areas have the appropriate knowledge and skills.

The Community of Practice will be established as a virtual network to share ideas, good practice and learning.

13. Risk Training and Awareness Raising

The Health Board recognises that this Strategy can only be successful through good training and awareness raising and that this is a key priority. Staff will be provided with training in the principles of risk management and the appropriate skills to undertake risk management activities effectively within their work areas. This training and awareness raising will cover both clinical and non-clinical areas and will be delivered via ESR. Three levels of training will be provided including

level 1, basic training for all staff, Level 2, Management training and Level 3, Board level training.

Risk training, including health and safety, incident reporting, fire, security, data protection, infection control and waste management will be provided to all new staff on induction by the relevant departments.

Training and awareness raising will also be undertaken with Board Members to enable them to discharge their responsibilities properly. The Health Board will ensure that the risk management strategy forms part of the Health Board's induction processes.

In addition risk training will also be undertaken with leads of Health Board Programme Boards and other key strategic driver forums that have responsibility for implementing Health Board Strategy and Plans. This training will be delivered by the Corporate Risk Management Team and ongoing support and advice will be available. This will ensure that the Health Board integrates risk management as a core function of all programmes of work associated with delivery of organisational objectives and will support in identifying risks to objectives at the outset of planning processes.

Similarly, support, advice and training will also be offered to Divisional Management Teams to further underpin consistency of risk management reporting and approach across the Health Board.

14. Monitoring, Reviewing and Auditing of this Strategy

This Strategy will be subject to regular review and updated as required by legislation or changes in best practice and, as a minimum, reviewed in full every three years.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk and Assurance Committee 7th April 2022 Agenda Item: 6.2b

Aneurin Bevan University Health Board

Audit, Risk and Assurance Committee - Strategic Risk Report

Executive Summary

This report provides an overview of the profile of the current most significant risks to be reported to the Audit, Risk and Assurance Committee (ARAC). The risks reflect the continuing challenges of the COVID pandemic along with restart and recovery of previously paused operational services and ongoing uncertainties related to Variants of Concern (VoC).

The report also provides an update in respect of:

- National Once for Wales (OfW) development of a risk management specific module;
- Continued embedding of the Risk Management Strategy and associated delivery framework within operational and Divisional teams;
- Current, high level, status of all strategic risks; and,
- A proposal for a new risk in relation to the Ukraine crisis, for inclusion on the Corporate Risk Register.

The ARA Committee is asked to note this report for assurance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Board Secretary
Report Author:	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**N/A**	**Committee of the Board:**	• **Audit, Risk and Assurance Committee**

Date of the Report: 15th March 2022

Supplementary Papers Attached:
Appendix 1 – High level Overview of Corporate Risk Register
Appendix 2 – Summary of Risk Profiles Routinely Reported to ARA Committee.
Appendix 3 – Risk profile for Ukraine Crisis.

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks which encompass the Corporate Risk Register and form the strategic risk profiles for the Health Board.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the revised Risk Management Approach, the Health Board is able to review and assess its strategic risks against achievement of objectives as set out in the Annual Plan 2021/22.

This report provides the Audit, Risk and Assurance Committee with an opportunity to review the organisational strategic risks which receive oversight across all Committees and the Board.

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Assessment & Overview of Current Status

Revised Risk Management Approach and Update on National OfW Risk Module

The revised risk management approach remains in the embedding phase throughout the organisation. A plan for implementation and full realisation of the risk management strategy has been developed and is also presented to the Committee through a separate report.

Continued engagement throughout the organisation has taken place to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX). This is being driven, informed and underpinned by the National work being undertaken by Once for Wales to develop a dedicated and specific Risk Management module. It is anticipated that the electronic risk management system will form one of the key sources of business intelligence in respect of identification and escalation of operational risk, in conjunction with Executive level horizon scanning led risk identification.

The 'go live' date for implementation for the OfW risk module remains as April 2022 with Betsi Cadwaladr University Health Board and Shared Services becoming 'early adopters' of the new platform. However, recommendations have been made for the Committee to support deferring the implementation date to the end of the calendar year 2022 to provide the Health Board with the opportunity to develop a comprehensive implementation plan. This plan will then track, monitor and evaluate the implementation of the new module through the Health Board's OfW project implementation group meeting and will report, by exception, to the Audit, Risk and Assurance Committee.

Divisional and Operational Risk Management Development

Further development work alongside Divisions continues to be undertaken to ensure risks are being captured on the system appropriately and consistently in terms of scoring, risk assessment and descriptors. This work is underpinned and supported by

Executive Team which provides an overarching position in relation to each risk area. In parallel to horizon scanning, strategic risk identification, the Health Board's risk management approach and infrastructure, is continually improving.

The plan outlined in a separate report to the Committee highlights the development actions being undertaken during March 2022 and further actions due to be undertaken over the coming months.

Current Status

There are currently **22** Organisational Risk Profiles, of which **15** form Principal Risks due to the scoring being 15 or greater and are included within the Board Assurance Framework. The following table provides a breakdown of the risks and level of severity:

High	15
Moderate	5
Low	2

A high-level breakdown dashboard of all strategic risks including, current score, target score, risk appetite level, risk treatment and trend (in respect of escalation and de-escalation) since last reporting period is included at ***Appendix 1***. The overview of the Corporate Risk Register was considered and reviewed by the Board at its meeting on 23rd March 2022.

Detailed risk profiles for which the Committee provides oversight (**6 profiles in total**), are appended to this report at ***Appendix 2***.

We will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk.

Ukraine Crisis

The Health Board recognises the current military crisis in Ukraine and as such is taking steps to position itself for a state of readiness for all eventualities. A group has been established to meet fortnightly to discuss and review the steps required to ensure the Health Board's preparedness. This group will report to Executive Team fortnightly and by exception with any pertinent concerns raised directly with the Board as and when required.

A risk assessment has been undertaken as a baseline and is attached at ***Appendix 3***. The Committee is requested to approve the risk to be included as part of the Health Board's Corporate Risk Register.

Development Plan and Next Steps

The Health Board's Risk Management Community of Practice met during the last reporting period and received an update on development of the National OfW RLDatix risk management module. Members were offered access to the 'sandpit' version of the system and comments were encouraged from members across the varying Divisions and Departments through the organisation. These comments will be communicated back to

the National team to ensure any issues or concerns are highlighted and addressed whilst still in the development stage of the module.

The Committee has also received a high-level plan for further implementation and benefit realisation of the risk management strategy and members are welcomed to comment or provide suggestions on the plan.

Development of risk management training has commenced in terms of development of literature to be communicated throughout the Health Board and forms a section of the 'supporting documentation/toolkit' to underpin the implementation of the risk management strategy.

Recommendation & Conclusion

The Committee is asked to:

- Note the content of this report for assurance purposes, recognising that there will be further iterative development work to embed the revised risk management approach across the organisation;
- Acknowledge the updates that have been received and reflected in the appendices for the last reporting period; and,
- Approve the inclusion of an additional risk regarding the Ukraine crisis.

Supporting Assessment & Additional Information

Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP

The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None
Public Interest	Report to be published

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Mar 2022 Board)** 	**PQSO**	**Director of Operations**
CRR002 Failure to recruit and retain staff across all disciplines and specialities leading to adverse impacts on delivery of care to patients across acute and non-acute settings and non-compliance with safe staffing principles and standards **(re-**	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles.	**No**	**Treat** the impact of the risk by using internal controls.	**(Mar 2022 Board)** 	**P&C**	**Director of Workforce and OD**

framed Jan 2022)								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	15	10	**Zero or low** due to patient safety and quality of service.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**PQSO**	**Director of Nursing**
CRR020 Failure to implement WCCIS leading to inaccessibility of essential patient information.	16	15	**High** level of appetite for risk in this area to innovate in the area of digital technologies. **Low** level risk appetite for the realisation of this risk and to maintain patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**AFR**	**Director of Planning, Digital and ICT**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Mar 2022 Board)** 	**PQSO**	**Director of Operations**
CRR007 Inability to reflect demands of an increasingly aging population.	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.	**(Mar 2022 Board)** 	**PQSO**	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships**

CRR010 Inpatients may fall and cause injury to themselves.	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**PQSO**	**Director of Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Mar 2022 Board)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR030 Limited contact with public and NHS services in addition to clinical deployment to support Public	16	5	**Low** risk appetite in this area due to potential impact on quality, experience and patient outcomes.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**PQSO**	**Director of Nursing**

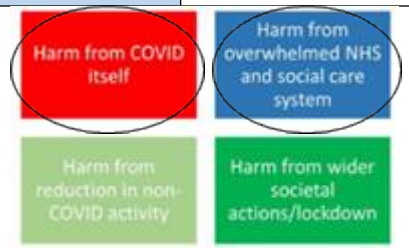
Health Mass Vaccination programme contributing to a compromised ***Safeguarding*** position (**re-framed to reflect DoLs position**) ***links to Workforce risk – CRR002**								
CRR001 High levels of seasonal influenza	8	8	**Low** level of risk appetite in relation to patient experience. **Moderate** levels of risk appetite can be applied to pursue innovative models and technologies to encourage uptake.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work. ***Managed within agreed risk appetite level, therefore proposed to remove as a strategic risk and continue to be managed locally.***	**(Mar 2022 Board)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Mar 2022 Board)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

CRR026 Risk to the general population and patients already within our services, due to less than adequate surge capacity to address any further exponential increase in pandemic response. ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**PQSO**	**Director of Operations**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**(Mar 2022 Board)** 	**AFR**	**Director of Public Health and Strategic Partnerships and Board Secretary**
CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**AFR**	**Director of Planning, Digital and ICT**
CRR016 Achievement of Financial Balance	4	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However responding to COVID 19	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**AFR**	**Director of Finance and Procurement**

			implications and maintaining safe services take precedence.					
CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**AFR**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate. **Moderate** risk appetite with regard to innovation and developments across the Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence should the risk be realised, is significant.***	**(Mar 2022 Board)** 	**AFR**	**Director of Operations**
CRR032 Failure to achieve underlying	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)**	**AFR**	**Director of Finance and Procurement**

recurrent financial balance								
CRR033 (Dec 2021) Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**AFR**	**Director of Planning, Digital and ICT**
CRR021 Welsh Language Act Compliance	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**P&C**	**Director of Workforce and OD**
CRR025 Well Being of Staff and normalisation of risk	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**P&C**	**Director of Workforce and OD**

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="3">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Enabler risk and links to all priorities</td><td colspan="3">CRR017 (Dec-2018)
Threat Cause: Complete or partial failure of ICT systems to protect patient information (malware attack) across the Health Board (including independent contractors and partners) incorporating system outages, provided nationally by third parties or locally provided systems.
Threat Event: Security of Patient, Staff or Health Board information is compromised leading to harm or damages.
TREAT</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Patient Outcomes and Experience
Quality and Safety
Reputational
Public confidence
Finance</td><td>Risk Appetite</td><td colspan="2">Low appetite in relation to adverse impact on Quality, Safety, Outcomes and Experience however, moderate to high level risk appetite for innovating to identify digital ICT system solutions.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Audit, Risk and Assurance Committee</td><td>The Cyber Resilience NIS/CAF has superseded the local risk review
CWS is being redesigned to be resilient to patching and allow for business continuity tests to be carried out without interrupting live service.
Implementing relevant Capital schemes on the critical replacement programme.
Regular vulnerability scans are undertaken.
Anti-Virus, Firewall, Web filtering and other up to date threat management technologies.
Operating system replacement plan</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

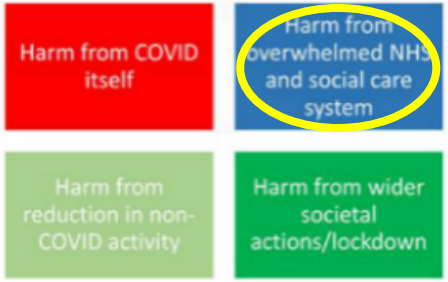
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			4	5	3	5	2	5
• The team is waiting for the WG CRU to provide the baseline report for comment. This is expected Q4 21-22. • The business continuity and disaster recovery plan is under review and expected to be completed in March 2022. • Continue working with vendors for Log 4j patches • Templar execs report received and considered by Executive team. Agreed immediate next steps and priority actions which will be shared at a Board briefing session (Nicola)		31st March 22 31st March 22 Ongoing 31st May 2022	**20**		**15**		**10**	
Trend			**Executive Owner: Director of Planning, Digital and ICT**					
			March 2022: • The WG Cyber Resilience Unit (CRU) has completed their assessment. ABUHB is waiting for the report to be received from WG CRU • The Cyber Resilience consultants have concluded their report and presented to an executive session. Next steps agreed with clear actions for next six months. The report and action plan will be shared via a Board briefing session. • CWS high availability work is nearing completion with a target of Q4 21-22 • As part of our own Cyber Security team's target operating model, internal vulnerability scanning is regularly undertaken to identify vulnerabilities in the estate and identify mitigating actions. • A considerable effort was undertaken to identify and address the Log4j vulnerability when realised. 22/475 servers are affected by the vulnerability – 2 of these have solutions. The team are working with third party software vendors for patches to resolve the remaining issues. This will be monitored until completed. • Inspection in weblinks in email has been implemented to enhance protection for staff from malicious email. Mitigations are consistent with the previous update				

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="3">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">This is an enabler risk which would impact on the Health Board's ability to delivery against all of its strategic priorities.</td><td colspan="3">CRR033 (NEW RISK) –
Threat Event: Widespread harm to Health Board staff and patients
Threat Cause: Failure to comply with the full set of civil protection duties;

• Assess the risk of Emergencies occurring and use this to inform contingency planning
• Put in place Emergency plans
• Put in place Business Continuity Management arrangements
• Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
• Share information with other local responders to enhance coordination
• Cooperate with other local responders to enhance coordination and efficiency

TREAT</td></tr>
<tr><td>High Level Themes</td><td>• Reputational
• Public & staff confidence
• Partnership working
• Patient, Quality and Outcomes</td><td>Risk Appetite</td><td colspan="2">LOW</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Audit, Risk and Assurance Committee.</td><td>• Plans & Policies that cover Pandemics, Major Incidents & Business Continuity Incidents.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			4	5	4	5	3	3
			20		**20**		**9**	
Further engagement with Divisions, Directorates and service areas to conduct BIA's develop plans, exercise and review to mitigate the risks and threats to service delivery. This has progressed although due to service pressures, further activity is ongoing.		April 2022 - complete						
Engagement commenced in July/August 2021 with Specialities, Departments and Wards to start the BIA process to record principal service activities or functions to assess the risk of not being able to provide the activity or service. This will be scored against impact and likelihood to provide a rational for score and RAG rate. Progress in some areas but some still in development.		April 2022 Ongoing						
When Divisions, Directorates and Departments have completed this process, we will start to develop individual Business Continuity Plans to mitigate vulnerabilities or single points of failure. The high-level plans will take into account, loss of; building/department, Staff, IT, Utilities and Procurement. Some of these plans are in place however others are yet to commence.		April 2022 – extend to July 2022						
Update - Service BC leads have made good progress with BIA's and the development of plans given the pressures on the HB at this time of year and the effects of the tail end of the Omicron Covid variant.								
Trend			**Executive Owner: Director of Planning, Digital and ICT**					
Mapping Against 4 Harms of COVID			**Update**					

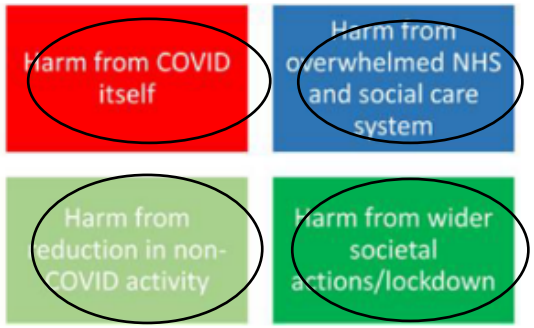
	March 2022 A business continuity incident that disrupted the Health Board IT networks in mid-November 2021 highlighted the Board's reliance on informatics and the gaps in service plans to maintain normal functions. The incident debrief report by Informatics and Emergency Planning details several actions required by departments to review or develop plans that take account of the service or function they provide to stakeholders and how that information is passed between departments during BC disruptions. A serious incident debrief meeting has been held with BC leads to discuss the communications cascade of timely information and recovery time objectives. Workshops have also taken place, and more are planned to further enhance BC knowledge and awareness across the Health Board.

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="4">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="4">CRR008 (Nov 2021) – (Reframed)
Threat Cause: The current Health Board estate is not fit for purpose
Threat Event: Service delivery and patient experience is compromised

TREAT</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Quality and Patient Safety
Patient Outcomes and Experience
Finance
Public Confidence
Reputational
Environmental</td><td colspan="2">Risk Appetite</td><td colspan="2">Moderate risk appetite regarding innovation and developments across the Health Board estate.

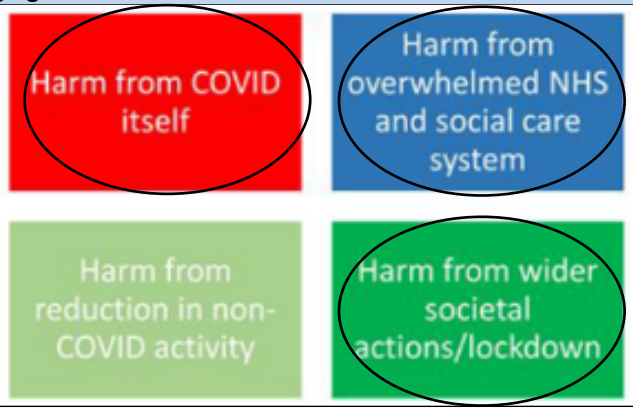
Low risk appetite in relation to adverse staff and patient experience due to poor Health Board estate.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Audit, Risk and Assurance Committee</td><td>6 Facet survey completed in 2019 and the Division is currently updating this to reflect the present position.
The divisional risk register reviewed quarterly at SMB this is reported to QPSOG and risks escalated via this route.
Multiple policies and SOPs published and communicated to staff.
Stat and Mand training to include FIT testing on commencement of employment with the Division.
Estates strategy completed in 2019/20 to align with the Clinical Futures program.
Recently appointed an external authorising engineer for Water Management providing independent external audits.
Robust internal training program in place covering all aspects of Estates management including food hygiene.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• Regular annual audits across all services conducted by NWSSP. Attached are three of the most recent audits conducted by specialist estates shared services HV, Water, Ventilation. All scored reasonable assurance.  2022_03_18_ABUHB_A E(V)%20annual%20rep  2022_03_18_ABUHB_A E(V) annual report 20  HYR37725 - ABNHSHB - AUDIT MI • A previously agreed asbestos reinspection programme taking place over a 3 year period has now been extended to 4 years due to the availability of capital funding. It is not envisaged that this will change the current risk rating.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	3	5	3	5
Estates Prioritisation takes place annually to focus available investment. Plan for replacement Nurse Call Systems which is an additional Capital Requirement. PPD submitted but due to high cost will need to be costed and set up in priority order. Capital bid has been submitted for consideration of the replacement of obsolete Nurse Call systems throughout the Health Board. Additional services arranged to mitigate risk – external company introduced to complete flushing programme on infrequently used outlets. Additional sampling undertaken. Water Risk assessment brought forward for RGH. New contract set up for Water Risk Assessments – spec is now	Annual Capital bids reviewed monthly awaiting outcome	**25**		**15**		**15**	

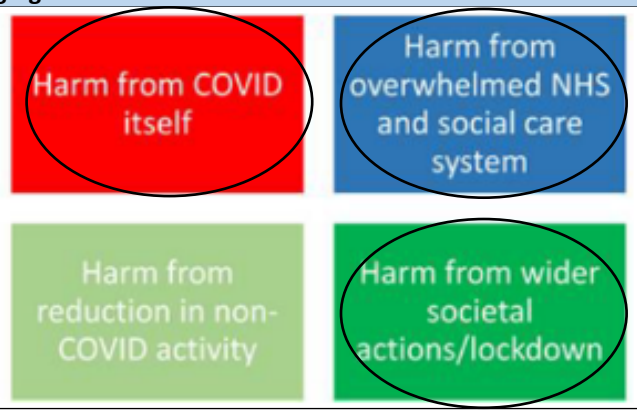
more specific and detailed than previous contracts. Alert to all divisions RE communication/notification with Estates on closures/re-opening of wards to ensure appropriate steps can be taken such as additional flushing and sampling prior to re-opening and during closures. External AE water currently being set up including further auditing by external organisation. The external AE now been appointed formally and has commenced.	This is carried out 3 x weekly Completed			
Trend		**Executive Owner: Director of Operations**		
Mapping Against 4 Harms of COVID		**Update**		
		March 2022: A recent paper was presented to Exec Team to request £820k per annum recurring to provide preventative measures to attempt to slow the Health Board estate deteriorating any further. The request was agreed, and progress will be monitored and reviewed as part of the management of this risk, going forward, however due to the reduction in available finance from April 2022 the Health Board is unable to support the request at this time. This will be reviewed later in the financial year. This does not mean that the risk score will increase; however, the backlog maintenance work will increase. A paper is scheduled to be presented to Executive Team in April 2022 proposing solution to include a water safety team to strengthen current mitigations. Over the last 4 years the department has expanded the Health, Safety and Compliance Team to provide expert training and guidance on issues such as Legionella, asbestos and deliver statutory and mandatory training to all staff at all levels. The Division now has included statutory and mandatory training as part of the induction process, for all new starters, this includes FIT testing for masks. This will inevitably increase compliance in this area. A high emphasis is placed on food safety training. We recently employed an Environmental Health Officer to ensure compliance at a very high standard. External training has been provided for high-risk engineering areas i.e. Authorised person High Voltage, Medical Gas, Water Management, Ventilation and decontamination services. In addition to this specialist estate shared services have appointed all personnel to carry out these duties in writing; and audit annually, each of these specialities. An upgrade of the liquid oxygen systems at NHH and RGH following the first wave of COVID which has effectively doubled our capacity to meet the increased demand. During the planning stage for GUH the site has 100% back up in respect of oxygen supplies. The current risk score reflects all actions undertaken in order to mitigate the critical risks. So the target for the Division will be to maintain this position, continuing to assess the opportunities to reduce the risk further with the progression and implementation of the Estates Strategy.		

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="4">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">This is an enabler risk and therefore applies to all Health Board priorities</td><td colspan="4">CRR016 (Dec-2020) –
Threat Event: Failure to achieve financial balance at end of 2021/2022.
Threat Cause: Due to the COVID-19 Pandemic and the uncertainties and potential significant cost of the organisational response above IMTP/AOF planned levels.

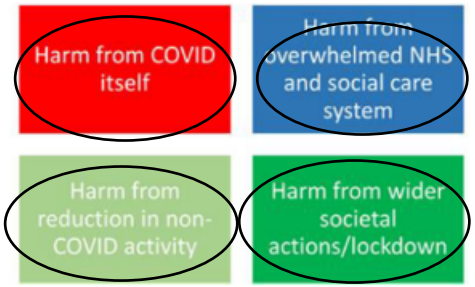
TREAT</td></tr>
<tr><td>High Level Themes</td><td>• Reputational
• Public confidence
• Financial
• Patient Outcomes</td><td>Risk Appetite</td><td colspan="3">Low level of risk appetite in relation to the Health Board's financial statutory requirements. However responding to COVID 19 implications and maintaining safe services take precedence.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Audit, Risk and Assurance Committee</td><td>• Health Board Annual Plan 2021/22
• Standing Financial Instructions (SFIs)
• Health Board Standing Orders
• Recurrent savings plans.
• Regular monitoring at Executive Team reviewing level of deliverable recurrent savings along with assessing cost avoidance and deferred investments.
• Health Board financial escalation processes.
• Health Board Pre-Investment Panel (PIP) process.
• IMTP/AOF Delivery Framework and Divisional Assurance meetings in place which will incorporate implementation of savings plans and delivery of service</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td colspan="2">Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	and workforce plans within available resources. • Financial assessment and review (as agreed at Board, regular monthly COVID and financial reports to Board and Welsh Government) to incorporate financial impact of COVID-19. • Quarterly financial plan approach agreed.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	4	1	4	1	4
• Plans submitted to Welsh Government include financial consequences of COVID-19 response as part of ongoing discussions to secure additional funding to meet Covid-19 spend. • Ongoing discussion with Welsh Government with regard to clarifying Covid-19 allocations and 'recovery' funding allocations for this financial year. • As new priorities emerge service, workforce and financial plans developed to identify financial risks and support funding discussions with Welsh Government (e.g. mass vaccination programme).		**20**		**4**		**4**	
Trend	⟷	**Executive Owner: Director of Finance and Procurement**					
Mapping Against 4 Harms of COVID		**Update**					
		March 2022: Additional Non–recurrent funding has been provided to ABUHB as part of the Sustainability funding issued by WG to support operating in a 'COVID safe environment'. Additionally there are several other COVID-19 related funding streams supporting recovery and system pressures that have provided sufficient funding to support a forecast financial balance for 2021/22. There remains a risk that responding to uncertain pandemic implications may influence the financial costs to the end of the year. The implications of Omicron variant Covid-19 may impact on the spend patterns for ABUHB for quarter 4 – monthly financial reviews will monitor this and appropriate action considered. This risk profile has achieved the target score.					

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
This is an enabler risk and therefore applies to all Health Board priorities		***CRR032 –*** ***Threat Event: Non-achievement of the Health Boards long term strategy.*** ***Threat Cause: Failure to achieve underlying recurrent financial balance.*** **TREAT**					
High Level Themes	• Reputational • Public confidence • Financial • Patient Outcomes	**Risk Appetite**		Low level of risk appetite in relation to the Health Board's financial statutory requirements.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Audit, Risk and Assurance Committee	• Health Board Annual Plan 2021/22 • Standing Financial Instructions (SFIs) • Health Board Standing Orders • Recurrent savings plans. • Regular monitoring at Executive Team reviewing level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Focus in IMTP planning process	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	4	4	4	3	4
• Using the new Health system Improvement framework for 2021/22 - to focus on the strategic priorities for sustainable system change, annual plan priorities should be delivered through this arrangement and will need to achieve service, workforce changes which improve the underlying financial position. E.g. Eye Care Pathway redesign, Outpatients redesign, MSK model redesign, Up-stream public health and Mental Health schemes and levering GUH & Digital opportunities benefits. Use the Pre-Investment Panel to test major	Ongoing monthly review	**20**		**16**		**12**	

investment proposals. Only invest recurrently where recurrent funding is confirmed. Ongoing review of deliverable savings and opportunities for 2021/22 and for the 2022/23 IMTP. • New approach established for 2021/22 with a 'Health Systems Leadership Group', AB Connect - a reconfigured Value/Innovation/ABCi/Research transformation group and investment in a Project Management Office to support system change at scale to deliver recurrent sustainable improvement and improve resource utilisation through service, workforce and financial planning for the health board.	Ongoing monthly review	
Trend		**Executive Owner: Director of Finance and Procurement**
Mapping Against 4 Harms of COVID		**Update**
		March 2022: Additional funding from Welsh Government identified for 2022/23 for ABUHB of £32m recurrently to support recovery and other service pressures, subject to WG approval of proposals. As part of the agreed principles of the IMTP this funding needs to consider the unfunded service plans established to date as well as other high priorities identified by ABUHB as part of the IMTP. There should also be further recurrent savings and efficiencies developed and delivered. There should be a reasonable expectation of reducing the recurrent underlying deficit as we enter 2022/23 as part of IMTP planning. The 2022/23 Health Board IMTP is due to be submitted and the allocation letter for 2022/23 has been received from WG, current assessments identify a continuing underlying deficit, which will require a greater focus on recurrent savings, cost avoidance and prioritisation of service proposals.

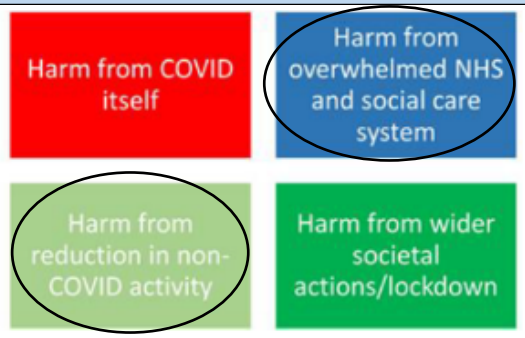
Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		***CRR004 (Nov 2021) – (Reframed)*** ***Threat Event: The Health Board does not meet its statutory duty under the Well-Being of Future Generations (Wales) Act 2015 or the Socio-Economic Duty.*** ***Threat Cause: Non-compliance with relevant Legislative requirements.*** **TAKE OPPORTUNITIES** **TREAT**					
High Level Themes	• Partnership • Research, Innovation Improvement Value • Quality and Patient Safety • Patient Outcomes and Experience • Health Inequalities • Financial • Public Confidence	**Risk Appetite**		**LOW/MODERATE** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Audit Risk and Assurance Committee	Programme Board in place to ensure the duties in the WBFA are applied across the organisation. Each Division has developed and agreed wellbeing objectives which have been signed off by Board and published. Organisational wellbeing objectives and PSB(s) wellbeing objectives reflected within the IMTP and Divisional Plans.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		3	4	1	4	1	4
Internal Audit Report was completed in 2019 and reasonable assurance given, but a number of key recommendations are being taken forward including a refresh of the Programme Board governance arrangements. Development work is underway to incorporate the statutory obligations of the Socio-economic Duty to the corporate reporting templates of the Health Board to emphasise the importance of the Duty across the organisation.	Jan – 21 Dec-21	**12**		**4**		**4**	

Trend		Executive Owner: Director of Public Health and Partnerships
Mapping Against 4 Harms of COVID		**Update**
		March 2022 The Health Board is leading the Gwent Public Service Board Response Analysis to inform the development of the health inequality element of the PSB Wellbeing Plan and the drafting of collective Wellbeing Objectives in line with the Socio-Economic Duty and the HB's collective (partnership) duties under the WBoFG Act. Work to review the HB's individual Wellbeing Objectives remains paused due to operational pressures, but the pause will enable that review to align the ABUHB Individual Wellbeing Objectives with the draft Gwent PSB Wellbeing Objectives once agree at the June meeting of Gwent PSB.

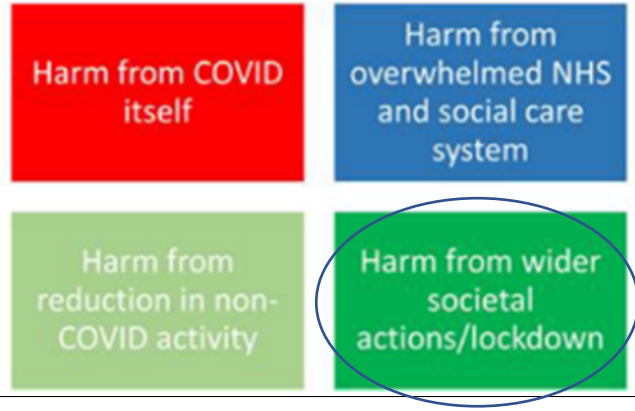
Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Enabler risk and links to all priorities**		***CRR020 – (May-2019)*** ***Threat Cause: Failure to implement Welsh Community Care Information System (WCCIS)*** ***Threat Event: Inability to access patient clinical information across all services, departments and partner organisations (such as Local Authority).*** **TREAT**					
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Financial • Public confidence	**Risk Appetite**	There is a high level of appetite for risk on this areas to innovate in the area of digital technologies however, low level risk appetite to maintain patient safety. Therefore the Health Board will ***Treat*** this risk.				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Audit, Risk and Assurance Committee	• Risks managed at Local ABUHB & Regional Programme Boards • Escalation routes in place to ABUHB exec team, Regional Partnership Board and National Leadership Board • Internal audit carried out by NWSSP gave substantial assurance that arrangements to secure governance, risk management and internal control are applied effectively • Extension of current supplier contract into 2022	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		2	5	4	4	3	5

• Twice weekly meetings in place in the lead up to go LIVE for MH&LD services with supplier and national programme team • Develop Cutover Plan and confirm Service Management Arrangements for go LIVE towards the end of April 2022 • Review impact on later phases of the programme and realign implementation plan	April 2022	**10**	**16**	**15**

Trend since last reporting period		**Executive Owner: Director of Planning, Digital and ICT**

Mapping Against 4 Harms of COVID	**Update**
	March 2022: ePEX contract extended beyond March 2022 to support the transition to WCCIS & sunset activities. WCCIS refresher training commenced with MH&LD service. Data Migration testing and a refresh of the system configuration is underway. Weekly meetings scheduled in the lead up to go LIVE which is currently planned for the End of April, with weekly escalation meetings being held with the service, supplier and national programme team. National WIAG support received for go LIVE. Communication plan in place. Cutover plan being finalised, and service management arrangements drafted for sign off of operational acceptance.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **This is an enabler risk and therefore impacts the Health Board's ability to achieve all objectives and strategic priorities**		***CRR034 NEW RISK*** ***Disruption to Health Board services due to the Ukraine crisis.***					
High Level Themes	• Partnership • Quality and Patient Safety • Patient Outcomes and Experience • Finance • Public Confidence • Reputational	**Risk Appetite**		Risk appetite is low in this area in respect of patient safety however, a higher risk appetite will need to be applied when reviewing regional responses to the crisis and how the Health Board and its Partners can work collectively to address and mitigate the risks.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Audit, Risk and Assurance Committee	• Service Business Continuity Plans (BCPs) • Service Contingency Plans • Internal demand modelling data • Welsh Government guidance on healthcare provision for asylum seekers/refugees • Internal bi-weekly meetings convened to report directly to Executive Team with escalations and by exception.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		3	5	2	5	1	5

Conduct analysis of Business Continuity Plans across sites and Divisions to ensure a state of readiness and ensure that this is communicated with key individuals across the organisation. Review and testing of Health Board Civil Contingencies Plans. Workforce colleagues identify and ensure support for staff who have family or friends in the Ukraine or Russia.	April 2022 April 2022 March 2022	**15**	**10**	**5**
Trend	**NEW RISK**	**Executive Owner: Director of Planning, Digital and ICT**		
Mapping Against 4 Harms of COVID		**Update**		
		March 2022 A focus group has been established to meet bi-weekly to discuss any potential risks as the crisis develops. This group will report to Executive Team and by exception as and when required.		

Internal Audit Progress Report

Audit, Finance and Risk Committee

April 2022

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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

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

Contents

1. Introduction

The purpose of this report is to:

- highlight progress of the 2021/22 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the April 2022 Audit, Finance and Risk Committee;
- present the draft 2022/23 Internal Audit Plan; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2021/22 Internal Audit Plan

There are 38 individual reviews in the 2021/22 Internal Audit Plan including four GUH reviews, provision for follow-up work and three audits which are undertaken at NWSSP.

The table below details progress against the 2021/22 Internal Audit Plan.

Number of audits in plan:	38
Number of audits reported as final	17
Number of audits reported in draft	3
Number of audits in progress	8
Number of NWSSP audits	3
Number of audits to be reported in 2022/23	1
Number of audits deferred	6

The following reports have been issued since the meeting of the Audit, Finance and Risk Committee on 3 February 2022:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
CHC – Mental Health and LD	Limited
Risk Management	Reasonable
Flu Immunisation	Reasonable
Falls Management	Reasonable
GUH: Quality	Reasonable

Further information over the assurance ratings detailed above is included with Appendix B.

3. Summary of Findings

Limited assurance reports are considered by the Audit, Finance and Risk Committee in detail. The following summary provides the Committee with the main messages from the reasonable assurance reports issued since the last meeting on 3 February 2022.

Risk Management (reasonable assurance)

The Health Board is continuing towards becoming a risk mature organisation. The fundamental principles of risk management are largely embedded throughout the governance structures established as an NHS organisation. We found numerous examples of risk being managed as staff undertook their daily activities.

Further work is required to clearly and effectively communicate the 'risk vision' and create a culture where everyone has ownership and responsibility for doing the right thing for the organisation.

The matters requiring management attention included:

- The objectives of the Risk Management Strategy should be monitored for implementation.
- Formal risk management training should be considered throughout the Health Board, to help standardise and promote risk management.

Flu Immunisation (reasonable assurance)

This audit focussed primarily over the staff flu immunisation uptake. However, we did review the governance arrangements in place for the community / primary care roll-out of the programme.

Overall, we found good processes in place, with active communication and promotion of the flu immunisation programme. These were stepped down during the Omicron variant surge during December 2021. When comparing 2020/21 and 2021/22 there has been a decrease in staff flu uptake from 65.8% to 57.8% (as at 15th February 2022). For the year 2019/20, the rate during the same week was 60%. The ambition target set by the Welsh Government is 80%.

However, the overall primary care uptake for children and vulnerable adults within the Health Board's area is the highest across Wales within the majority of categories.

The matters requiring management attention included:

- Terms of reference for the Flu Working Groups are not complete.
- We found a lack of flu immunisation reminders issued for staff and a decrease in the number of flu champions.
- There were less flu clinics available for staff compared to 2020/21.

Falls Management (reasonable assurance)

Within this audit we selected a large sample of patients where a documented multi-factorial risk assessment (MFRA) is required. This included patients 65 years or older or at a risk of a fall. We also selected a sample of inpatients that had been subjected to a fall, to determine if a subsequent MFRA had been completed, together with the corresponding Datix entry.

Overall, we found that the number of inpatient falls declined following the introduction of the revised multi-factorial risk assessment (MFRA) and policy. However, the assessment was not always documented.

Within the sample tested, we did find that the completion rate of the assessment forms to be consistent with our previous audit of Falls Management. Therefore, the decline may be linked to the recent promotion of the updated policy and associated training.

In our sample testing we found the following exceptions:

- Six of 30 patients, where a fall had occurred, did not have a completed MFRA recorded prior to the fall.
- 12 of a separate sample of 29 patients tested did not have a MFRA completed within the timeframe required. However, we recognise this was within a pandemic environment.
- Three of the same sample of 29 patients tested did not have a MFRA recorded, when one should have been completed.

We also identified that fall investigation notes documented within Datix for six patients sampled were marked as 'unexpected falls'. However, there was no MFRA completed prior to the fall.

GUH: Quality (reasonable assurance)

We sought to provide assurance across a number of areas including the quality of the delivered build of the Grange University Hospital (GUH).

Accordingly, this audit sought to determine whether the GUH provision, had been reviewed against the objectives of intended functionality, and capital investment objectives, as specified at the business case.

We found that the build of the GUH substantially provides the ability to deliver enhanced services, in accordance with the objectives of the business case. However, the delivery of capital investment benefits has been impacted by the pandemic, and accordingly it may be appropriate for revised targets to be put in place. These were being reviewed by management to amend accordingly.

The matters requiring management attention included:

- Reporting against the aspirations of the business case.
- Reviewing and the monitoring of targets for the capital investment benefits, in accordance with the ongoing utilisation of the facility.

4. 2022/23 Internal Audit Plan

The 2022/23 Draft Internal Audit Plan has been produced and is reported to the April Audit Committee meeting for review. As we have yet to receive formal feedback from the Executive Team (due 13th April 2022) we will represent the Plan to the May 2022 Audit, Finance and Risk Committee for formal approval and sign-off. The process for the development of the plan is the same as for previous years.

The draft Plan reflects the general risk profile of the organisation as shown in the corporate risk register and rotational coverage of key areas. As the Health Board continues to exit from the Covid-19 pandemic, the possibility of future surges and uncertainty remains. The Plan may require revision, both in terms of coverage and timing when it is appropriate to do so. If required, this will be done through the established governance and approval processes.

5. Other Activity

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

- monthly meetings between the Acting Head of Internal Audit and Director of Corporate Governance;
- monthly meetings with the Director of Finance and Performance;
- Audit, Finance and Risk Committee pre-meeting with the Audit, Finance and Risk Committee Chair;
- meetings with the Chair and Chief Executive;
- review and advice over financial control procedures;
- audit scoping meetings; and
- liaison with senior management.

6. Recommendation

The Audit, Finance and Risk Committee is invited to note the above.

Appendix A: Progress against 2021/22 Internal Audit Plan

Review	Status	Draft report date	Management Responses received	Rating	Summary of recommendations	Actual / Anticipated AFR Committee [1]
Corporate Governance	Work in progress					May
Risk Management	Final Report	7th March	24th March	Reasonable	2 Medium	April
Financial Sustainability	Work in progress					May
Continuing Healthcare	Final report	3rd December	13th March	Limited	4 High, 2 Medium	April
Flu Immunisation	Final report	10th March	21st March	Reasonable	1 Medium, 1 Low	April
Mental Capacity Act	Final report	10th September & 19th October	25th October	Reasonable	1 High, 3 Medium, 1 Low Priority	December
Gifts, Hospitality and Declarations of Interest	Final report	28th July	30th July	Reasonable	2 Medium Priority	August
Clinical Negligence Costs	Final report	8th & 17th November	22nd November	Substantial	1 Medium, 1 Low Priority	December
Putting Things Right	Final report	3rd & 20th September	27th September	Reasonable	2 Medium Priority	October
Charitable Funds	Final report	2nd November	19th November	Substantial	1 Medium Priority	December

Medical Equipment and Devices	Work in progress					May
Medicines Management (including Controlled Drugs)	Work in progress					May
Falls Management	Final report	22nd February	14th March	Reasonable	1 High, 1 Medium	April
Datix	Work in progress					May
NIS Directive	Work in progress					May
IT System Controls (WRIS)	Final report	8th November	15th December	Reasonable	1 High, 9 Medium Priority	February
Operational Plan for Resumption of Services	Draft report					May
Flow Centre	Work in progress					May
Pathology	Final report	9th November	24th November	Reasonable	4 Medium, 6 Low Priority	December
Facilities Directorate Review	Draft report	23rd March				May
Occupational Health	Final report	27th October	10th November	Substantial	2 Low Priority	December
Tredegar Health and Well Being Centre	Final report	7th October	21st October	Reasonable	4 High, 6 Medium, 2 Low Priority	December
Waste Management	Draft report					May

GUH: Financial Assurance (Follow-up)	Final report	3rd November	9th November	Substantial	No findings	December
GUH: Technical Assurance	Final report	8th November	10th November	Substantial	1 Low Priority	December
GUH: Follow-up	Final report	15th October	18th November	Reasonable	2 Medium Priority	December
GUH: Quality	Final report	1st & 20th December	31st January	Reasonable	2 Medium Priority	April
Follow-up on Previous Recommendations	Work in progress					May
Decarbonisation	Deferred					N/A
Catering	Deferred					N/A
Agile Working	Deferred					N/A
Monitoring Action Plans	Deferred					N/A
Clinical Futures – Care Closer to Home	Deferred					N/A
Quality Framework	Deferred					N/A
CHC - Children	C/fwd					N/A

Reviews at other bodies (undertaken within NWSSP Plan)		
Purchase to Pay	Draft report	TBC
Payroll	Work in Progress	TBC
PCS Contractor Payments	Draft report	TBC

[1] May be subject to change

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.

Continuing Healthcare

Quality Governance arrangements for the commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities Division

Final Internal Audit Report

March 2022

Aneurin Bevan University Health Board

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

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

Contents

Review reference:	AB-2122-06
Report status:	Final
Fieldwork commencement:	20th September 2021
Fieldwork completion:	3rd December 2021
Draft report issued:	3rd December 2021
Debrief meeting:	11th November 2021 / 18th November 2021 / 22nd February 2022
Management response received:	13th March 2022
Final report issued:	17th March 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Emma Rees, Interim Deputy Head of Internal Audit
Executive sign-off:	Rhiannon Jones, Director of Nursing Chris O'Connor, Interim Director of Primary, Community & Mental Health Services
Distribution:	Mental Health & Learning Disabilities Divisional Management Team Mental Health & Learning Disabilities Commissioning Team
Committee:	Audit, Finance and Risk Committee Quality and Patient Safety Committee

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

Acknowledgement

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

Executive Summary

Purpose

To provide assurance that there are robust commissioning arrangements in place within the Mental Health and Learning Disabilities Division (the Division), focusing on quality and safety.

Overview

We have provided **limited assurance** on this area. The matters which require management attention include:

- Ensuring sustainable improvements in terms of accountability and scrutiny for commissioned services;
- Wider Divisional attention and oversight of CHC / S117 commissioning activity;
- Assessing the quality of services delivered by providers on the All Wales Framework (AWF);
- Ensuring Divisional preparedness for the implementation of the new national policy and framework for CHC (due April 2022), to include a robust approach to training.

Whilst this review has highlighted a number of areas where rapid improvement is required in terms of oversight of quality and safety for commissioned services, it is recognised the Division had identified the need for work in these areas. Some progress has been made but it has been halted by the Covid Pandemic.

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	CHC / S117 commissioning arrangements:	
	i. Governance and management	Limited
	ii. Risk management	Reasonable
	iii. Monitoring non-framework providers	Reasonable[2]
	iv. Monitoring AWF providers	Limited
	v. Reporting and scrutiny	Limited
	vi. Resource and staff support	Reasonable[2]
2	CHC / S117 commissioning policies and procedures	Limited
3	Assessment of clients in receipt of CHC / S117 care	Limited

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

[2] Whilst we have provided reasonable assurance over this objective, increased CHC / S117 demand and resource capacity concerns within the Team present a risk to the longer-term sustainability of the controls in place. See matter arising two.

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Accountability, scrutiny and risk	1	Design	High
2	Future of MH&LD commissioning – appraisal options	1	Design	Medium
3	All Wales Framework providers – quality assurance	1, 3	Design	High
4	Compliance and internal quality assurance	1, 3	Design	High
5	CHC policy and procedure	2	Operation	High
6	Non-framework providers – contracts	1, 3	Design	Medium

1. Introduction

1.1 Following the recent conclusion of the Gwent Coroners Inquests into the deaths of several people between 2003-2006 at Care Homes associated with Operation Jasmine, Aneurin Bevan University Health Board (the 'Health Board') has undertaken further reflection exercises – for assurance purposes – regarding its governance arrangements for adults eligible for Continuing NHS Healthcare (CHC).

1.2 Having satisfied itself in terms of general complex care, the Health Board recognised a similar approach was required for children with complex care needs and for people with a learning disability or mental health need.

1.3 As part of the 2021/22 Internal Audit Plan, we reviewed the quality governance arrangements in place within the Health Board's Mental Health & Learning Disabilities (MH&LD) division (the 'Division') for the commissioning of CHC and Section 117[3] (S117) care.

1.4 Specific consideration was given to:

- contractual arrangements in place;
- monitoring against Fundamentals of Care and Health & Social Care standards;
- case reviews;
- evidence of 'what matters' assessment and person-choice;
- the process for gathering triggers of service concerns, together with collating and analysing intelligence;
- whether the Social Service Well Being Act (2014) and Regulation Inspection of Social Care Act (2016) are considered;
- the Escalating Concerns Policy, including implementation; and
- the approach to monitoring provider performance, including formal review.

1.5 Our review took into account the impact of the Covid-19 pandemic, as set out in paragraphs 1.19 to 1.23, specifically the impact of lockdowns, restricted visiting, staff redeployment and staff absenteeism.

Associated risks

1.6 The key risk considered in this review is failure to identify and address inadequate care arrangements within a care home/commissioned placement, potentially leading to:

- poor client experience &/or harm;

[3] Patients who have been detained in hospital under sections 3, 37, 45A, 47, or 48 of the Mental Health Act 1983 are entitled to S117 aftercare upon discharge. The Health Board and Local Authority have a duty to provide S117 aftercare to prevent patients' mental health conditions from deteriorating and to avoid readmission to hospital.

- failure to comply with relevant legislation; and
- financial or reputational damage.

Limitations of scope

1.7 The audit excluded:

- Funded Nursing Care packages;
- CHC commissioning for children with complex needs (we are undertaking a separate review in this area); and
- testing of individual patient records for compliance with the CHC National Framework for Implementation in Wales 2014 and the associated Decision Support Tool – our review is focused on how the Health Board is assured the care delivered by CHC/S117 providers is of adequate quality rather than the patient placement process; and
- testing of client contact outside of the legally required annual patient reviews (dependent upon the client these may be: CHC eligibility, S117 eligibility, CHC Care Plan or Care and Treatment Plan (CTP) reviews).

Background

1.8 MH&LD CHC / S117 placements fall across several types of setting, including secure units, nursing and residential homes. Figure 1 shows client placements in June 2021.

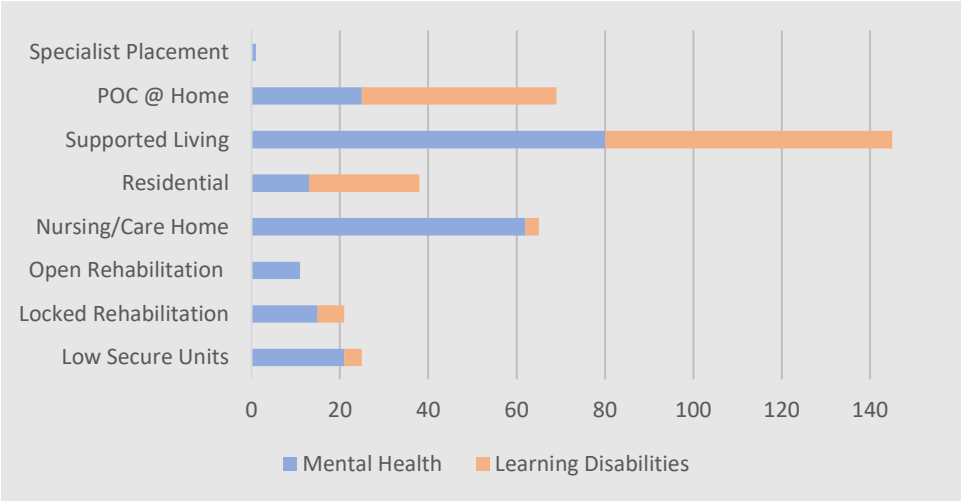


Figure 1: Patient placements in June 2021 (source: 2021/22 Q1 Commissioning Performance Report)
Notes:

- *The specialist placement is an NHS facility due to the complexities of the individual*
- *POC @ Home packages in MH are Medication Prompts*
- *POC @ Home packages in LD are for individuals that still live in the family home and do not have a tenancy – they include domiciliary care support, transport, day services and respite*
- *Placements in Open Rehabilitation, Locked Rehabilitation and Low Secure Units are within a hospital setting on the All Wales Framework (total of 57 placements in June 2021)*

1.9 On average in quarter one of 2021/22, 77 of the placements each month were outside of the Gwent area, with 19 of those being outside Wales (see figure 2)[4].

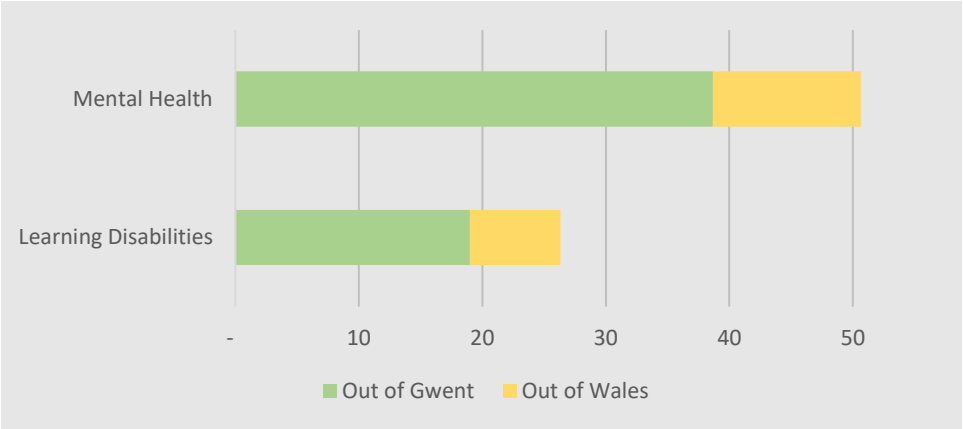


Figure 2: average out of Gwent placements, Q1 2021/22 (source: 2021/22 Q1 Commissioning Performance Report)

1.10 The Division has a CHC/S117 Commissioning Team (the 'Commissioning Team') which is responsible for commissioning CHC/S117 care and monitoring provider performance, including the quality of care delivered (further details under objectives one and three in section two). The Commissioning Team works collaboratively with colleagues across the Division and is not a standalone directorate.

1.11 The clinical monitoring of a placement is the responsibility of the Multidisciplinary Team (MDT) involved. S117, CHC eligibility / Care Plan reviews, and Mental Health measure compliance are the responsibility of the Care Coordinators.

1.12 Our review focused mainly on the work of the Commissioning Team, with consideration also given to compliance with the requirements to undertake S117 / CHC eligibility and Care Plan (CHC or CTP) reviews annually.

1.13 The MH&LD CHC / S117 caseload has increased significantly over the past five years (figure 3), resulting in increased placement costs (figure 4). Correspondingly, this has increased the workload of the Commissioning Team and Care Coordinators.

1.14 The monthly average for Q1 2021/22 was 371 commissioned placements, split as:

- 224 for Mental Health (of which 203 were S117); and
- 147 for Learning Disabilities (of which 29 were S117).

1.15 In comparison, there were around 225 commissioned placements in September 2015.

1.16 The increased demand has been exacerbated by the Covid-19 pandemic, as certain provider performance activities were stood down by Welsh Government (see paragraphs 2.17 and 2.68 for further detail). We understand that this work has

[4] The underlying principle of the Division is to commission care as close to home as possible in the least restrictive environment. This is usually within the Gwent area. However, there are occasions where this cannot be achieved, for example, due to the service not existing locally or lack of local placement capacity at the time it is required.

now restarted, and the Division has secured additional, fixed-term funding for resource to address the backlog created.

1.17 The Team is aware of the challenges it faces and is keen to identify and deliver service improvements. We understand the Deputy Divisional Nurse has led on a review of the Division's commissioning activities to support this. The review commenced in September 2019 but was paused when the Division re-prioritised its focus at the start of the Covid-19 pandemic (see paragraphs 1.19 – 1.23). Work recommenced in August 2021, when additional capacity was brought into the Team. Whilst this has now been impacted by the prevalence of the Omicron variant, the Team provided recommendations to the Divisional Senior Management Team (SMT) for consideration in early January 2022.

Covid-19 impact

1.18 We recognise the Covid-19 pandemic has had a profound effect on the delivery of CHC / S117 commissioning and that, at an operational level, dealing with the unprecedented nature of the pandemic over a sustained period brought intense pressures.

1.19 As expected, the events of the pandemic have determined to a large extent the areas of priority for the Division. Priority has been given to maintaining essential services during the pandemic, utilising all operational resource available.

1.20 As noted in paragraph 1.17, an impact of this was that some of the CHC/S117 commissioning improvement work was put on hold to enable resources to be diverted to the pandemic response. Had this not been the case, the Division's original intention was to be further progressed with this work by the time of our audit.

1.21 During the pandemic, the Commissioning Team continued to carry out their duties and support patient pathways, except for Clinical and Non-Clinical Standards Audits which were stood down in line with Welsh Government guidance (see further details in paragraphs 2.17 and 2.68).

1.22 We were informed that, on top of this, the Team carried out additional duties in support of the pandemic response.

1.23 Whilst the commissioning improvement work was paused for a time during the pandemic and has been impacted more recently by the prevalence of the Omicron variant, it remains a priority for the Division and is incorporated into the Division's 2021/22 Annual plan – see paragraph 2.1.

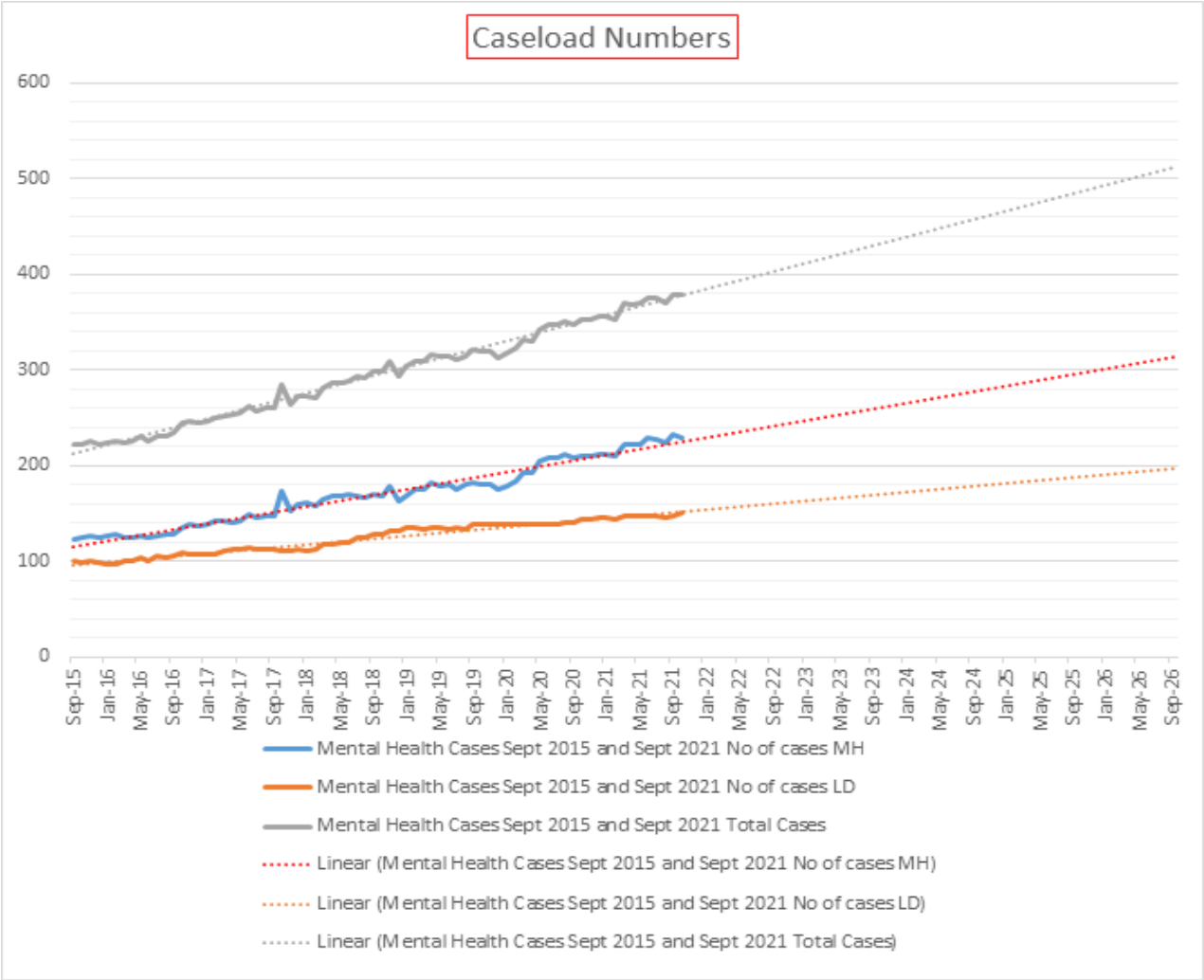


Figure 3: CHC / S117 caseload, September 2015 onward (source: MH&LD Commissioning Team)

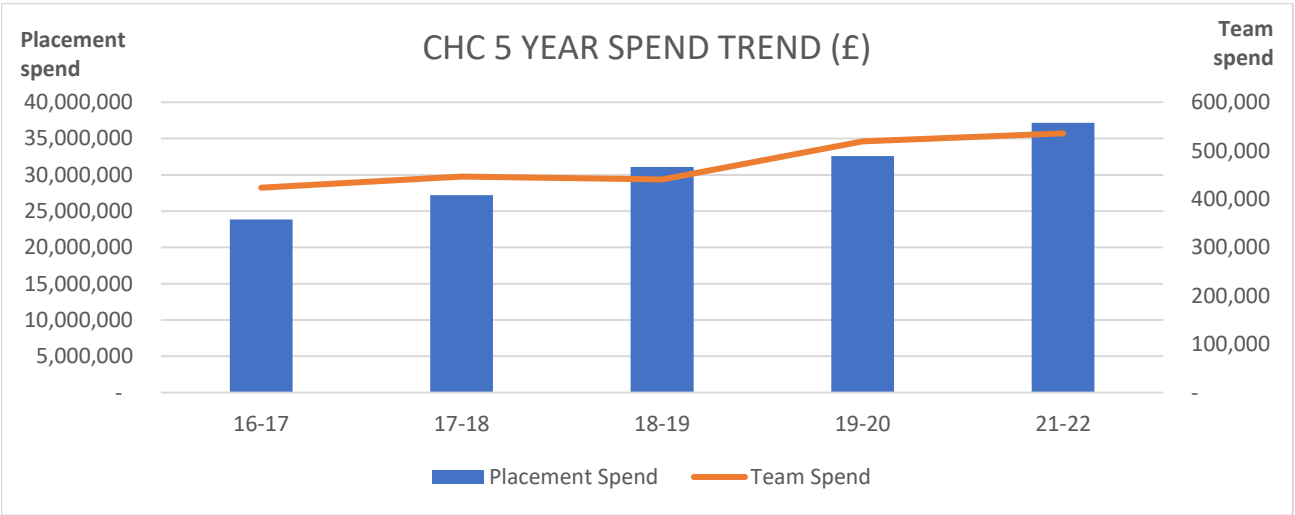


Figure 4: CHC / S117 placement spend vs Commissioning Team spend, 2016/17 onward (source: MH&LD Commissioning Team)

2. Detailed Audit Findings

Audit objective 1: the Division has robust CHC/S117 commissioning arrangements in place

Governance and management of CHC/S117 commissioning

2.1 The quality of care for clients with complex needs, including CHC/S117, is clearly embedded in the Division's priorities. The 2021/22 Annual Plan contains three strategic priorities, one of which is the Complex Needs Programme (CNP). The CNP will cover a five year period and was in development at the time of our review.

2.2 Prior to the Covid-19 pandemic, the Divisional SMT identified the need for improved governance and oversight of the Division's commissioning activities, including the Commissioning Team.

2.3 Work to identify where improvements were needed was delayed by the pandemic. We were informed that the Deputy Divisional Nurse has now progressed this work, with the pace picking up during summer 2021, and understand that many of the findings of our review were also identified by this work. A report was presented to the Divisional SMT in January 2022.

2.4 During our fieldwork, staff interviewed indicated a lack of clarity in:

- roles and responsibilities within the Commissioning Team – roles have changed over time, creating ambiguity; and
- the split of responsibilities between the Commissioning Team and Care Coordinators has led to the potential duplication of effort, particularly regarding monitoring compliance with annual patient reviews, and may be contributing to the capacity concerns raised by the Team (see paragraph 2.39-2.42).

2.5 The Team's Lead Nurse was undertaking a demand and capacity review, which was ongoing at the time of our audit. We were informed this would include identifying the needs of the Team and clarifying roles and responsibilities, ensuring clarity.

2.6 The MH&LD Quality Assurance Panel (QAP) meets weekly and is responsible for oversight of CHC/S117, including client care and provider performance issues. The Commissioning Team also discusses these topics.

2.7 Until October 2021, reporting upwards from the QAP (i.e. to Divisional management and beyond) was by exception only. We could find no evidence of commissioning performance and activity being reported formally to the Director of Primary Care, Community and Mental Health/LD, Executive Team or Patient Quality, Safety & Outcomes Committee.

2.8 See **findings 1** and **2** in **Appendix A**.

Risk management

2.9 Year on year CHC cost increases, increasing CHC demand and the impact on the Team's workload are included in the Division's risk register. Whilst the risks in the register highlight the potential financial impact, they do not draw out the potential impact on the quality and safety. See **finding 1** in **Appendix A**.

2.10 Covid-19 related CHC / S117 risks are clearly stated in the Division's Covid-19 risk register.

Monitoring individual provider performance – non-framework providers

2.11 The Health Board has standard overarching contracts used for commissioning CHC/S117 care from non-framework providers, one for personal care and one for residential care. Each patient then has a supporting contract outlining their care package and costs (the individual patient contracts were out of scope for our review, so we did not undertake testing of this area).

2.12 The standard overarching contracts do not cover processes for monitoring provider performance and quality nor are key performance indicators (KPIs) /metrics identified.

2.13 We identified that the overarching contracts are signed by the Contract & Performance Managers (within the Commissioning Team) on behalf of the Health Board. Whilst we understand this does not commit the Health Board to any financial expenditure or service, this is not in line with the Health Board's Scheme of Delegation.

2.14 See **finding 6** in **Appendix A**.

2.15 The Commissioning Team maintains a provider database listing all providers, including information such as whether the contracts and insurances are in date, when Non-Clinical Standards Audits have been undertaken, the date of the most recent inspections (e.g., Care Inspectorate Wales, Care Quality Commission etc), and any regulator notices / suspensions / embargos / etc.

2.16 The Non-Clinical Care Standards Audits should be undertaken annually by the Health Board's Contract & Performance Managers (within the Commissioning Team). These audits are key to monitoring overarching provider performance and cover topics such as inspectorate registration, staffing matters, incidents / accidents, complaints, confidentiality, safeguarding, general accommodation and cleaning matters, nutrition / hydration, and general patient personal matters.

2.17 We were informed by the Commissioning Team there were challenges to robust completion of annual audits pre-Covid but the pandemic has further exacerbated the issue, with auditing impacted by the inability to physically visit commissioned placement providers.

2.18 Throughout the pandemic, working arrangements in place included:

- weekly meetings with each of the Gwent Local Authorities (separate meetings for each provider) and provider visits undertaken by Infection

Prevention & Control Teams, Environmental Health Officers and inspectorates / regulators. These meetings have now been stood down;
- clinical teams and Case Managers continued to maintain reviews of patient care, either face to face (if required) or via Teams – whilst we did not test this specifically (out of scope for this review), we did see evidence of this on patient files; and
- we were informed that:
  - escalation processes are through meetings between the Team, MDTs, providers and other stakeholders to address concerns;
  - providers reported using twice weekly SITREP reports;
  - safeguarding procedure remained in place with face-to-face review of incidents and Teams-based strategy meetings; and
  - the Closed Settings Group meeting would be convened if 15% of homes with residents became infected, or onward transmission in the community reached 15%.

2.19 The Commissioning Team was restarting the Non-Clinical Care Standards audits during our fieldwork. At that time, there was a backlog of 61 out of 64 non-framework providers that had not received a Non-Clinical Care Standards Audit within the past 12 months. We understand that the Division has secured additional, fixed-term funding for resource to address the backlog.

2.20 Where concerns are identified within providers, action plans are developed to support improvement. These action plans are monitored regularly with the provider to ensure implementation and updates are provided weekly to the QAP. Where necessary, other stakeholders (e.g., local authorities, inspectorates etc.) are involved in this process.

2.21 Where required, follow-up visits to Non-Clinical Standards Audits should be undertaken to ensure actions are implemented appropriately.

2.22 During our fieldwork, we saw evidence that significant concerns are escalated to Divisional Management and, where necessary, to the Executive Team.

<u>Monitoring individual provider performance – All Wales Framework</u>

2.23 The Health Board also commissions CHC and S117 care from providers on the All Wales Framework (AWF). This is usually for clients with more complex needs and requiring secure facilities. The AWF is managed by the National Collaborative Commissioning Unit (NCCU), which is hosted by Cwm Taf Morgannwg University Health Board (CTMUHB). As part of its role, the NCCU provides assurance over the quality of care at AWF providers via annual provider performance audits.

2.24 Whilst the NCCU manages the AWF, the Health Board still has a responsibility to ensure the care commissioned from AWF providers is appropriate and of good quality. We considered the Health Board's relationship with the NCCU and its assurance mechanisms for the quality performance work the NCCU undertakes.

2.25 The NCCU was able to continue to operate throughout the pandemic, although due to restrictions was not able to undertake performance audits at every

provider. According to its 2020/21 annual report, it was able to adapt its monitoring processes accordingly.

2.26 The Commissioning Team's provider database identified 32 AWF providers at the time of our review. We selected a sample of five, noting that for three an audit had been undertaken within the past 12 months and for one, an audit had been undertaken within the past 24 months. All four audits had been followed up by the NCCU to ensure actions were implemented.

2.27 For the fifth AWF provider in our sample, we identified that:

- The Commissioning Team could not locate a recent audit, subsequently discovering that the provider had chosen not to re-join the AWF;
- The Team further identified the NCCU does not inform commissioners when providers do not re-join (although we understand it would communicate if a provider had been removed due to performance issues);
- The Team placed a patient at this provider in June 2021. Unaware that the provider was no longer on the AWF, the Team did not undertake the pre-placement checks or issue a contract, as would be required for non-framework providers. We were informed the Team is in the process of rectifying this matter; and
- Additionally, had this not been identified through the audit, the Team would not have undertaken the annual Clinical Care Standards (see objective 3) and Non-Clinical Care Standards Audits for this client/provider.

2.28 Divisional management and the Commissioning Team are aware of the responsibility to ensure the quality of care at AWF providers. We were informed that the Division's Clinical Care Standards (see audit objective 3) and Non-Clinical Care Standards Audits should also take place at AWF providers. However, we were informed that, before the pandemic due to resource availability, the Team focused its efforts on areas of higher risk (i.e. non-framework providers), so these audits have not been undertaken at AWF providers for several years[5].

2.29 We identified that whilst there is a formal relationship between the Health Board and NCCU:

- it is not referred to in any of the Health Board's or Division's CHC/S117 policies or procedures; and
- aside from the annual NCCU report, there is no performance monitoring or assurance mechanism in place over the quality of the service delivered by the NCCU. Note: we appreciate there are governance mechanisms for the NCCU within CTMUHB, but this finding relates to performance management and quality assurance mechanisms we would expect to see in place where services are provided by other organisations on behalf of the Health Board,

[5] Whilst Clinical Standards and Non-clinical Standards Audits have not been carried out at AWF providers, the Health Board still has regular contact with patients through the patient review process set out under objective 3.

for example, performance reporting/monitoring against agreed KPIs, independent quality assurance over the NCCU work.

2.30 We understand that there was a quarterly All Wales Commissioners Forum with the NCCU which allowed for discussions and updates on audits, concerns, etc. However, these meetings ceased prior to the pandemic. It is not clear if these will start again.

2.31 The Commissioning Care Assurance and Performance System (CCAPS) managed by the NCCU should provide the main form of communication between the NCCU and the Health Board. It is an information portal on AWF providers and should alert commissioners to issues (e.g. incidents, safeguarding concerns) and quality assurance activity.

2.32 See **finding 3** in **Appendix A**.

CHC/S117 reporting and scrutiny

2.33 Our review of the Commissioning Team and QAP papers and minutes identified that provider concerns are reported to, and discussed at, the weekly meetings. We also saw evidence of significant concerns being escalated to Divisional management and beyond where necessary.

2.34 In early 2021/22, the Commissioning Team recognised there was a gap in performance reporting for CHC/S117 commissioning. Prior to 2021/22, performance was being reported by exception and there was no overarching, balanced view of commissioning activity and performance at any level within the Health Board. Due to the lack of performance reporting in the period under review, we cannot provide assurance on the completeness of the exception reporting that has taken place.

2.35 The Team developed a commissioning performance report for quarter one (Q1) of 2021/22 containing information on the types of packages of care, patient flow, costs, disputes, duty to report and provider concerns. The report was considered by the QAP in July 2021. We were informed that it has also been informally shared with the Divisional SMT.

2.36 We understand that further consideration has been given to the performance report, as the Team recognised improvements were required to the layout and content. In particular, the Team intends to include KPIs around training and compliance with annual client reviews and audits.

2.37 The performance report requires significant manual input due to reliance upon data held within spreadsheets (patient and provider databases). At the time of reporting (November 2021), the Team had not produced a performance report for Q2. We understand the use of QlikSense is being considered to support the reporting process.

2.38 See **finding 1** in **Appendix A**.

CHC/S117 resource and staff support

2.39 Due to the increasing demand for CHC / S117 care, the Commissioning Team raised concerns over capacity within the Team. We were informed these concerns existed prior to the Covid-19 pandemic and were the reason the Team:

- focused its efforts on higher-risk areas (i.e. non-framework providers), thus suspending the Clinical Care Standards and Non-Clinical Care Standards Audits at AWF providers (paragraph 2.28);
- had fallen behind with the Non-Clinical Care Standards Audits at non-framework providers (paragraph 2.17); and
- had not produced the Q2 performance report (paragraph 2.37).

2.40 The Team's Lead Nurse was undertaking a demand and capacity review at the time of our audit to identify the needs of the Team, clarify roles and responsibilities and identify the resource needed to support service improvement within commissioning.

2.41 The short-term aim for the Team is to develop a five-year business plan and supporting business case outlining options for the future of CHC/S117 commissioning within the Division.

2.42 To support the development of the five-year business plan, the Team presented the results of the demand and capacity analysis alongside future options for commissioning within the Division to the Division's January 2022 SMT meeting, which made it clear the current situation is not sustainable. See **finding 2** in **Appendix A**.

2.43 The Division does not have a programme of training for CHC[6]. We understand that the Welsh Government will roll out CHC training in support of the new national 2021 CHC framework, which is anticipated to take effect from April 2022. Additionally, we were informed that training is a Divisional priority, and the Commissioning Team is keen to ensure the sustainability of CHC training and maintenance of competence going forward. This was highlighted in the January 2022 presentation to the Divisional SMT. See **finding 4** in **Appendix A**.

Conclusion:

2.44 Under this objective we identified three high priority matters arising relating to: accountability, scrutiny and risk; quality assurance for AWF providers; and compliance and internal quality assurance. We also identified two medium priority findings concerning non-framework provider contracts and engaging the wider Health Board in considering the future of MH&LD commissioning. We have provided **limited assurance** for this audit objective.

[6] We were informed the Health Board provides training around S117 under the requirements of the Mental Health (Wales) Measure 2010, which also requires regular audits of the CTP process. This was out of scope for this audit, so was not tested.

Audit objective 2: the Division has clear CHC / S117 commissioning policies and procedures in place, including accountability, roles and responsibilities, and reporting and escalation lines

2.45 The Health Board has CHC policies and procedures[7] in place aligned to the 2014 CHC Framework (dated 2015). We understand these will be updated in line with the 2021 Framework once it is finalised and to take into account learning from Operation Jasmine and Coroner's Inquests.

2.46 Whilst we were informed that the Commissioning Team was aware of the Health Board policies and procedures and members attended and supported the delivery of training thereon in 2015, it is evident the Commissioning Team has implemented local processes, highlighting the Health Board's policies do not adequately address the complex needs of MH/LD CHC and S117 patients.

2.47 We identified that the local process is not formally documented or approved, although:

- the QAP has approved Terms of Reference;
- some standard documents are in place, including a Quality Assurance Proforma (for use when presenting cases to the QAP), Financial Sustainability Assessment Approvals (package of care > £250,000), and a pre-placement checklist; and
- we were informed that the client / provider audit tools used by the Commissioning Team (Clinical Care Standards and Non-Clinical Care Standards Audits) were derived from the audit standards used by the NCCU provider audits.

2.48 During our fieldwork, we noted:

- there is a lack of clarity in the alignment of the standard templates for the Clinical Care Standards and Non-Clinical Care Standards Audits with Fundamentals of Care (FoC) and the Health & Care Standards (HCS); and
- whilst there is space to document patients' / carers' / relatives' views in the standard documentation used for client reviews, the Division does not have formal templates which enable clear demonstration of 'what matters' assessments and person choice[8].

2.49 We identified a number of Health Board templates are not utilised within the MH&LD commissioning process, for example:

- Weekly Provider Monitoring Update Proforma;
- Annual Provider Placement Checklist, Annual Placement Validation, Contract Compliance Annual Monitoring Return and Contract Monitoring Validation

[7] Operational Procedure and Guidelines for Placements, Monitoring and Escalating Concerns: Where NHS Patients Receive Care From External Providers (version 8 updated in June 2015), including the 25 appendices setting out various proforma documents covering the placement, monitoring and escalation process.

[8] Whilst there is no standard documentation for 'what matters' assessments and person choice, the Commissioning Team feels the Division could clinically demonstrate these matters have been considered. It is out of scope for us to judge this assessment.

Tool (note: we acknowledge some aspects of these may be covered by the Non-Clinical Care Standards Audits);

- the FoC audit template; and
- the Feedback form for NHS Visiting Professionals – this supports the identification and escalation of concerns, including on informal patient visits (i.e. contacts between the legally required client reviews set out in objective 3).

2.50 See **finding 5** in **Appendix A**.

Conclusion:

2.51 Considering the points raised above, we have provided **limited assurance** for this audit objective.

Audit objective 3: the Division regularly assesses clients in receipt of CHC/S117 care, including concordance with the individual plan of care, on-going CHC eligibility and the quality and safety of care provision

Client reviews – legal requirement

2.52 The Health Board is legally required[9] to undertake the annual reviews for its CHC and S117 clients (figure 6).

2.53 The Division's Care Coordinators (managed by the directorates) are responsible for coordinating the client reviews. Relevant health care professionals and Case Managers would be included in the review process.

2.54 Aside from being legally required, the reviews provide assurance that patient status (i.e. CHC eligibility or S117 applicability) and care plans remain appropriate to patient needs. They also provide an opportunity for identifying and communicating service concerns.

2.55 Client reviews remained a legal requirement throughout the Covid-19 pandemic. The Division continued to undertake them, although some were undertaken virtually where appropriate to reduce footfall in provider settings. Due to this approach the documentation was often not signed by the client.

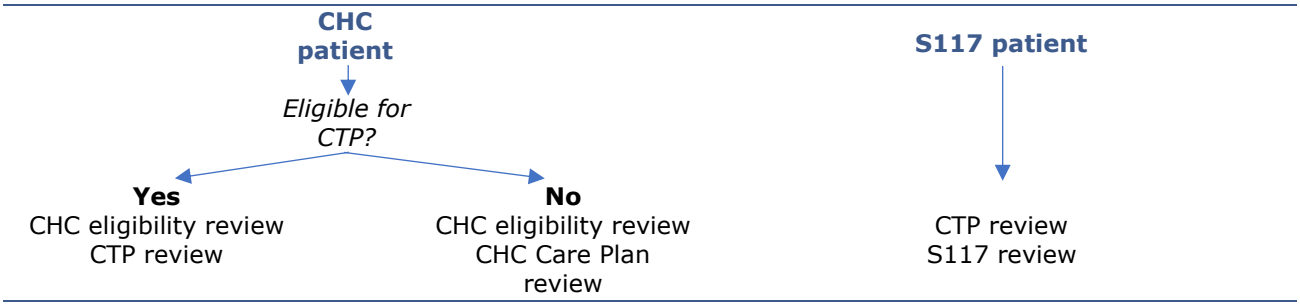


Figure 6: Legally required annual patient reviews
Note: patients subject to S117 are not eligible for CHC, therefore the two are mutually exclusive.

[9] Required by the 2014 CHC Framework and the Mental Health (Wales) Measure 2010.

2.56 We undertook a review of 20 client files to ensure the required annual reviews had been undertaken, identifying exceptions including four instances where client reviews were overdue and two instances where there was no supporting documentation for the client reviews. Further details are included in **finding 4** in **Appendix A**.

Patient databases

2.57 The Commissioning Team maintains two patient databases, one for Mental Health (MH) and one for Learning Disabilities (LD). Held on spreadsheets, these databases contain monitoring information for CHC/S117 commissioning, including the dates of the latest Clinical Care Standards Audit and the legally required reviews for each client.

2.58 We identified that Case Managers were not keeping the MH database up to date for the legally required client reviews undertaken. Dates had been left blank for 178 of the 225 patients (79%) in the August 2021 MH database. We have been assured that the Case Managers are updating the database.

2.59 Our review of client files revealed that nine of the ten Mental Health cases selected were in date for reviews. At the time of writing, we could not provide figures for overall compliance with the requirement to undertake annual reviews for Mental Health clients due to the MH database not being up to date[10].

2.60 Our review of 20 client files highlighted eight instances where the data held in the databases was not accurate for client review dates or S117 status. Whilst we recognise the client databases are not the primary records for such reviews (the Mental Health directorate uses EPEX and the Learning Disabilities directorate uses SharePoint), the databases are used by the Team for monitoring and reporting purposes (see paragraphs 2.35 – 2.37). Inaccuracies will impact the effectiveness of this process.

2.61 We further identified that:

- it is difficult to fully monitor compliance with the annual reviews on both databases due to there being insufficient columns to record the separate dates for CHC eligibility and CTP/CHC Care Plan reviews; and
- there is duplication in the recording of client information due to the Commissioning Team needing access to data which is stored on different systems within the Division (e.g., Mental Health uses EPEX for patient records, Learning Disabilities uses SharePoint, etc), with further duplication via the National Complex Care Database[11] (NCCD – this is mandatory for patients placed with AWF providers).

[10] We understand monitoring of compliance of the legally required reviews may take place within the Division's directorates. Our work focused on the activities of the Commissioning Team. Therefore, directorate monitoring was not tested. See finding 1.

[11] We understand that the NCCD (national system which is part of the financial governance mechanisms for CHC and is hosted by the Health Board) does not have the functionality to report on patient review or audit dates. This was raised as a finding in our 2014/15 report 'Commissioning of Care Home Placements', but a solution has yet to be implemented.

2.62 We were informed that the Division has been planning to move onto the Welsh Community Care Information System (WCCIS) for several years. The move has been significantly delayed, outside of the Divisions' control, but we were informed the transfer to WCCIS should happen within the next few months which may address the issues with the databases we identified.

2.63 This is included within **finding 1**in **Appendix A**.

Clinical Care Standards Audits

2.64 Clinical Care Standards Audits should be undertaken annually for each client by the Case Managers (within the Commissioning Team). Whilst not legally required, these audits (combined with the Non-Clinical Care Standards Audits) satisfy the 2014 CHC Framework requirement for ongoing monitoring and oversight of client care, providing assurance that clients receive an appropriate standard of care.

2.65 These audits cover wider aspects of the care received than the client reviews set out in figure 6, including care / treatment planning, activities in the setting, health / wellbeing, relationships / social contact, risk assessments, equipment, clinical records, medication, and staffing levels for the patient needs.

2.66 The Clinical Care Standards Audits provide assurance of the quality of care delivered for individual clients.

2.67 These audits have not been carried out for clients in AWF provider settings for several years. See paragraph 2.28 and **finding 3** in **Appendix A**.

2.68 As with the Non-Clinical Care Standards Audits, the Clinical Care Standards Audits were stood down at non-framework providers as a result of the Covid-19 pandemic, in line with Welsh Government guidance, with reliance placed on the working arrangements set out in paragraph 2.18, except where concerns were identified. To note: the Commissioning Team undertook 22 virtual Clinical Care Standards Audits between May 2020 and July 2021.

2.69 Per Welsh Government guidance, the Commissioning Team was restarting the face-to-face Clinical Care Standards audits during our fieldwork. As of August 2021, there was a backlog of 353 out of 370 patients (95%), of which 51 patients are placed with AWF providers that have not received a Clinical Standards Audit within the past 12 months. We understand the Division has secured additional, fixed-term funding to address the backlog. Auditing has been further impacted by the Omicron Variant of Concern and the on-going challenges of Covid through the Winter 2021/'22.

Monthly client reports

2.70 The Commissioning Team requests monthly patient reports from non-framework providers. These reports are part of the mechanism for ensuring the ongoing quality of care for MH&LD clients, including client goals and objectives being met to support step-down of care.

2.71 We have been informed some providers are non-concordant with this request for reports as there is no requirement in the overarching provider contracts. See **finding 6** in **Appendix A**.

Quality assurance

2.72 The Division has not recently undertaken any audits regarding compliance with the CHC processes[6] or the quality of client / provider performance reviews. See **finding 4** in **Appendix A**.

Conclusion:

2.73 We identified three high priority findings under this objective regarding quality assurance for AWF providers and compliance associated with quality assurance. We also identified one medium priority finding. We have provided **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter arising 1: Accountability, scrutiny and risk (Design)	Impact
Accountability and scrutiny We were informed that the Division has undertaken work to identify improvements needed for the oversight and accountability of its commissioning activities, including the Commissioning Team. This work was started before, but halted by, the Covid-19 pandemic. It picked up pace again over summer 2021 and was ongoing at the time of our review. Some improvements had already been implemented, including: • the development of a commissioning performance report for Q1 2021/22, with further consideration to extending its content (prior to this provider performance was reported by exception, with no balanced overview of commissioning performance at any level of the Health Board); and • from October 2021 onwards, the Commissioning Team has been given a regular slot on the Divisional Quality & Patient Safety (QPS) meeting agenda (prior to this, reporting beyond the QAP was by exception only when an issue required escalation). Whilst these improvements have been made they are recent and, as such, we were unable to provide assurance regarding the completeness of commissioning performance reporting and accountability within the Division. We noted the Team has not produced a Q2 performance report. **Risk management** Whilst the increasing demand for CHC care and the related financial implications are reflected in the Division's risk register, the potential risk and impact around quality of CHC / S117 care is not included.	Potential risk of: • lack of accountability and scrutiny over MH&LD commissioning activities; • commissioning risks not appropriately managed; • poor commissioning performance not identified and addressed; • poor patient experience or patient harm; and • missed opportunities to share positive news or good practice.
Recommendations	**Priority**
Steps have been taken by the Division to strengthen governance arrangements for commissioned services but more work is required with pace to provide assurance and ensure the quality and safety of client care. 1.1 The Division should further strengthen performance reporting, with a heightened focus on QPS metrics (akin to the processes embedded with the Complex Care Division: general adults).	High

1.2	The Division should explore interim options to automate and streamline the existing databases until the introduction of WCCIS, and ensure the databases are up to date.	
1.3	The Division should improve the reporting arrangements of commissioned services ensuring Executive sightedness together with Patient Quality, Safety & Outcomes Committee.	
1.4	The Divisional Risk Register should be updated to include the risk associated with the backlog of auditing.	

Management response		Target Date	Responsible Officer
1.1	The Performance report will be strengthened to include PQS metrics.	April 2022	Divisional Nurse
1.2	The utilisation of the databases will be reviewed with an interim plan developed to reduce duplication and ensure completeness.	May 2022	Divisional Nurse
1.3	A quarterly performance report will be produced and discussed at Divisional level and the Executive Assurance meeting, together with inclusion in the PQSOC Performance Report as per the business cycle.	June 2022	Divisional Director
1.4	The Divisional Risk register will be updated to include the risks associated with the auditing backlog.	April 2022	Divisional Nurse

Matter arising 2: Future of MH&LD commissioning – appraisal options (Design)	Impact
Due to increasing CHC / S117 demand, the Commissioning Team raised concerns over capacity within the Team and the sustainability of assurance activities over provider performance and the quality of patient care. We were informed that capacity issues prior to the pandemic were behind the decision to stop Clinical Care Standards and Non-Clinical Care Standards Audits at AWF providers, and were the reason the Team had fallen behind with Non-Clinical Care Standards Audits at non-framework providers. Additionally, the Team stated this is why it had not produced the 2021/22 Q2 performance report. As part of the service review started in September 2019 (paused by the pandemic in March 2020 and restarted in August 2021), the Team's Lead Nurse was undertaking a demand and capacity review at the time of our audit with a view to developing a five-year business plan outlining options for the future of CHC / S117 commissioning within the Division. To support the development of the five-year business plan, the Team presented the results of the demand and capacity analysis alongside future options for commissioning within the Division to the Division's January 2022 SMT meeting, which made it clear the current situation is not sustainable. The options analysis focused on potential Divisional solutions. There is a risk the demand and capacity and business planning work undertaken by the Team may not reach its full potential if a Health Board view is not sought. Staff interviewed during our review identified that they felt there is a lack of clarity in: • roles and responsibilities within the Commissioning Team – roles have changed over time, creating a lack of clarity; and • the split of responsibilities between the Commissioning Team and Care Coordinators. This has led to the potential duplication of effort, particularly regarding monitoring compliance with annual patient reviews, where we were informed that both the Commissioning Team and directorates are undertaking monitoring. Additionally, we identified duplication in recording of patient data via the patient databases maintained by the Commissioning Team. The perceived lack of clarity and duplication may be a contributing factor in the capacity concerns.	Potential risk of: • insufficient capacity to sustain sufficient assurance activities over provider performance and the quality of patient care; • patient care or provider performance issues not identified and addressed; and • poor patient experience or patient harm.

Recommendations	Priority
A demand and capacity review is being undertaken by the Division, identifying the gaps and potential options to strengthen commissioning oversight and ensure clarity in terms of roles and responsibilities. This work needs to be completed within a reasonable timeframe, whilst being cognisant of the on-going impact of the Pandemic. A further recommendation is raised below. 2.1 Clarity should be provided in terms of the roles and responsibilities of the Commissioning Team and the Care Coordinators, particularly associated with annual reviews.	Medium

Management response	Target Date	Responsible Officer
2.1 The respective roles and responsibilities of the Commissioning Team members and Care Coordinators will be reinforced, ensuring clarity.	31 March 2022	Deputy Divisional Nurse

Matter arising 3: All Wales Framework providers – quality assurance (Design)	Impact
Whilst there is a formal relationship between the Health Board and NCCU, it is not referred to in any of the Health Board's CHC / S117 policies or procedures. We understand that there was a quarterly All Wales Commissioners Forum with the NCCU which enabled discussions and updates on audits, concerns, etc. These meetings ceased prior to the pandemic and it is not clear if the meetings will re-commence. For one AWF provider in our sample, the Commissioning Team could not locate a recent audit, subsequently discovering that the provider had chosen not to re-join the AWF. The Team further identified the NCCU does not inform commissioners when providers do not re-join. The Team informed us that they placed a patient at this provider in June 2021. Unaware that the provider was no longer on the framework, the Team did not undertake the pre-placement checks or issue a contract, as would be required for non-framework providers. We were informed the Team is in the process of rectifying this matter. We identified that, aside from the annual report, there is no performance monitoring or assurance mechanism in place regarding the quality of the service delivered by the NCCU. *Note: we appreciate there are governance mechanisms over the NCCU within CTMUHB, but this finding relates to performance management and quality assurance mechanisms we would expect to see in place where services are provided by other organisations on behalf of the Health Board.* Divisional management and the Commissioning Team are aware of the responsibility to ensure the quality of care at AWF providers. We were informed that the Clinical Care Standards and Non-Clinical Care Standards Audits should also take place at AWF providers. Before the pandemic, due to resource availability, the Commissioning Team had to focus efforts on areas of higher risk (i.e. non-framework providers), so audits have not been undertaken for AWF providers for several years.	Potential risk of: • patient care or provider performance issues not identified and addressed; and • poor quality care or patient harm.

Recommendations		Priority
3.1	a. The Health Board should explore options for strengthening its oversight of services commissioned, on its behalf, through the NCCU, with reporting to the PQSOC. b. The Health Board should request the NCCU informs commissioners when providers do not re-join the AWF.	High

Management response		Target Date	Responsible Officer
3.1	a. This Audit recommendation will be discussed with the NCCU to explore opportunities for strengthening monitoring and ABUHB oversight	April 2022	EDoN & DoPCCMH
	b. The NCCU will be asked to inform ABUHB when a provider does not re-join the AWP list.	April 2022	EDoN/DoPCCMH

Matter arising 4: Compliance and internal quality assurance (Design)	Impact
CHC training The Division does not have a programme of training for CHC. We understand that Welsh Government will roll out CHC training in support of the new 2021 CHC framework, which is anticipated to take effect from April 2022. Additionally, we were informed that training is a Divisional priority. **Quality assurance** The Division has not recently undertaken any audits of its compliance with the CHC processes or the quality of client / provider performance reviews. **Compliance issues** We undertook a review of 20 case files to ensure the required annual patient reviews (CHC Eligibility, Care Plan (CTP and CHC) and S117, as appropriate) had been undertaken, identifying the following exceptions: • four instances where the client reviews were overdue (i.e., had not been undertaken for over one year); • two instances where there was no supporting documentation for the client reviews; • two instances where there was a delay between the review being undertaken and the updated CTP being documented and agreed (one over one month and the other over four months, the latter likely being due to long-term absence of the Care Coordinator); and • two instances where the client views (or the reason the client views were not obtained) were not clearly documented as part of the review process.	Potential risk of: • poor quality in patient or provider performance reviews; • non-compliance with policy, legislation or guidance; and • poor patient experience or patient harm.

Recommendations	Priority
4.1 Divisional management should ensure: a. the Division introduces a sustainable programme of training for CHC; and b. CHC compliance and quality audits are incorporated into the Divisional clinical audit plan.	High

Management response			Target Date	Responsible Officer
4.1	a.	A business plan inclusive of the training requirements for Commissioning is being considered by the Divisional Management Team in conjunction with other IMTP priorities. The CHC framework forms part of the training needs identified. A bid for temporary funding for training personnel will be prepared to address this issue quickly.	30 June 2022	Divisional Director
	b.	Clinical auditing of the CHC process will be added to the annual Divisional audit plan.	30 June 2022	Divisional Nurse

Matter arising 5: CHC policy and procedure (Operation)	Impact
The Commissioning Team has implemented local commissioning processes and does not use the Health Board's policies and procedures[7] in practice. We were informed this is because the Health Board documents do not address the complex needs of the CHC / S117 clients. We identified that the local processes are not formally documented or approved, although there are formal Terms of Reference for the QAP and some standard templates as set out in paragraph 2.47. During our fieldwork, we noted: • there is a lack of clarity in the alignment of the standard templates for the Clinical Care Standards and Non-Clinical Standards Audits with Fundamentals of Care (FoC) and the Health & Care Standards (HCS); and • whilst there is space to document client / carer / relative views in the standard documentation used for case reviews, the Division does not have any formal templates which enable clear demonstration of 'what matters' assessments and person choice. We also noted that some aspects of the Health Board processes are not utilised within the MH&LD commissioning process, including those related to annual provider performance checks, the FoC audit template and the Feedback form for NHS Visiting Professionals.	Potential risk of: • relevant staff not aware of policies and procedures; • non-compliance with policy and procedure; • non-compliance with laws and regulations; and • poor patient experience or patient harm.

Recommendations	Priority
5.1 A revised framework, following the launch of the new national CHC policy (anticipated April 2022), should include client-specific requirements for MH & LD and ensure consistent use across all Health Board services.	High

Management response	Target Date	Responsible Officer
5.1 The Deputy Divisional Nurse for MH/LD will work closely with the Divisional Nurse for Complex Care to ensure inclusion of MH/LD client specific requirements within the revised framework for CHC, following the launch of the new national policy.	June 2022	Deputy Divisional Nurse

Matter arising 6: Non-framework providers - contracts (Design)	Impact
Our review of the standard overarching contracts for non-framework providers identified they do not cover all aspects of contract performance monitoring: • personal care provider contracts: do not mention client reports, performance monitoring, quality assurance or KPIs/targets; • residential care provider contracts: do not mention client reports, performance reporting or KPIs/targets. Our review of 20 client files highlighted seven instances where monthly reports were not being received. These reports are a part of the mechanisms ensuring the ongoing quality of care for MH&LD clients, including client goals and objectives are met to support step-down of care. We understand that some providers are non-compliant in providing these details. We identified that the overarching contracts are signed by the Contract & Performance Managers (within the Commissioning Team) on behalf of the Health Board. Whilst we understand this does not commit the Health Board to any financial expenditure or service, this is not in line with the Health Board's Scheme of Delegation.	Potential risk of: • inability to enforce performance monitoring measures; and • poor patient experience or patient harm.

Recommendations	Priority
6.1 The Division should: a. undertake a review of its overarching CHC / S117 provider contracts, ensuring they include all aspects of performance monitoring; b. identify appropriate signatories for the contracts in line with the Standing Orders and Scheme of Delegation.	Medium

Management response	Target Date	Responsible Officer
6.1 a. A Task and Finish Group will be convened to review and strengthen the contracts	31 July 2022	MHLD Procurement Lead & Deputy Divisioinal Nurse
b. The authorised signatories list will be reviewed to ensure full compliance with the Scheme of Delegation and Standing Orders.	30 April 2022	Finance Business Partner

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

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

Grange University Hospital: Quality Assurance

Final Internal Audit Report

January 2022

Aneurin Bevan University Health Board

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

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

Contents

Review reference:	ABUHB-2122-06.4
Report status:	Final
Fieldwork commencement:	5 October 2021
Fieldwork completion:	29 November 2021
Draft report issued:	1 December 2021
Updated draft report issued:	20 December 2021
Proposed final report issued:	4 January 2022
Management response received:	31 January 2022
Final report issued:	31 January 2022
Auditors:	Audit & Assurance: Specialist Services unit
Executive sign-off:	Nicola Prygodzicz, Executive Director of Planning, Digital & IT
Distribution:	Robert Holcombe, Deputy Finance Director Hannah Capel, Interim Associate Capital Projects Director Neil Miles, Clinical Futures Programme Director Rachel Savery, Senior Programme Manager Rani Mallison, Board Secretary
Committee:	Audit Committee

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

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

The agreed audit brief sought to provide assurance in the area of Quality Assurance, focussing on an assessment of the delivery Grange University Hospital (GUH) building against the key business case objectives.

Overview

A reasonable assurance has been determined in this area.

It was evident that the build of the GUH substantially provides the ability to deliver enhanced services, in accordance with the objectives of the business case. However, the delivery of capital investment benefits has been impacted by Covid-19, and accordingly it may be appropriate for revised targets to be put in place. These were being reviewed by management to amend accordingly.

The matters requiring management attention include:

- Reporting against the aspirations of the business case; and
- Review and monitor of targets for the capital investment benefits in accordance with ongoing utilisation of the facility.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary [1]

Assurance objectives		Assurance
1	Functionality	Reasonable
2	Capital Investment Benefits	Reasonable
3	Performance	Substantial
4	Feedback	Reasonable

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1, 1.2	Post opening and re-baselined benefits	*1, 2, 4*	Operation	Medium
2.1	Ongoing monitoring	*2*	Operation	Medium

1. Introduction

1.1 The agreed Grange University Hospital (GUH) integrated audit plan for 2021/22, sought to provide assurance across a number of areas including the quality of the delivered build.

1.2 Accordingly, this audit sought to determine whether the GUH provision, had been reviewed against the objectives of intended functionality, and capital investment objectives, as specified at the business case.

1.3 The GUH, as the specialist critical care facility for the Aneurin Bevan University Health Board (the UHB) forms part of a major reorganisation of health delivery within Gwent. Delivery has therefore encompassed not only delivery of services from a new build, but a switch to a new delivery model across the county. The UHB has reported that the facility:

- is the first Gwent hospital directly accessible for Welsh Air Ambulance patients;
- is one of the busiest hospitals for ambulance demand in Wales; and
- has the third biggest Maternity Unit in the United Kingdom.

1.4 The GUH was originally targeted to open in Spring 2021, but opening was brought forward to Autumn 2020 recognising impending winter and Covid-19 pressures. Practical completion and handover of the entire facility was achieved on 12 November 2020, and the hospital subsequently opened on 17 November 2020.

1.5 A report prepared by the UHB '*The Grange University Hospital – Reflection on the First Six Months*' noted benefits of the new building to include:

- improved access to diagnostics / equipment;
- closer working of services such as respiratory, cardiology and critical care due to close proximity and location of services;
- new services e.g. Cardiac MRI, a new lung biopsies service; and inpatient cardiac MR service (the first in Wales);
- improved access to cardiology;
- additional Catheter laboratory capacity;
- more Emergency Department and Medical Assessment Unit capacity; and
- management of hospital acquired infections (HAI's) due to the single rooms at the site and the ability to contain any infection e.g. GUH had a total of 17 HAI's since opening compared to 493 at the Royal Gwent Hospital within the same timeframe.

1.6 The potential risks considered at this review were:

- failure to achieve the required quality or anticipated benefits from the build;
- the build does not provide required functionality;
- anticipated benefits are not realised;
- parties performed poorly in delivering contractual obligations; and

- lessons are not learnt.

1.7 Where the objectives to be delivered by the build were impacted by Covid (as indicated by management), this has been noted at **Appendix D** , with analysis of full Covid data ongoing at the time of audit. Therefore, this audit does not represent an assessment of delivery in the context of Covid-19.

1.8 Further, an assessment of the quality of services provided at the GUH was outside the scope of this audit.

1.9 Noting the ongoing impact of Covid 19, the delivery of the integrated audit plan for 2021/22 included an increased element of remote working.

2. Detailed Audit Findings

Functionality: Review of the functionality of the delivered build against the objectives of the business case and the cost implications of any issues or risks which remained post completion.

2.1 Key intended benefits specified at the Full Business Case (FBC), relating to functionality i.e. delivery enabled by the building itself were stated as:

a) delivered capacity / occupancy; and
b) delivered schedule of accommodation.

Delivered capacity / occupancy

2.2 Bed capacity (being the intended number of beds to support the clinical model of the FBC) was reviewed as a measure of functional provision at the project: A summary of the capacity is as follows:

	FBC Target	Actual[1]
GUH	462	464 Nov 20 – March 21 471 recurrent
Other (other hospital sites / community beds)	(625)	Not published
Whole Health Board	(163)	Not published

[1] *The "actual" figures at the above table were as reported to the Executive Board in September 2020 (two months prior to opening), and remain the most recent data (recognising the fixed nature of the build at this point). Covid pressures have impacted on the wider utilisation of beds across the UHB, details of which remain to be confirmed.*

2.3 Management confirmed that a one-year review will be undertaken, based on data to November 2021, and reported to the UHB Board in March 2022. While the terms

of reference for the review had yet to be published, it was evident that analysis to provide a more complete data set was ongoing at the time of audit.

2.4 Targets (in this case, bed targets) were originally set in 2015, yet the required bed numbers evolved up to the date of opening.

2.5 It is further acknowledged that the handover point represented early opening which was required to meet Covid demand. As a result, the UHB did not require a field hospital facility to be opened as at other Health Boards. Bed provision and services delivered were affected, and remain as such whilst the UHB strives to manage the ongoing impact of the pandemic.

2.6 Accordingly, to better understand the impact of the GUH facility and its optimum level of performance (amended given the current circumstances), there is a need to assess data pre- and post-handover to better inform management (**MA1**).

Delivered schedule of accommodation

2.7 The schedule of accommodation was reviewed to compare accommodation provided at GUH against that specified at the FBC. Audit analysis has shown that the accommodation was in line with that originally specified (see **Appendix B**)

2.8 A review of the functional changes, as requested by the UHB (see **Appendix C**) also indicated that no significant changes to the original functionality had been requested during the construction phase of the project.

2.9 A *'Lessons Learnt Review'* was published by the Executive Director of Planning, Digital and IT in July 2021. This reported that it remains relevant to re-evaluate the building's facilities and spatial requirements in light of evolving usage (additionally noting the impact of Covid) (**MA1**).

2.10 It was noted that the agreed build had been subject to a value engineering process, and that it may now be relevant to re-validate this exercise. Also noting the passage of time since the approval of the FBC (approved 2015), certain changes have been instructed from the project under-spend e.g. in relation to doctor's rest facilities, external footpaths and additional car parking. Consideration of further works (additional to these) was ongoing, notably:

- conversion of Level 1 agile working space to a Same Day Emergency Care Unit; and
- conversion of ground floor Grange House single storey block into a Wellbeing Centre.

2.11 However, these changes do not relate to delivery as determined at the FBC, and accordingly have not been assessed at this audit.

Functionality - conclusion

2.12 It is recognised that the UHB are undertaking a wider review to provide more comprehensive assessment of delivery against the FBC expectations. However,

based on the data that was available at the date of the reporting, **reasonable assurance** has been determined with regard delivery of the intended functionality.

Capital Investment Benefits: Assurance that the capital investment benefits identified at the business case have been realised.

2.13 This section focussed on the targeted benefits arising from the construction specific elements outlined at the FBC (see **Appendix D**). The FBC specified the core aim of providing a facility to attain English upper quartile performance (based on benchmarking against the Northumbria Specialist Emergency Care Hospital, which opened in 2015). The associated capital investment benefits arising from the new development included:

- Facilities;
- Efficiencies facilitated by the design e.g. adjacencies;
- Quality, and compliance;
- IT utilisation;
- Estate rationalisation / economy; and
- Sustainability

2.14 It is recognised that a number of indicators await data while some others have been impacted by Covid, e.g. indicator D4 (**Appendix D**), in relation to use of high tech assets. It is also recognised that data included the pre-handover period (2015 – November 2020).

Facilities

2.15 Facilities were delivered in accordance with the specified Schedule of Accommodation (see **Appendix C**).

2.16 A report prepared by the UHB '*The Grange University Hospital – Reflection on the First Six Months*' noted benefits to include:

- new provisions – e.g. Cardiac MRI, a new lung biopsies facility; and inpatient cardiac MR facility (the first in Wales);
- an additional Catheter laboratory capacity; and
- more Emergency Department and Medical Assessment Unit capacity.

2.17 Improved provision has also included enhanced ratios of parking, staff changing and sanitary facilities. Delivery facilities, as tested by the audit was evidenced to be in accordance with the aspirations of the benefits plan.

Efficiencies facilitated by the design

2.18 The build has optimised departmental adjacencies in accordance with its design. As a result, the *'Reflection on the First Six Months'* report was able to document positive impacts of the build on working models including:

- ability to meet Covid demand within its own footprint;

- co-located CT and MRI scanners (rare in the UK);
- close working between respiratory, cardiology and critical care due to close proximity and location of departments;
- an embedded psychology well-being facility within Critical Care; and
- the only UK facility to have 24 in-shift and post shift day / night rest rooms.

Quality and compliance

2.19 The build now provides a facility, compliant with NHS Wales Technical and Building requirements (e.g. for space provisions). The building was certified as free of defects that would prevent use at handover, and there has been timely resolution of snagging remediation. It has also obtained full building certification.

IT Utilisation

2.20 The facility utilises new/enhanced IT systems e.g. remote patient monitoring (to provide safer care for single bed wards) and real time patient and bed information (which enhances effective delivery of care). However, the use of an effective communication system for clinicians remains under review, therefore full compliance with the aims of the benefits realisation plan remains to be demonstrated.

Estate rationalisation / economy

2.21 It is recognised that revisions in service models since 2015 will have impacted on estate rationalisation (2015 being the date at which business case targets were set). Impact on the Estates backlog maintenance requirement across the wider Health Board also remains to be assessed. A review of benefits such as estates rationalisation and reduction in backlog maintenance has therefore been recommended at a later date (**MA1**).

Sustainability

2.22 The Building Research Establishment's Environmental Assessment Method (BREEAM) provides a sustainability assessment tool. The GUH obtained a BREEAM "*Excellent*" rating in accordance with NHS requirements for new buildings (*NHS Wales Infrastructure Investment Guidance WHC 2018-043 9.6)*.

2.23 Ongoing monitoring and reporting of both UHB energy and sustainability to Welsh Government are subject to defined arrangements. However, noting the additional need for ongoing monitoring of the GUH performance against the specified benefits of the business case, management should determine an appropriate forum to provide appropriate scrutiny (**MA2**).

Capital Investment Benefits – conclusion

2.24 There remains a need to further assess a number of key outcomes (in part, due to the impact of Covid). However, where data was available, objectives were met. **Reasonable assurance** has therefore been determined in this area.

Performance: Assurance that the performance of all parties involved in the delivery of the contract have been appropriately assessed and reported.

2.25 The *'Lessons Learnt Review'* reported that good relationships with the Supply Chain Partner (the contractor) and external advisers had been key to the success of the build.

2.26 Snagging issues were appropriately addressed in a timely fashion and in accordance with the requirements of the contract.

2.27 Additionally, Key Performance Indicators (KPIs) were actively monitored by the external Project Manager, with reporting to Project Board on an exception basis only The KPIs were also utilised as a return to NWSSP: SES to monitor performance by parties appointed to the NHS: Building for Wales framework. These recorded excellent performance by the parties, including the UHB, as assessed by other contracted parties.

2.28 Substantial assurance is therefore determined in this area.

Feedback: Assurance that user feedback or other technical post-project evaluations, have identified causality in relation to any issues identified to inform lessons learnt.

2.29 The *'Reflection on the First Six Months'* report included patient, staff and visitor feedback; and positively assessed a range of issues.

2.30 *The 'Lessons Learnt Review'* assessed a wider range of performance including, project governance; programme management, contractor and adviser performance; equipping; workforce planning; financial planning; communication; handover; service delivery; and IT; deriving 26 key lessons to be learnt for future UHB capital projects, and sharing with other health bodies.

2.31 As *previously* noted, management have confirmed that a one-year review will take place, based on data to November 2021, and a full appraisal of the GUH facility will be facilitated by NWSSP: SES 15 months post-handover (in accordance with Welsh Government guidance).

2.32 Post *project* reviews undertaken to date, have not been supported by comprehensive data (see **MA1**). However, noting the range of feedback both planned and undertaken, **reasonable assurance** is determined.

Appendix A: Management Action Plan

Matter Arising 1: Post opening and re-baselined benefits (Operation)	**Impact**
Included in the '*Lessons Learnt Review*' (published July 2021), is the section "Scope Creep". This states that: *"The bed plan to enable savings system-wide has not been implemented - some of this is a result of Covid-19 but particularly in an environment where demand is ever increasing. Benefits realisation as a concept was accepted in the project but could be seen as subjective and rarely included sufficient metrics… To conclude, the revenue implications of opening the GUH have resulted in significant changes to the original …models included for the FBC. The GUH should act as a key enabler to improve system efficiency and patient outcomes for ABUHB patients".* The business case benefits were set in 2015 (and recognising the passage of time that has elapsed) it would be informative to report data pre and post opening against objectives for the facility (i.e. up to and post November 2020). Following such appraisal, there will be a need to re-baseline relevant objectives for building functionality.	Potential risks that: • Management are not appropriately informed • Planning in not appropriately informed

Recommendations	**Priority**
1.1 Management should confirm available data and conclusions relating to functionality of the GUH, by comparison to business case objectives pre and post opening.	**Medium**
1.2 Management should re-baseline relevant, objectives for the facility based on current information in order to inform revised functional models.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Agreed.	At relevant reporting	Director of Planning, Digital and IT

1.2 Agreed.	The one year, and NWSSP:SES delivery reviews.	Director of Planning, Digital and IT

Matter Arising 2: Ongoing monitoring (Operation)		**Impact**
On an ongoing basis, monitoring of Energy usage, will be reported via the annual Estates & Facilities Performance Management System (EFPMS) return. This is monitored by NWSSP: SES on behalf of Welsh Government. Defined arrangements for monitoring sustainable use of the facility are also in place. Sustainability reporting is also now a requirement for all health bodies direct to Welsh Government; and sustainability planning is also required as part of the UHB within its annual report, against objectives specified at its (three yearly) Integrated Medium Term Plans. However, noting the additional need for ongoing monitoring of the GUH build performance against the specified benefits of the business case, management should determine an appropriate forum to provide appropriate scrutiny.		Potential risk that: • Appropriate scrutiny is not applied to ongoing performance
Recommendation		**Priority**
2.1 Management should confirm an appropriate forum to which to report on-going monitoring of the investment benefits derived from the GUH facility .		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed. The reporting of the energy efficiency benefits of GUH will be picked up as part of the broader energy review and discussed at the Strategic Capital & Estates Group.	At relevant reporting	Director of Planning, Digital and IT

Appendix B: Schedule of Accommodation

Areas specified at the final business case for delivery			Delivered ?
Main Entrance (including restaurant)			✓
Emergency Department (including Adult, Paeads, & Medical & Surgical Assessment)			✓
Emergency Diagnostics	Radiology	Radiology / CT / support	✓
		Ultrasound	✓
		MRI	✓
	Cardiac	Non-invasive	✓
		Vascular	✓
Interventions suite (including Theatres & anaesthetics)			✓
Critical Care Unit (ICU / HDU/ CCU & including inpatient CCU Levels 2 / 3)			✓
Adult Inpatient unit (including inpatients, acute ward & support)			✓
Maternity & neo-natal	Maternity	Incl obstetrics & wards	✓
	NICU	NICU EGAU & support	✓
Children's services (including inpatients, PAU & ED)			✓
Clinical support	Pathology	Inc. hispathology, cytology & blood services	✓
		Mortuary	✓
	Pharmacy	Total Pharmacy	✓
	Others	CSSD	✓
Whole hospital services		Offices / other	✓
	Education & training Centre	Meetings, conference, skills lab	✓
		Library	✓
		Staff change	✓
		Catering & FM	✓
Circulation			✓
Plant			✓
Total net room area			✓

Note: data was extensive, and in some cases could not be precisely matched within the time frame of the audit, due to differences in classification e.g. inclusion of corridors or remote storage.

Appendix C: Major changes requested to the build contract

Major changes requested to build provision	COST	Totals
	£	£
Major functional changes to handover		
Radiology redesign	£998,148	
Radiology additional equipment	£687,887	
Radiology - other technical changes	£115,487	
8 nr new rest rooms on Level 2 Zone 30, and 22 nr study beds (4nr elsewhere)	£381,296	
Pathology redesign including a Discharge Lounge	£352,035	
Mobile Telephony and IT workspace rooms	£216,680	
Omit en-suite bariatric hoists	-£85,132	
Omit endoscopy storage from Room CAU.01.010	-£17,789	
TOTAL		**£2,648,612**

% of original build contract of £206,457,458 1%

Appendix D: Capital Investment Benefits

(as sampled by audit from the GUH Business Case - Benefits Realisation Plan)

Key

Blue	Data not available
Red	Data impacted by Covid

CLINICAL FUTURES BUSINESS CASE – BENEFITS REALISATION PLAN
APPENDIX 3A

Investment Objective 1 : A65 **To provide by 2019 a configuration of services that supports clinical outcomes and standards of patient care equivalent to English upper quartile performance delivered in appropriate and modern health care environments.**						**Out-turn**		
REF	**Benefit Descriptor**	**Improvement Indicators**	**Specified Information Source**	**Performance Measure**		**Data**	**Target Met ?**	**Comments**
				Baseline	**Target**			
A4	Provides safe and appropriate settings for modern specialist health care delivery.	Ensuites and increased ratio of sanitary facilities.		Design Spec at Full Business Case	Delivered to budget specification	Schedule of Accommodation	✓	
		Adequate car parking		Design Spec at Full Business Case	Delivered to budget specification	Delivered specification	✓	The contract originally provided: 57 Accessible parking 239 Visitor 652 Staff 20 Emergency An additional 274 spaces were provided by

								Compensation Event 274C at a cost of £228k, plus £126k for 18 electric charging points.
		Provision of staff change		Design Spec at Full Business Case	Delivered to budget specification	Schedule of Accommodation	✓	
		New builds meet AEDET (Achieving Excellence Design Evaluation Toolkit) Key Performance Indicators (KPI's) to ensure building quality and functionality is designed within a commonly agreed framework	AEDET report	Design Spec at Full Business Case	Delivered to budget specification	Building control certificate	✓	
A6	Evidenced based design supports more efficient and effective working practices	Improved utilisation of IT e.g. Vocera (staff communication system / patient Flow management system)						While use of Vocera by clinicians remains under review, other systems such as Careflow (a real time patient status tool), Mindray (a remote monitoring system), and Qlik (a reporting tool) have successfully been commissioned.
		NHS Wales Health Technical Memorandum (HTM) / Health Building Notice (HBN) compliance.		Design Spec at Full Business Case	Delivered to budget specification	Building control certificate	✓	

		Compliant clinical spaces, designed for modern healthcare.		Design Spec at Full Business Case	Delivered to budget specification	Schedule of Accommodation	✓	
		Departmental adjacencies minimising travel distances.		Design Spec at Full Business Case	Delivered to budget specification	As build drawings / "six month on" document	✓	
		Designed & Built to be easily cleaned and maintained.	C4C	Design Spec at Full Business Case	Delivered to budget specification	Health & Safety file	✓	
Investment Objective 4: **To deliver a configuration of services and supporting infrastructure by 2019 that optimises financial effectiveness and delivers efficient use of available resources.**						**Out-turn**		
REF	**Benefit Description**	**Indicator/Measurement**	**Information Source**	**Performance Measure**		**Data**	**Target Met ?**	**Comments**
				Baseline	**Target**			
D3	Improved functionality and inter relationships between sites and individual departments	Outline interdependencies with other depts./physical adjacencies. Measure through team working/mortality rates/staff sickness/infection rates/risk reduction			Improvement	As build drawings / six month on document	✓	

D4	Improved utilisation of high tech assets	Improved utilisation of high tech assets : improved theatre utilisation MRI utilisation CT (computerised tomography) utilisation Increased Catheter laboratory capacity		Current usage	Increased usage				**Data significantly impacted by Covid** Both scheduled and emergency use of high tech assets has been significantly impacted by Covid, and accordingly, management have deferred publication pending more robust / steady state data.
D5	Allows rationalisation of the existing estate / release of existing estate	Existing sites rationalised i.e. Neville Hall Hospital/ Royal Gwent Hospital/ St. Woolos Hospital (NHH/RGH/SWH)	EFPMS (Estates and Facilities Performance Management System)	Current Gross Internal Floor Area (GIFA) of rationalised sites	Reduced GIFA of rationalised sites		No. of sites		**Data significantly impacted by Covid.** Site rationalisation plans were significantly impacted by Covid, and accordingly, management have deferred publication pending more robust / steady state data.
D6	Backlog Maintenance reduced	Change from Baseline	EFPMS	Current data	Reduction in Backlog maintenance				Data not yet available, also noting that defects at GUH within its first year of operation are contractually rectified at £0 cost.
D7	Improved sustainability / energy efficiency	Carbon Emissions/BREEAM Excellence (Building Research Establishment's Environmental Assessment Method)	EFPMS	Design Target at Full Business Case	Actual after 12 month operational use		BREEAM Excellent certification obtained	✓	

Appendix E: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

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

Falls Management
Final Internal Audit Report
March 2022

Aneurin Bevan University Health Board

Contents

Review reference:	AB-2122-15
Report status:	Final
Fieldwork commencement:	1st December 2021
Fieldwork completion:	22nd December 2021
Draft report issued:	22nd February 2022
Debrief meeting:	15th February 2022
Management response received:	14th March 2022
Final report issued:	17th March 2022
Auditors:	Simon Cookson, Acting Head of Audit and Assurance Stephen Chaney, Deputy Head of Internal Audit John Cundy, Principal Auditor
Executive sign-off:	Peter Carr, Director of Therapies and Health Science
Distribution:	Karen Hatch, Assistant Director of Therapies and Health Science
Committee:	Audit, Finance and Risk Committee

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

Acknowledgement

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

Executive Summary

Purpose

We sought to provide assurance that the Falls Policy for Hospital Adult Inpatients was being adhered to by staff and monitored appropriately.

Overview

We have issued reasonable assurance on this area.

Overall, we found that the number of inpatient falls declined following the introduction of the revised multi-factorial risk assessment (MFRA) and policy.

Within the sample tested, we also found the completion rate of the assessment forms to be consistent with our previous audit of Falls Management.

However, we did identify the following exceptions:

- Six of 30 patients sampled, where a fall had occurred, did not have a completed MFRA recorded prior to the fall.
- 12 of a separate sample of 29 patients tested did not have a MFRA completed within the timeframe required. However, we recognise this was within a pandemic environment.
- Three of the same sample of 29 patients tested did not have a MFRA recorded, when one should have been completed.

We only selected patients for our sample where a MFRA was required to be documented.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Trend

2018/19 – reasonable assurance

Assurance summary[1]

Assurance objectives		Assurance
1	Falls Management Policy	Substantial
2	Policy Application and Adherence	Reasonable
3	MFRA completion	Limited
4	Oversight and Monitoring	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	MFRA completion	2	Operation	High
2	Datix entries	2	Operation	Medium

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

1. Introduction

1.1 The review of Falls Management was completed in line with the 2021/22 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'). The review sought to provide the Health Board with assurance that falls management procedures are appropriately implemented and monitored within the Health Board.

1.2 The Health Board recognises that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge for the Health Board, in common with all Health Boards.

1.3 To minimise falls, and as far as possible their impact on patients and staff the Health Board has adopted the National Institute of Health and Care Excellence (NICE) clinical guidance. This guidance provides recommendations for the assessment and prevention of falls in older people for use by healthcare and other professionals and staff who care for older people who are at risk of falling.

1.4 During July 2021, the Health Board issued a revised Falls Policy for Hospital Adult Inpatients (the 'Policy'), which was accompanied by an awareness raising campaign. Alongside this process, the governance arrangements have been restructured with the re-establishment of the Falls and Bone Health Steering Group, but now entitled the Falls and Bone Health Committee (the 'Committee'). The Committee reports directly to the Patient Quality, Safety and Outcomes Committee.

1.5 Supporting the Committee within the newly established structure are two sub-groups, the Hospital Falls and Bone Health Group and Community Falls and Bone Health Group.

1.6 The key risks considered in this review were:

a. failure to properly risk assess patients leading to increased falls and patient harm;

b. lack of appropriate monitoring of falls leading to missed opportunities to identify weakness and implement improvements;

c. reputational risk from negative publicity arising from increased or serious falls; and

d. financial loss to the Health Board.

1.7 Due to the pandemic, we did not visit wards to complete our testing. Instead, we reviewed electronic copies of the clinical notes, to determine if multi-factorial falls risk assessments (MFRAs) had been fully completed.

2. Detailed Audit Findings

Audit objective 1: to ensure that there are adequate policies / procedures in place, detailing processes to support minimising inpatient falls incidents and embedding the requirements of NICE CG161.

2.1 We confirmed that the updated Policy is hosted on the intranet site, with supporting links to the document correctly referenced.

2.2 We tested to ensure that the Policy continues to encompass the requirements of NICE CG161. We also selected a sample of best practice guidance and ensured the contents of the Policy incorporated relevant details.

2.3 We found the revised Policy to be comprehensive, with a multi-disciplinary approach adopted, additional medication review tools, a head injury pathway, nutritional risk screening tool and frailty referral forms included. Each of these have the potential to improve inpatient falls management.

2.4 The Policy includes a MFRA, which is more detailed than the previous version. However, when interviewing staff over their awareness of the Policy and supporting documents, we were informed that the length of the MFRA was considered overly detailed. Furthermore, the total amount of time to complete the assessments and the frequency was also a concern raised throughout the audit. We tested the completion of a sample of MFRAs under audit objective three.

Conclusion:

2.5 We confirmed that the Policy is readily accessible and provides detailed tools to assist with the management of falls. In addition, the requirements of NICE CG161 and supporting best practice has been incorporated into the documentation. Therefore, we have provided substantial assurance for this objective.

Audit objective 2: to ensure, that the applicable policies / procedures are adhered to by staff within the Health Board as appropriate.

2.6 We tested adherence to the Policy through sample testing, with our findings detailed below under audit objective three. However, we also tested the following controls, which are in place to assist with compliance to the Policy and supporting procedures:

- the launch of the new policy;
- falls management training;
- the content of the operating procedure; and
- controls in place following the completion of the MFRA.

New policy launch

2.7 We found that the revised Policy was launched with an awareness campaign and supporting communications. Alongside this an update to the falls management training programme was completed.

Falls Management Training

2.8 A programme of falls management training was commenced when the Grange University Hospital (GUH) opened. This was to assist with the different nursing practices required for single rooms, as opposed to the multiple occupancy bays predominantly used at the other hospital sites.

2.9 We found that the training has continued since the opening of the GUH. Alongside the delivery of the training and the introduction of the Policy there has been a noticeable decline in the number of falls recorded. This has continued month on month in the total number of falls and the number of falls per 1,000 bed days. Further detail is provided under audit objective four. We also reviewed the training feedback provided by the participants and found this to be positive.

2.10 However, as mentioned above, some of the feedback did focus on the MFRA detail required and the amount of time to complete it. We have raised this within **matter arising one.**

Procedural Documentation

2.11 Paragraphs 6.0 to 8.0 of the Policy form the Standard Operating Procedure (SOP) sets out the requirements for a member of staff to complete an assessment. We found that it covers adult inpatients from admission to discharge and sets out the actions required to apply the policy.

Operational Controls

2.12 We were advised that there is no 'universal' admissions control checklist that requires confirmation and sign-off of a MFRA, nor any other required documentation. We have raised this within **matter arising one.**

2.13 The operational controls covering MFRA completion are:

- MFRAs are quality checked via DECis (Dignity and Care Inspections);
- 1P1D – one patient, one day checks by a registered nurse, ward manager or a senior nurse; and
- ward managers also visually inspect their documents (but this is not recorded).

2.14 We reviewed examples of the inspections detailed above and confirmed that they are designed as one-off reviews with immediate feedback to ward staff. Common improvement areas identified include incomplete or missing documentation. We have raised this within **matter arising one.**

Conclusion:

2.15 There is a significant reduction in the number of falls recorded, following the introduction of the updated Policy and supporting falls management training. However, we feel that there are still further control improvements to be introduced to ensure the MFRAs are fully completed. We have provided reasonable assurance for this objective.

Audit objective 3: to determine for a sample of applicable patients that a risk assessment has been completed and where required, appropriate action taken to reduce the risk a fall.

2.16 We reviewed two samples to establish if the MFRAs were being completed, in accordance with the Policy. The first sample (of 30) was selected from falls data recorded on Datix, where a patient fall had occurred. The second sample (of 29) was selected from patients admitted to a hospital. To consider the effect of the updated policy and the new MFRA, we looked at admissions and falls from August and September 2021. For both samples, we only included patients that should have had a MFRA completed i.e. they met the requirements as outlined within the Policy.

2.17 As we did not visit wards to complete our testing, we utilised Clinical Workstation (CWS) to locate the MFRAs and the assistance of the Health Board, where documents were absent.

2.18 Whilst the Policy requires a MFRA to be completed within six hours of admission, we applied a tolerance parameter to this requirement, due to the impact of the pandemic and the exceptional pressures that staff were facing. As such, we tested to determine if a MFRA had been completed on the same date that the patient was admitted. However, we did not identify any instances within our sample where the impact of the pandemic was directly attributable.

Datix Falls Sample

2.19 We selected a sample of 30 patients recorded onto Datix that had suffered a fall whilst in hospital during August and September 2021. For seven of the sample we found that no MFRA had been documented, prior to the fall.

2.20 In addition, we found that for six of the seven exceptions identified that the falls prevention section within Datix did not record 'no falls risk assessment was completed' following an investigation - in spite of this question being presented to the user. Instead, the falls were marked as 'unexpected'. We have raised this within **matter arising two.**

Admissions Sample

2.21 We also selected a sample of 29 patients that were admitted to hospital, to determine if a MFRA had been completed, in accordance with the Policy.

2.19 For each of this sample, the completion of a MFRA was a requirement, however, we found that for three patients MFRAs had not been completed. We have raised this within **matter arising one.** However, we have been informed that one of the missing falls assessments may not have been required.

2.20 Furthermore, we found that nine of the 29 within the sample had not been completed within the time limit set out within the Policy (taking into account the points raised within paragraph 2.18). We have raised this within **matter arising one.**

Conclusion:

2.21 The MFRA is a key tool for the management of inpatient falls, so should be completed for all relevant patients, in a timely manner. Due to the number of exceptions identified and compared to our previous audit findings from 2018/19[2], we have provided limited assurance for this objective.

Audit objective 4: to ensure that there is appropriate oversight and monitoring over the management of patient falls throughout the Health Board.

2.22 We obtained the falls data for recent years for the months August to December and ensured that action was undertaken to achieve a downward trend of falls. We found that the data is utilised to provide oversight of falls from the 'ward to Board'. Overall, we found a suite of active reporting in place, with continuing improvement accompanying key actions introduced (training programmes and the revised MFRA / Policy).

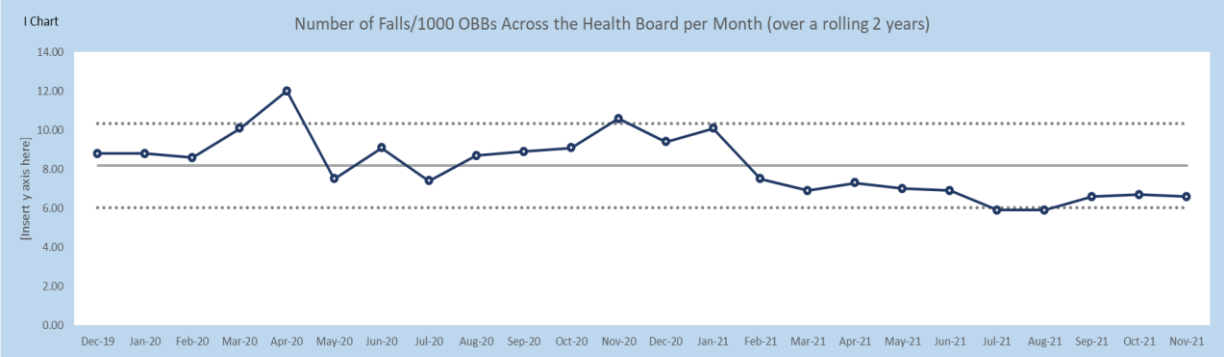
2.23 The latest falls volume information is detailed below in total numbers and per 1,000 bed days.

Falls Volume

	August	September	October	November	December
2017	349	323	302	343	337
2018	348	318	303	285	272
2019	345	304	328	294	359
2020	308	315	331	364	330
2021	219	242	269	261	264

[2] Our 2018/19 Falls Management audit found that two from 39 patients, where a MFRA had not been completed, but should have been.

Falls volume per 1,000 bed days



2.24 We confirmed that there is appropriate oversight of falls management within the Health Board, via the Falls and Bone Health Committee, which reports directly to the Patient Quality, Safety and Outcomes Committee. Whilst there is formal reporting to the Executive Team, which takes place on a quarterly basis, there is also regular reporting and feedback to individual wards.

2.25 We also noted that there is Health Board representation within the Welsh Government initiative, 'The National Inpatient Falls Network'. This is a forum for the sharing of best practice, which has taken place with the medicine review tools and the head injury pathway.

Conclusion:

2.26 We found good reporting mechanisms in place across all levels of the Health Board. We have provided substantial assurance fort his audit objective.

Appendix A: Management Action Plan

Matter arising 1: MFRA completion controls (Operation)	Impact
In spite of a rolling training programme, an updated policy and a revised multi-factorial risk assessment (MFRA) we identified non-completion of falls risk assessments. We selected a sample of 30 patients that had experienced a fall whilst in hospital, to determine if a MFRA had been completed. In all instances the patients should have had a multi-factorial risk assessment (MFRA) documented. However, we found that for seven of the patients a MFRA had not been completed. We also selected a sample of 29 patients that were admitted to hospital, to ensure a MFRA was completed on the same date of admission. However, we found three instances (although we were informed that one MFRA may not have been required) where a MFRA had not been completed and a further nine patients where the MFRA was not completed on the same date / shortly after admission.	Potential risk of: • Patient harm from a failure to properly assess the risk of an unexpected fall • Reputational damage due to non-adherence to the Policy • Financial loss to the Health Board

Recommendations	Priority
1.1 The Health Board should: a. Identify any underlying reason for the non-completion of MFRAs and the impact of the pandemic. b. Review the MFRA documentation to determine if it can be rationalised / updated to be more concise. For example, a permanent section and an ongoing care plan that is periodically revised. c. Continue with the falls management training, but target the programme towards areas of poorer compliance rates. d. Remind staff of the falls management requirements. e. Where 1P1D/DECi inspections identify failures an immediate correction of the patient record and a rerun of the check (and potentially training) should be completed.	**High**

Management response	Target Date	Responsible Officer
1.1 a. It is recognised that the non-completion of the falls risk assessment is multifactorial and the challenges have been heightened during the Covid pandemic. This is both in association with the changing levels of comorbidities for our patient cohort and the availability of staff resources due to competing demands in support of the Health Boards response to the pandemic. Some wards were also	July 2022	Karen Hatch

	subject to changes in their functions with the redistribution of patients in support of the management of the pandemic. The Health Board through its falls management structure will continue to utilise both qualitative and quantitative information to identify themes and trends to instigate the necessary quality improvement initiatives. This will look to include a broader remit of evaluating compliance with the completion of the MFRA through the development of an audit suite aligned to and extending the existing methods being adopted by the wards. The outcomes will look to define any change requirements and will be communicated at all levels within the organisation structures.		
b.	The MFRA represents one assessment within the suite of the Welsh National Care Records (WNCR). This is due to be adopted in its intended electronic format in ABUHB in the Summer of 2022 and will provide a more streamlined systematic MFRA. Although currently being used in a paper format ABUHB as part of the process have submitted a number of change requests, which have been accepted. The detail held within the MFRA is reflective of the many factors which influence the risks of falls and likewise contribute to the wider understanding of the patient's condition. ABUHB is represented at National level and will continue to contribute to the discussions.	Summer 2022	Peggy Edwards
c.	It is recognised that training is a key component in supporting the ABUHB's approach in minimising inpatient falls. The aim is to build on what has already been established. The evaluation of data will look to underpin a focussed approach where areas of concern are identified and will look to inform the training strategy going forward. Aligned to the work of ABUHB we are also represented at an 'All Wales's level in discussions to develop a generic learning platform linked to ESR to support all staff who have a role in falls management. It is intended that this will translate into a national product and provided consistency of approach across Wales. This platform will support enhancing knowledge and skills from both an inpatient and community perspective. The learning package will provide a level 1-2 education upon which additional modules will be developed.	ABUHB - Commencing April 2022 Timelines will be defined at National Level for the ongoing development and implementation of a generic level 1-2 platform.	Karen Hatch

d. Through the newly established structure in support of falls management an ongoing awareness campaign is to be established. The further development of the intranet pages through SharePoint will the provide enhanced communication approaches. This will be looked at in the context of falls from a Hospital and Community perspective. This will be used to develop a falls network, provide a platform to share good practice, research and act as a resource depository. The concept of falls champions will be promoted. All will look to support quality improvement initiatives across the falls pathways. The agendas set for the fall's forums will look to ensure such good practice, learning and necessary change initiatives continue to promote the requirements to manage falls.	Ongoing	Karen Hatch Tracey Partridge Wilson
e. Should non-compliance concerns be identified the findings are shared with the Nurse in Charge, Ward Manager along with the Senior Nurse and QPS Lead. The outcomes are relayed to the member of staff responsible for the care of the patient and the wider team as a means of learning. The responsible member of staff looks to action any requirements to rectify non-compliance. The QPS Lead subsequently undertakes a more extensive focussed audit to identify any systemic concerns within the given ward and to inform the Divisional 'deep dive' discussions. Work is underway to look at how the data can be cross referenced with the overarching falls management data and on the reinstatement of the Health and Care Standards Audits. This approach will look to be supported by the training strategy.	Ongoing	Tracey Partridge Wilson Karen Hatch

Matter arising 2: DATIX Completion (Operation)	Impact
We found six instances where a MFRA for a patient had not been completed, but that patient had experienced a fall. We also found that the identification of the fall was marked as 'unexpected', but yet no MFRA was completed when it should have been. In the previous version of Datix there was a section to identify if a MFRA was not completed when a fall incident has occurred. Consequently, where there is no record of a MFRA completed pre-fall (when one was required) it is incorrect to mark a fall as 'unexpected'.	Potential risk of: • Incorrect data entered onto national systems • Incorrect assumptions on the effectiveness of controls

Recommendations	Priority
2.1 The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	**Medium**

Management response	Target Date	Responsible Officer
2.1 An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	September 2022	Scott Taylor Karen Hatch

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

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

Flu Immunisation
Final Internal Audit Report

March 2022

Aneurin Bevan University Health Board

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

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

Contents

Review reference:	AB-2122-07
Report status:	Final
Fieldwork commencement:	5th November 21 Covid delay and restarted 8th February 2022
Fieldwork completion:	25th February 2022
Draft report issued:	10th March 2022
Debrief meeting:	4th March 2022
Management response received:	21st March 2022
Final report issued:	22nd March 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Rhian Gard, Principal Auditor
Executive sign-off:	Sarah Aitken, Executive Director of Public Health and Strategic Partnerships
Distribution:	Arif Mahmood, Public Health Consultant
Committee:	Audit, Finance and Risk Committee

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

Acknowledgement

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

Executive Summary

Purpose

The review sought to provide assurance that the flu immunisation programme in place for staff, and the governance arrangements over the community programme are working efficiently to provide maximum protection during the seasonal flu campaign.

Overview

We have issued reasonable assurance for this area.

This audit focussed primarily over the staff flu immunisation uptake. When comparing 2020/21 and 2021/22 there has been a decrease in staff flu uptake from 65.8% to 57.8% as at 15th February 2022. For the year 2019/20, the rate during the same week was 60%. The ambition target set by the Welsh Government is 80%.

However, the overall primary care uptake for children and vulnerable adults within the Health Board's area is the highest across Wales within most categories.

The identified matters requiring management attention include:

- Terms of reference for the Flu Working Groups are not complete.
- We found a lack of flu immunisation reminders issued for staff and a decrease in the number of flu champions.
- There were less flu clinics available for staff compared to 2020/21.

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

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A Not audited separately previously

Assurance summary[1]

Assurance objectives		Assurance
1	Governance arrangements	Reasonable
2	Supply of the flu vaccine	Substantial
3	Communication	Substantial
4	Promotion and engagement	Reasonable
5	Vaccine arrangements	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Vaccination arrangements	5	Design	Medium

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

1. Introduction

1.1 The review of Flu Immunisation was completed in line with the 2021/22 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that the programme in place for the immunisation of staff and the community is working efficiently to provide maximum protection.

1.2 The influenza virus (flu) is a key factor in contributing towards winter pressures facing the NHS each year. It impacts on those who become ill, the NHS services that provide direct care as a result and on the wider health and social care system that supports people in 'at risk' groups.

1.3 Maximising the uptake of the flu vaccine amongst eligible individuals helps improve public health and reduces pressure on health and social care services during the winter. This has become even more important during the Covid-19 pandemic, as it helps to help ease the overall demand on services within the Health Board and to further protect the public and staff.

1.4 Staff that work for the NHS are entitled to receive a flu vaccination and are encouraged to receive one. This helps to prevent the transmission of the virus to patients that staff come into contact with and to reduce staff sickness absences.

1.5 The key risks considered this review were:

- limited governance arrangements in place to monitor co-ordination and implementation of the flu immunisation programme to staff and eligible residents within the Health Board's region;
- insufficient supply of the flu vaccine resulting in low immunisation rates across the Health Board's region;
- lack of effective engagement with the public, staff and other stakeholders;
- slow rollout of the immunisation programme, leading to increased outbreaks of flu;
- insufficient flu vaccination uptake leading to an increase in health issues associated with the virus; and
- increased staff sickness rates, resulting in increased financial costs associated with safely staffing service areas.

1.6 The audit excluded:

- testing within GP practices, pharmacies and other associated organisations that administer flu vaccinations. In addition, we did not review individual patient files; and
- confirmation that all applicable patients considered to be in an 'at risk' group were offered a vaccination. Instead, we tested the communication of the eligibility requirements and other key processes for the organisation to adhere to when offering appointments.

However, we took into account the impact of the Covid-19 pandemic.

2. Detailed Audit Findings

Audit objective 1: to ensure appropriate governance arrangements are in place over staff and community flu immunisation programmes, including the monitoring of flu vaccination rates

2.1 We reviewed the Health Board's governance arrangements against the requirements of the Welsh Health Circular 2021-019 (The National Influenza Immunisation Programme 2021 to 2022) and the age parameters set out by the Chief Medical Officer correspondence (CEM CMO 2022 003 seasonal Influenza – Actions for Wales). We confirmed that the Health Board adhered to these requirements.

2.2 We reviewed the Board and Patient Quality, Safety and Outcomes Committee minutes from the last twelve months and confirmed the seasonal flu campaign for 2021/22 is regularly discussed and monitored. Alongside the regular updates there is also mention of different methods and approaches to help improve the staff vaccination uptake.

2.3 During December 2021, as the impact of the Omicron variant increased, a decision was made to reallocate staff resource from the flu programme to the Covid-19 vaccination programme. We were informed that the rationale and impact from this decision was presented to and agreed with by the Executive Team. We also reviewed planning papers presented to the Executive Team, which set out key details of the flu vaccination programme approach.

2.4 We confirmed that the two working groups to support the roll-out of flu vaccinations, the Staff Flu Immunisation Working Group (the 'Group') and the Primary Care Seasonal Influenza Vaccination Group (the 'Primary Care Group') were operating appropriately and assisted with the delivery of the staff flu and primary care vaccinations programmes respectively. We reviewed minutes from the last twelve months from both groups and found detailed scrutiny taking place within each of the forums.

2.5 However, neither group had a finalised terms of reference and we also identified the following points for the Group:

- There are 18 members, but no quoracy requirements are stipulated. Following a review of the minutes, we identified that c. 11 or 12 attendees are present at each meeting.
- Roles and responsibilities of the Group members are brief, with no escalation process defined, when required.
- There is no member assigned as the Chair or Vice Chair.
- The meeting frequencies are not detailed within the terms of reference.

This has been raised as **matter arising two.**

Conclusion:

2.6 There are good governance arrangements in place for the seasonal flu campaign, which are operating as anticipated. Furthermore, the Primary Care Group is operating positively, with evidence of challenge and accountability. Both groups could be enhanced further with their terms of reference updated and finalised. However, this was not impacting significantly on the quality of the arrangements. Therefore, we have provided **reasonable assurance** for this objective.

Audit objective 2: to confirm that arrangements are in place to ensure sufficient supply of the flu vaccine is available to meet staff and community demand

2.7 We confirmed that there is a process in place for ordering the flu vaccine and this is through a contract with the supplier via NHS Procurement Services. The ordering process commences during February to March, at the start of the calendar year.

2.8 The process is completed in partnership with Occupational Health who provide details of the staff flu vaccine uptake rate from the previous year. A surplus is ordered in addition to the prior year staff numbers, which is typically 5-10%. For this year, the volume of the flu vaccine ordered translated into a sufficient level for 60-70% of staff within the Health Board.

2.9 Within the primary care setting the number of vaccines is determined by two main factors, the number of vulnerable patients and the vaccine uptake rate from the previous year. Once this figure is calculated, a 5% contingency is included.

2.10 We were told if shortages of the flu vaccine occur then the Health Board and GP practices collaborate (via the Neighbourhood Care Networks, 'NCNs') to redistribute the available vaccines and ensure all 'at risk' groups are covered. This provides a temporary buffer of supply until further deliveries are received. There is always a supply available for staff within the hospital pharmacies.

Conclusion:

2.11 The processes for ordering flu vaccines for NHS staff and patients within the Health Board's region is determined by the total population and previous demand, combined with a surplus to account for any increased interest. In addition, the supply is profiled over the winter period to identify any emerging peaks in demand. Therefore, we have provided **substantial assurance** for this objective.

Audit objective 3: to determine if the Health Board has communicated the immunisation process and accompanying expectations to individual GP practices, community pharmacies and other applicable organisations

2.12 We found there to be effective on-going communication with all stakeholders regarding the flu immunisation process and other related expectations.

2.13 We reviewed communication with stakeholders against the expectations stipulated in the Welsh Health Circular (WHC 2021-019) and found the requirements were adhered to.

2.14 The process and expectations are relayed through the relevant working group and cascaded to the Divisional Flu Leads (DFLs), within the Divisions and Directorates and Neighbourhood Community Networks (NCNs) within primary care. We found there is coverage through all organisations across the Health Board.

2.15 The review of minutes of both working groups confirm there is regular scrutiny, discussion and regular updates received from the Welsh Government, NIAG (National Immunisation Action Group) and VPDP (Vaccine Preventable Disease Programme), which set out flu immunisation expectations. We confirmed that these requirements are regularly monitored and discussed at the Primary Care Group.

2.16 We reviewed the flu vaccination rates for eligible residents within the Health Board's region. We found that the Health Board has the highest vaccination rate for the majority of 'at risk' categories within Wales. The combined rate for the Health Board for at risk patients at 15 February 2022 was 79.5% (Wales 77.6%) for people aged 65 years or older and 53% (Wales 47.6%) for six months to 64 years old.

Conclusion:

2.17 We confirmed that communications were frequent, with supporting monitoring within the groups to ensure the requirements are being worked towards. We have provided **substantial assurance** for this objective.

Audit objective 4: to ensure that a sufficient level of promotion and engagement (e.g. reminder letters) with staff is undertaken and, where required, supporting action to maximise the uptake of the immunisation programme with staff

2.18 During the Omicron outbreak during December 2021 there was a pause of focus on the flu campaign, with staff reallocated to the Covid-19 vaccine programme. However, during January 2022 there was a re-launch of promotional materials, to help increase the uptake of staff flu vaccinations and to raise awareness amongst staff.

2.19 We reviewed a suite of promotional materials throughout the vaccination period, including posters, flu videos, the flu intranet page, 'call to action' venue posters and flu graphics within emails and ESR. We confirmed that there was a high volume of promotion, but we are unable to quantify how much of it has been seen by staff or how effective it has been in encouraging staff to receive a vaccination.

2.20 There was also an email sent out in January 2022 to all Health Board staff from the Director of Public Health and Strategic Partnerships. We also confirmed that the Executive Team was often engaged and updated on the challenges affecting the vaccination rate, with multiple solutions suggested. However, whilst the actions and steps undertaken are entirely appropriate, there is an opportunity for

the Health Board to reflect post-campaign, to determine which methods were the most effective. This is key, particularly in view of the reduced uptake of the vaccine, which was 57.8% at 15 February 2022 (2021: 65.8% and 2020: 60%). There was a considerable increase in the vaccination rate during 2021, also during the pandemic. These techniques can be expanded upon in future years. We have raised this within **matter arising one.**

Conclusion:

2.21 We confirmed that a range of promotional material and engagement was in place to support the vaccination roll-out. However, in spite of this, the vaccination rate was lower than last year. We recognise that the emergence of the Omicron variant hindered the programme, but there is an opportunity to determine the reasons for a higher uptake last year, which was also during the pandemic. Alongside this, the role and availability of the flu champions should be reviewed, to maximise the opportunity for all staff to receive a vaccination. Therefore, we have provided **reasonable assurance** for this objective.

Audit objective 5: to confirm that there are arrangements in place for flu champions and clinics to accommodate all Health Board staff requiring vaccination.

2.22 The Welsh Government *ambition* target for staff flu vaccination uptake is 80%. However, across Wales the flu vaccination rate is 54.8% (at 15 February 2022). At the same point in time, the Health Board's rate was the 4th highest across NHS Wales organisations.

2.23 Whilst we did not calculate the correlation co-efficient for the use of flu champions during the campaign against the vaccination rate, we did confirm that 37.4% of staff vaccinations are delivered by flu champions. Therefore, they play an important role in the achievement of a higher vaccination rate.

2.24 We were unable to determine the exact number of active flu champions, as this information has not been regularly maintained on the database. However, we understand from reviewing the database that there could be between approximately 300 and 500 flu champions. Previously, flu champions within the Health Board delivered vaccinations during their allocated shift. However, due to the pressures faced within the Health Board, this now is not always the case.

2.25 To become a flu champion, annual training is required. We were informed that less staff received training during this flu season. However, as this information has not been accurately maintained, we were unable to verify this. We have raised this within **matter arising one.** The database is currently being reviewed by the newly appointed Project Manager, to identify any personnel gaps.

2.26 We also reviewed the number of occupational health clinics operating over the winter period and found this was less than previous years, as detailed below. This may have impacted upon the staff uptake rate.

2021/22	116 occupational health clinics held across 10 sites within the Health Board
2020/21	153 occupational health clinics held across 12 sites within the Health Board

The Omicron variant may have impacted on the number of clinics possible. Consequently, there have been multiple flu clinics (alongside additional promotional activities) operating during February and March 2022, to accommodate staff that may have missed previous opportunities to obtain their flu vaccination. As mentioned above, the Health Board should review the staff flu vaccination programme upon completion, to identify areas for development. This has been included within **matter arising one.**

Conclusion:

2.27 We found a wide range of initiatives to support the flu vaccination programme, with further promotion from February 2022 onwards, but the availability of flu champions should be reviewed and assessed. The staff flu vaccination uptake rate is lower than last year (also during the pandemic), but comparable to other NHS Wales organisations. There are staff groups that are significantly lower than others, e.g. estates and ancillary – 49.1% (end of January 2022). Further, the number of clinics is less than in the previous year. A review following the conclusion of the flu vaccination programme will assist in determining the range of initiatives for the next campaign. Overall, we have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter arising 1: Vaccination arrangements (Design)	Impact
The Welsh Government's ambition target for staff flu vaccination uptake is 80%. However, at 15 February 2022, the Health Board had delivered flu vaccinations to 57.8% of its staff. Whilst the Health Board was the 4th highest amongst the NHS Wales organisations, the rate was overall comparable with other Health Boards. The Health Board utilises flu champions across each division to promote and deliver the flu vaccination. We found that the number and location of flu champions could not be identified and that the entries within the database for the management of them is out of date. We confirmed that flu champions delivered 37.4% of vaccinations and thus are key in working towards the Welsh Government's target. Flu champions are provided with a benchmark of 30 vaccinations to administer. However, a staff survey, with 41 responses identified that most were not achieving this figure. We also identified that there were less occupational health clinics that operated this year, compared to the previous year - with 116 to the end of January (153 last year). Due to the emergence of the Omicron variant, 14 additional clinics were scheduled for February and March 2022, but this still remains less than the previous year. Furthermore, with multiple promotional activities and opportunities taking place, the Health Board should evaluate the success of each of them, to help inform priorities in future years.	Potential risk of: • Insufficient flu champions and clinics across the Health Board may result in less flu vaccination uptake. • Failure to achieve the Welsh Government ambition target of 80%. • Increased staff absences due to a low uptake of the flu vaccination.

Recommendations	Priority
1.1 a. The Health Board should review and investigate all promotional activity and flu vaccination delivery methods to determine the degree of success each brings. Alongside this, a reflection exercise should be completed to identify any lessons to be learnt or improvements to incorporate in future campaigns. b. The flu champion database should be reviewed, updated and regularly maintained.	Medium

Management response	Target Date	Responsible Officer
1.1 a. The Health Board will be holding annual Staff Flu Vaccine planning event for 2022-23 in April/May 2022. This report will be shared with the Staff Flu Working Group in advance to ensure that members have the opportunity to reflect on this report.	31st July 2022	Arif Mahmood / Sarah Aitken

	This event will both reflect and act on the lessons learnt during the provision of staff vaccines during 2021/22, from an operational, communication and organisational view; as well as providing analysis of all available division/flu champion/vaccination data. Lessons learnt will be highlighted during this event and 2022/23 will be planned strategically to take advantage of positive aspects, such as the mass vaccination centre approach (if an option), improving the flu champion model through improved digital innovation/organisational planning as well as mitigating barriers to vaccine uptake born of the staff survey/reflections. It is intended to be supported by a staff survey of "how they felt the vaccine programme did." It will form the basis of a user centred approach by listening to employee concerns as well as an opportunity to capture staff ideas. In addition, it is anticipated that greater use of technology will be implemented which will offer a greater array of options and opportunities, the team are keen to explore.		
b.	The flu champion database is to be discussed as part of the reflective and planning process. It is the intention to be updated and regularly maintained. Possibly by the Project Manager to ensure all aspects of the database are up to date. It is also an ambition to integrate data capture through power apps to update flu champion vaccination numbers within one resource. This can then be accessed to support flu champions.	31st July 2022	Arif Mahmood / Sarah Aitken

Matter arising 2: Governance arrangements (Design)	Impact
We confirmed that the two working groups to support the roll-out of flu vaccinations, the Staff Flu Immunisation Working Group and Primary Care Seasonal Influenza Vaccination Group were operating appropriately and assisted with the delivery of the staff flu and primary care vaccinations programmes, respectively. However, neither group had a finalised terms of reference and we also identified the following points for the Staff Flu Immunisation Working Group: • There are 18 members, but no quoracy requirements are stipulated. Following a review of the minutes, we identified that c. 11 or 12 attendees are present at each meeting. • Roles and responsibilities of the Group members are brief, with no escalation process defined, when required. • There is no member assigned as the Chair or Vice Chair. • The meeting frequencies are not detailed within the terms of reference.	Potential risk of: • The terms of reference for both groups may not be fit for purpose or complete.

Recommendations	Priority
2.1 a. The terms of reference for both Working Groups should be reviewed and updated where required. b. The terms of reference for each group should be finalised.	Low

Management response	Target Date	Responsible Officer
2.1 a. Staff Flu Immunisation Working Group will review and update the Terms of Reference at the planning event	31st July 2022	Arif Mahmood / Sarah Aitken
b. Staff Flu Immunisation Working Group Terms of Reference will be finalised once reviewed.	31st July 2022	Aimee Clement-Rees / Will Beer / Sarah Aitken
c. Community Flu Immunisation Working Group Terms of Reference will be reviewed and finalised.	31st July 2022	Aimee Clement-Rees / Will Beer / Sarah Aitken

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

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

Risk Management
Final Internal Audit Report

March 2022

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

Contents

Review reference:	AB-2122-02
Report status:	Final
Fieldwork commencement:	7th January 2022
Fieldwork completion:	28th February 2022
Draft report issued:	7th March 2022
Debrief meeting:	16th February 2022
Management response received:	24th March 2022
Final report issued:	25th March 2022
Auditors:	Simon Cookson, Interim Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Laura Howells, Principal Auditor Rhian Gard, Principal Auditor
Executive sign-off:	Rani Mallison, Director of Corporate Governance
Distribution:	Glyn Jones, Interim Chief Executive Danielle O'Leary, Head of Corporate Services, Risk and Assurance
Committee:	Audit, Finance and Risk Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

To provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board to ensure strategic objectives are achieved.

Overview

We have issued reasonable assurance for this area.

The matters requiring management attention include:

- The objectives of the Risk Management Strategy should be monitored for implementation.
- Formal risk management training should be considered throughout the Health Board.
- There should be a consistent approach across divisions towards the management of risk.

The Health Board is continuing towards becoming a risk mature organisation. The fundamental principles of risk management are largely embedded throughout the governance structures established as an NHS organisation. We found numerous examples of risk being managed as staff undertook their daily activities.

Further work is required to clearly and effectively communicate the 'risk vision' and create a culture where everyone has ownership and responsibility for doing the right thing for the organisation.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2018/19

Assurance summary[1]

Assurance objectives		Assurance
1	Risk management strategy	Reasonable
2	Risk appetite	Reasonable
3	Risk management training	Limited
4	The documentation of risk	Reasonable
5	The management of risk registers	Limited
6	Monitoring and reporting information	Reasonable
7	Escalation procedures for risks	Reasonable

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

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Risk Management Strategy and Risk Appetite	1, 2, 7	Design	Medium
2	Risk Management Training	3	Design	Medium
3	Divisional Risk Management	4, 5, 6	Operation	Medium

1. Introduction

1.1 The Risk Management internal audit was completed as part of the 2021/22 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board').

1.2 All levels of the organisation (directorates, service areas and / or divisions) are required to maintain a risk register and record risk details in the electronic risk management system, Datix (which has recently been replaced with DatixCloudIQ across NHS Wales). Risks within the Health Board are managed on its behalf through the relevant committees. The most significant risks within the Health Board are reported to the Board through the Strategic Risk Report and through the Board Assurance Framework.

1.3 A revised Risk Management Strategy and Framework (the 'Risk Strategy') was endorsed in September 2021. This Framework applies to all staff members, irrespective of grade or role.

1.4 The key risks considered in this review are:

- lack of awareness of the Risk Management Strategy and Framework;
- key risks are not identified, assessed, and recorded within risk registers;
- risks identified are not effectively managed;
- risks are not being escalated throughout the Health Board; and
- increased financial costs and reputational damage due to failure to effectively manage risks.

1.5 We interviewed Divisional Risk Leads to understand the risk management arrangements in place within the following divisions:

- Family and Therapies;
- Complex Care;
- Mental Health and Learning Disabilities;
- Informatics; and
- Facilities.

2. Detailed Audit Findings

Audit objective 1: the Risk Management Strategy and Framework

2.1 The Health Board has a documented risk strategy in place. The Risk Strategy was last reviewed during 2021 and formally approved by the Board. The latest review led to a reduction in the detail of the Risk Strategy. We were frequently told by managers interviewed that this change was welcomed.

2.2 The Risk Strategy aims to provide a framework for the Health Board's development towards becoming a 'Risk Enabled'[2] organisation. To achieve this the Risk Strategy highlights outstanding objectives, including the development of supporting procedures to underpin and support the embedding of risk

[2] See Appendix B

management arrangements. Currently, this documentation is still being developed.

2.3 Risk assessment guidance is only available in relation to health and safety, but not for the development of risk registers or other key areas, although there are examples of good practice operating within the Health Board which are utilised for sharing. We recognise that guidance / procedures are still being developed to support the Risk Strategy.

2.4 In addition, we found a number of objectives within the Risk Strategy still outstanding. Whilst work is underway to progress these objectives, capacity and the pandemic has significantly impacted the delivery of these actions. However, we found that the remaining actions / objectives are not being monitored or assurance provided on the delivery of these. We understand that an action plan is being presented to the Audit, Finance and Risk Committee (AFRC) in April 2022. However, we recommend that this is reported on a regular basis to the Committee for assurance. This has been included within **matter arising one**.

2.5 The Office of Government Commerce (which was responsible for advocating best practice for the management of risk at public sector organisations) identifies a list of topics a Risk Strategy would usually contain. The Health Board's strategy is consistent with this list (and other guides), although there are sections that require further development, for example the risk appetite. However, the Health Board is already aware of these areas and there are plans to review the Risk Strategy during 2022.

2.6 The Risk Strategy sets out that twice a year all divisional risk registers should be submitted to the Corporate Risk Team for a full organisational review to be undertaken. We confirmed the last time this review had been completed was during October 2021, but was informed that not all divisions responded. The completeness / standardisation of risk throughout the Health Board should be considered as part of the action plan.

2.7 We also found that meetings between risk leads within the divisions and the Head of Corporate Governance, Risk and Assurance have taken place over the past year, to aid the embedding of risk within the Health Board.

Conclusion:

2.8 The objectives of the Risk Strategy are partially embedded, with further work required to progress this. We have provided **reasonable assurance** over this objective.

Audit objective 2: the Health Board's risk appetite

2.9 Risk appetite is the Health Board's unique attitude towards risk taking, which in turn dictates the amount of risk that it considers acceptable. The Board, as the highest level of organisational governance, is directly responsible for setting the risk appetite.

2.10 Within the Risk Strategy is the Health Board's general Risk Appetite Statement (the 'Statement'), which was approved by the Board during 2021. However, the Statement does not clearly define the level of risk the Health Board is willing to accept, nor does it fully set out the Health Board's risk tolerance (the acceptable deviation from the Health Board's risk appetite). We were provided with the Risk Matrix (which is separate to the Risk Strategy) and we found this to be fit for purpose.

2.11 The Good Governance Guide for NHS Wales Boards (the 'Guide') sets out that Boards must be clear about their risk appetite and keep it under regular review i.e. a clear determination on what level of risk it is prepared to accept for each significant type of risk it may face. An effective assurance framework should be able to rationalise and consolidate multiple assurance inputs, providing greater oversight of assurance activities for the Board and supporting committees, in line with the Statement. The Health Board already maintains a Board Assurance Framework, and this is being tested as part of a separate internal audit (ABUHB 21/22 – 01, Corporate Governance). The Health Board is planning to update the Statement during 2022, with the inclusion of risk attitude and capacity levels.

2.12 We interviewed managers to understand how risk is managed within their area, but none described how the management of their risks are aligned to the Health Board's risk appetite. However, we anticipate that this will be addressed as the risk management training programme continues.

2.13 To assist the Health Board with the development of the Statement we shared examples of good practice from other NHS Wales organisations. We found one example to be consistent with best practice.

Conclusion:

2.14 The current risk appetite requires further development. The Health Board is undertaking steps to improve this area and, as such, we have provided **reasonable assurance** for this objective.

Audit objective 3: risk management training and the promotion of best practice

2.15 An electronic training programme for all staff is an objective within the Health Board's Risk Strategy. Currently, formalised risk management training is not implemented across the Health Board. We were informed that there is a plan to provide staff with training in the principles of risk management and the appropriate skills to undertake effective risk management. This training will encompass clinical, non-clinical areas and other categories of risk management and will be delivered via ESR. Three levels of training will be provided, including:

- Level 1 - basic training for all staff;
- Level 2 - management training; and
- Level 3 - Board level training.

2.16 However, this training plan has yet to be implemented. Equally, as training is not undertaken, best practice is also not promoted – although we recognise that the Community of Practice Group (the 'Group') will facilitate this going forward.

2.17 We were informed this was due to the delay in the role out of the risk management module as part of DatixCloudIQ. This module is still under review, but vital for the programme to be fully implemented and an essential component of the training delivery. However, in the meantime, there is no delivery of risk management training to support staff. This has been raised as **matter arising two.**

2.18 We also reviewed a sample of divisions to determine if training programmes are in place. Currently, there is no specific risk management training completed within divisions. Through staff interviews, we were informed that training had been delivered in a variety of methods previously, but there was no current training programme underway. In the past, it was in the form of a third-party organisation delivering one-off training or an ad-hoc presentation.

Conclusion:

2.19 Whilst we recognise that the pandemic has delayed the roll-out of any formal management training, we have not seen a plan set out to ensure training is delivered going forward. Equally, without any significant training programme underway in the interim, the embedding of risk management arrangements will continue to be delayed. Therefore, we provided **limited assurance** for this objective.

Audit objective 4: the assessment and documentation of risk at a directorate / divisional / corporate level

2.20 We reviewed a sample of divisional risk registers and found that the inputting of risks onto Datix is inconsistent across the Health Board. We found good examples, with the Family and Therapies Division uploading their risks into Datix. However, other divisions hold their risks on Excel spreadsheets (e.g. Informatics and Complex Care). Whilst the Health Board has agreed that the risks not yet on Datix will not be included until the new DatixCloudIQ has been fully implemented, emerging risks or trends are not being fully reviewed at a corporate level. We have raised the inconsistent approach at a divisional level to recording risk as **matter arising three.**

2.21 We confirmed that access to the risk register on Datix is restricted to divisional senior managers, to ensure that it is protected from unauthorised changes. Where risks are held on an Excel Spreadsheet, we identified that these were held within a restricted SharePoint folder.

2.22 Risks on the divisional risk registers are updated in a variety of ways, and again, there is an inconsistent approach across the Health Board. Within the sample of divisions tested we found that they had at least monthly meetings to review risks. In some cases, we were informed that the risk review meetings would take place weekly to ensure the most up to date risk register was being maintained. Minutes

of these meetings are not maintained; however, we were able to view other evidence (which varied by division). Examples included monthly updated Excel spreadsheets, emails to staff highlighting risks due for review and quality and patient safety reports detailing the status of risks. The inconsistent approach has been included within **matter arising three.**

Conclusion:

2.23 Risk registers are not kept in a consistent format, however, each staff member interviewed during our audit was able to take us through their respective risk register, including recent updates. We have provided **reasonable assurance** for this objective.

Audit objective 5: the management of risks (e.g. risk score, actions, target dates, responsible owners and impact on strategic objectives)

2.24 During our audit we reviewed risk registers on Datix for Facilities, Families and Therapies, Scheduled Care and Unscheduled Care.

2.25 We confirmed that a risk score had been allocated to each individual risk. However, we noted that the risk registers were not always completed fully, with some risks having their risk score lowered without any mitigating actions being put in place. We also found an example of a risk score significantly increased following mitigating actions, although it is likely that this is a clerical error.

2.26 We confirmed there is a risk matrix in place which details a scoring system for risks and provides a baseline for staff to assess a risk.

2.27 After reviewing risks within the sample of risk registers on Datix, we confirmed that the risks posted seemed appropriate. However, we did identify that a risk owner was often not assigned to a risk posted on Datix. This is important as it allows the system to issue a reminder for the risk to be reviewed. Consequently, all material risks are then reviewed at divisional meetings to ensure no gaps arise. This has been included within **matter arising three.**

2.28 Finally, we also identified that review dates, which assist in the tracking of individual risks, are not always populated either. This has also been included within **matter arising three**.

Conclusion:

2.29 Risk registers are often not fully completed, which have not been addressed by the respective division. We have provided **limited assurance** for this objective.

Audit objective 6: monitoring and reporting information

2.30 The Group has been established with the aim of sharing ideas, good practice and learning regarding risk management. This is to replace the role served by Risk Champions. The Group does not have a 'terms of reference', a required quoracy or a list of attendees. However, the Group is open to all staff who are interested

in risk. So far, the Group has met once, during November 2021 and no minutes were kept. Without a more formalised process and involvement of key individuals across the divisions, the benefits realised may be minimal to the Health Board. We were informed that the Health Board will be formalising the Group during 2022.

2.31 We reviewed the minutes of the Quality and Patient Safety Operational Group (QPSOG) to determine if divisional risks are escalated. We found that the number of divisions attending varies from one meeting to another. Additionally, the number of risks presented by a division also varies (e.g. top three or top eight risks). We were informed during our interviews with divisional representatives that there was some confusion over the limit of how many risks can be presented. Whilst the QPSOG provides a good avenue to escalate risks, we recommend that there is a consistent approach across all divisions. This is included within **matter arising three.**

2.32 Risks not managed at the operational level are then discussed at the Patient Quality, Safety and Outcomes Committee (PQSOC) (formally the QPS Committee). Review of minutes and attendance of a meeting confirmed there is a flow of information regarding risks going to the committee from the QPSOG. Equally, there was evidence of risks being scrutinised and concerns being noted.

2.33 The most significant risks to the Health Board are discussed at the Audit, Finance and Risk Committee (AFRC) and by the Board, through the presentation of risk reports.

Conclusion:

2.34 There is clear evidence risks are reviewed and appropriately scrutinised at relevant groups / committees. As there is a varied approach across the divisions and ongoing embedding of the Group, we have provided **reasonable assurance** for this objective.

Audit objective 7: escalation procedures for risks that cannot be resolved at an operational level

2.35 The Health Board manages risk at three levels: corporate; divisional and within local teams / departmental. The process for the escalation and de-escalation of risks between the three levels is not detailed, although the use of Datix is a key tool in this process. There is, however, a brief overview of the general escalation process within the Risk Strategy.

2.36 Equally, within the Risk Strategy there is an objective for creating a clear process for monitoring and reporting risks. An escalation procedure (or guidance) would complete this objective. The procedure would also enable staff to quickly identify the most efficient way to escalate any risks identified and assist staff in understanding their roles and responsibilities with the escalation of risk. This has been included within **matter arising one.**

Conclusion:

2.37 We saw evidence of risks escalated and staff interviewed detailed to us the process for doing this. However, there may be a benefit to documenting in further detail how risks should be escalated. We have provided **reasonable assurance** for this objective.

Assessment of the Health Board's current risk maturity

2.38 We reviewed the conclusions from each audit objective and utilised these to complete a risk maturity assessment, using the framework set by the Institute of Internal Auditors. This is detailed within Appendix B. We have assessed against five risk maturity levels, with further explanation behind each level included within Appendix B.

2.39 After completing this assessment, we graded the Health Board as between 'Risk Defined' and 'Risk Managed'. That is, the Health Board has risk management processes established and is working towards a pro-active risk management approach.

2.40 The nature of the organisation is such that risk management is naturally embedded within the majority of the Health Board's functions e.g. governance arrangements. Therefore, when determining how to continue with the improvement of the risk management process, the Health Board should consider what further improvements are required over and above existing management arrangements.

Appendix A: Management Action Plan

Matter arising 1: Risk Management Strategy and Appetite (Design)	Impact
The Health Board has a documented Risk Management Strategy and Delivery Framework (the 'Risk Strategy'). The Risk Strategy aims to provide a framework for the Health Board's development towards becoming a 'Risk Enabled' organisation. The Risk Strategy sets out a series of objectives for the Health Board to achieve. Whilst we identified elements of the objectives implemented (e.g. creating an electronic risk management system), there is no overall action plan setting out key milestones and deliverables for each of them.	Potential risk of: • The objectives of the Risk Strategy may not be achieved, leading to ineffective risk management arrangements. • Emerging divisional risks may not be identified.

Recommendations	Priority
1.1 The Health Board should: • Develop a plan setting out how key objectives within the Risk Strategy will be achieved, with milestones set out. The progress of the plan should be reported into the Audit, Finance and Risk Committee. • Review the Risk Strategy to determine if it still reflects current practice and update it accordingly e.g. the corporate overview or risks.	Medium

Management response	Target Date	Responsible Officer
1.1 A plan has been developed and is being presented to the Audit Committee on 7th April 2022 following discussion with Executive Team. A review of the Strategy will be undertaken as part of the plan, in September 2022, specifically to review effectiveness one year post implementation.	September 2022	Head of Corporate Governance, Risk and Assurance

Matter arising 2: Risk Management Training (Design)	Impact
An electronic training programme for all staff is an objective within the Health Board's Risk Strategy. Currently, formalised risk management training is not implemented across the Health Board. We were informed that there is a plan to provide staff with training in the principles of risk management and the appropriate skills to undertake effective risk management. This training will encompass clinical and non-clinical areas and will be delivered via ESR. Three levels of training will be provided, including: Level 1 - basic training for all staff; Level 2 - management training; and Level 3 - Board level training. However, this training plan has yet to be implemented. We were informed that this was due to the delay in the implementation of the risk management module for within DatixCloudIQ. In the meantime, there is a risk that staff are unaware of their responsibilities regarding risk management.	Potential risk of: • Staff not aware of the procedures to manage risk. • Risks not being identified and / or escalated.

Recommendations	Priority
2.1 The Health Board should: • Consider undertaking risk management training for key areas, whilst awaiting the implementation of the risk management module within DatixCloudIQ. • Develop a plan to deploy risk management training, to commence once the full implementation of DatixCloudIQ has been completed.	Medium

Management response	Target Date	Responsible Officer
2.1 As part of the strategy realisation plan, the Health Board will develop an in-house training package aimed at the three levels outlined within the Strategy (operational, management and Board level). This will be made available to relevant staff during May/June 2022. Further National development work will resume once the RLDatix risk management module has been finalised and bespoke training programmes can then be developed.	June 2022	Head of Corporate Governance, Risk and Assurance

Matter arising 3: Divisional Risk Management (Operation)	Impact
We reviewed a sample of divisional risk registers and found that the inputting of risks onto Datix is inconsistent across the Health Board. We found good examples, with the Family and Therapies Division uploading their risks into Datix. However, other divisions hold their risks on Excel spreadsheets (e.g. Informatics and Complex Care). Whilst the Health Board has agreed that the risks not yet on Datix will not be included until the new DatixCloudIQ has been fully implemented, emerging risks or trends are not being fully reviewed at a corporate level. After reviewing risks within the sample of risk registers on Datix, we confirmed that they seemed appropriate. However, we did identify that risk owners were often not assigned to a risk posted on Datix. Furthermore, we also identified that review dates are not always populated to assist in the tracking of individual risks. Finally, we were informed during our interviews with divisional representatives that there was some confusion over the limit of how many risks can be presented to the Quality and Patient Safety Operational Group (QPSOG).	Potential risk of: • An inconsistent recognition, monitoring, management and / or identification of risks across the Health Board

Recommendations	Priority
3.1 The Health Board should: • Provide guidance detailing how risks should be recorded and monitored at different levels within the organisation. • Ensure each risk entry is fully recorded in a standard format.	Medium

Management response	Target Date	Responsible Officer
3.1 This recommendation forms part of the Risk Management Strategy realisation plan. The Health Board training programme will provide material and literature to help support staff to populate Datix and risk registers appropriately and consistently ensuring alignment with best practice. The provision of in-house training will be made available to staff by May/June 2022.	June 2022	Head of Corporate Governance, Risk and Assurance

Appendix B: Risk Maturity Assessment

Key Characteristics	Risk Naïve	Risk Aware	Risk Defined	Risk Managed	Risk Enabled
The organisation's objectives are defined					✓
Management have been trained to understand what risks are, and their responsibility for them		✓			
A scoring system for assessing risks has been defined				✓	
The risk appetite of the organisation has been defined in terms of the scoring system			✓		
Processes have been defined to determine risks, and these have been followed			✓		
All risks have been collected into one list. Risks have been allocated to specific job titles			✓		
All risks have been assessed in accordance with the defined scoring system			✓		
Responses to the risks have been selected and implemented				✓	
Management have set up methods to monitor the proper operation of key processes, responses and action plans ('monitoring controls')		✓			
Risks are regularly reviewed by the organisation				✓	
Management report risks to Directors where responses have not managed the risks to a level acceptable to the Board				✓	
Responsibility for the determination, assessment and management of risks is included in job descriptions			✓		
Managers provide assurance on their risk management				✓	
Managers are assessed on their risk management performance			✓		

Risk Maturity Definitions Key

Risk Naïve	Organisation unaware of the need for the management of risk and has no structured approach to dealing with uncertainty. Management processes are repetitive and reactive, with little or no attempt to learn from the past or to prepare for future threats or uncertainties.
Risk Aware	Risk management applied inconsistently with limited standardisation. Some formal processes in place.
Risk Defined	A risk management framework exists with defined and documented risk principles. An organisation-wide view of risk is provided to executive leadership and the board in the form of a list of so-called 'top' risks. Not all processes have been fully implemented.
Risk Managed	The organisation is proactive in risk management. Risk management is consistently and fully implemented across the organisation. Key risk indicators are used for major risks. Risk management processes are monitored and reviewed for continuous improvements.
Risk Enabled	Risk management is considered a value driver and proactively used for day-to-day decision making and pursuit of opportunities. Key Risk Indicators and predictive risk analytics are proactively used to identify and monitor risks. Advanced and sophisticated risk management processes are used.

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.
 **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.

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

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

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

Annual Internal Audit Plan: Draft Internal Audit Charter

March 2022

Aneurin Bevan University Health Board

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2022/23 (the 'Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

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

Accordingly, this document sets out the risk-based approach and the Plan for 2022/23. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

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

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

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

2.2 Risk based internal audit planning approach

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

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

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19 and the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the

organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

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

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

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

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

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

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

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

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

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

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

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

2.3 Link to the Health Board's systems of assurance

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

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

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board

Executives and Independent members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's Executive team, the Chair of the Audit, Finance and Risk Committee and the Chair of the Board.

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

3. Audit risk assessment

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

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2022/23

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

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

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

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

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

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

4.2 Keeping the plan under review

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

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the ongoing impact of and recovery from the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

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

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

5. Resource needs assessment

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

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

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

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

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

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

6. Action required

The Audit, Finance and Risk Committee is invited to consider the Internal Audit Plan for 2022/23 and:

- approve the Internal Audit Plan for 2022/23;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Simon Cookson

Director of Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2022/2023

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Director of Corporate Governance	Q4
Risk Management	1		To provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board in order to ensure that strategic objectives are achieved.	Director of Corporate Governance	Q4
Corporate Governance	2		To review the effectiveness of corporate governance arrangements within the Health Board including a review of the People and Culture Committee.	Director of Corporate Governance	Q4
Financial Sustainability	3	CRR016 CRR032	To review the key financial management controls within the Health Board including the development and monitoring of savings programmes required for financial sustainability.	Director of Finance and Procurement	Q3
CF - Care Closer to Home	4	CRR007 CRR008	To assess whether the Health Board is on track to implement its overall	Director of Planning,	Q3

		CRR012 CRR023	objective of care closer to home.	Digital and IT / Director of Operations	
Clinical Audit	5		To review the process for clinical audit including how it is used by Committees of the Health Board to support assurance.	Medical Director	Q1
Urgent Care System	6	CRR019	To assess whether the six goals set out for urgent and emergency care by the Minister for Health and Social Services are being delivered.	Director of Operations	Q4
Access to Primary Care	7	CRR001 CRR007 CRR012	To assess the plans for increasing access to primary care services, as the Health Board implements its objective of care closer to home.	Director of Primary Care, Mental Health and Learning Disabilities	Q2
Neighbourhood Care Networks (NCNs)	8	CRR001 CRR007 CRR008 CRR012	To provide an opinion on the effectiveness of the controls in place to ensure Neighbourhood Care Networks (NCNs) are delivering on their plans.	Director of Primary Care, Mental Health and Learning Disabilities	Q2
Mental Health Transformation	9	CRR008 CRR016 CRR032 CRR019	Review of critical projects supporting the transformation of mental health services.	Director of Primary Care, Mental Health and Learning Disabilities	Q3
Dementia Services	10	CRR007 CRR008	To review the effectiveness of the arrangements for ensuring person	Director of Nursing/	Q4

		CRR012 CRR023	centred care is delivered throughout the Health Board regarding dementia services.	Director of Primary Care, Mental Health and Learning Disabilities	
Infection Prevention and Control	11	CRR013	To assess adherence to organisational policies and the Health and Care Standards in Wales	Director of Nursing / Medical Director / Director of Therapies and Health Sciences	Q3
Use of off-contract Agency	12	CRR002 CRR016 CRR032	To assess whether off-contract agency processes are adhered to and related expenditure is appropriately monitored.	Director of Operations / Director of Finance	Q1
Quality Framework	13	CRR008	To review the progress made to implement the framework and assess how it meets the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act.	Director of Nursing / Medical Director / Director of Therapies and Health Sciences	Q2
Discharge Planning	14	CRR007	To review the arrangements in place within the Health Board for the timely and safe discharge of patients and whether established processes are being adhered to	Director of Nursing / Medical Director / Director of	Q2

				Therapies and Health Sciences	
Integrated Wellbeing Networks	15	CRR007 CRR008	To provide an opinion on the Health Board's plan to further develop Integrated Wellbeing Networks (IWNs) across the region, including mental health provision.	Director of Public Health and Strategic Relationships	Q3
Recruitment Selection Process	16	CRR002	To review the key controls for ensuring the best candidate is selected for any given role, including the selection process.	Director of Workforce & OD / Director of Operations	Q1
Agile Delivery	17		Advisory review to assess the Health Board's progress in developing agile working practices and identification of good practice.	Director of Workforce and OD	Q2
Review of Bank Office and Temporary Staff	18	CRR002	Review of the operation of the Bank Office and the management of temporary staff.	Director of Workforce and OD	Q4
Workforce Planning	19		Review of workforce planning, to review service models and workforce plans and review progress, implementation, monitoring and benefits realisation.	Director of Workforce and OD / Director of Operations	Q3
Job Evaluation Process	20		To assess how effectively the principles of the NHS Job Evaluation Handbook are adhered to.	Director of Workforce and OD	Q1

Monitoring Action Plans	21		To review the arrangements in place within the Divisions for logging, tracking and implementing recommendations from external reviews.	Director of Corporate Governance	Q4
Follow-up of High Priority Recommendations	22		To assess whether high priority internal audit recommendations have been implemented.	Director of Corporate Governance	Q4
Benefits of Digital Solutions	23	CRR020 CRR032	To assess whether the benefits associated with the implementation of digital solutions are identified and appropriately realised.	Director of Planning, Digital and IT	Q1
Cyber Security	24	CRR017	To ensure appropriate progress is being made against the improvement plan.	Director of Planning, Digital and IT	Q4
Records Management	25		To assess the management of records and whether they are compliant with relevant legislation.	Director of Planning, Digital and IT	Q3
Management of the Robotic Process Automation (RPA)	26	CRR017	To assess project for the rollout of the Robotic Process Automation (RPA) and whether anticipated benefits are being achieved.	Director of Planning, Digital and IT	Q2
IT Strategy	27		To provide an opinion on the effectiveness of the Health Board's IT Strategy.	Director of Planning, Digital and IT	Q1
Decarbonisation	28		To determine the adequacy of management arrangements to ensure	Director of Planning,	Q2

			compliance with the Welsh Government decarbonisation strategy, and to provide assurance on capital allocations provided by Welsh Government to address decarbonisation issues across the estate during 2021/22.	Digital and IT	
Tredegar Health and Wellbeing Centre	29		Welsh Government approval of the £19.488m Full Business Case (FBC) was received on 18 March 2021. Work commenced on site on 6th September 2021, with all works scheduled for completion in August 2023. This will be the second interim audit of the project and may focus on the following areas: * Follow Up of previously agreed management actions; *Ongoing Project Governance and Management arrangements; *Interim valuation and payments processes; *Site Management; *Change Management arrangements; *Equipment procurement arrangements; and *Other – i.e. any other issues identified at the project affecting project delivery	Director of Planning, Digital and IT	Q3

Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	N/A		In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the UHB to "assess the risk profile of the scheme and provide appropriate levels of review". A small provision of days is included within the 2022/23 plan to enable us to work with the UHB to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.		

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

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2022/23
Audit plan 2022/23 agreed/in draft by 30 April	✓	100%
Audit opinion 2021/22 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit, Finance and Risk Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

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

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

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

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

2 Purpose and responsibility

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

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

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

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

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

3 Independence and Objectivity

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

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

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

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

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

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

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

4 Authority and Accountability

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

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

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

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

4.5 The Audit, Finance and Risk Committee approves all Internal Audit

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

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

5 Relationships

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

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

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

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

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

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

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

5.8 The Audit, Finance and Risk Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Finance and

Risk Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

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

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

7 Scope

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

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

risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

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

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

8 Approach

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

Figure 1: Audit planning hierarchy

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

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national

transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

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

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

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

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

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

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

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

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

9 Reporting

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

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

improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

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

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

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

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

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

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

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

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

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2022

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

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

Date issued: April 7, 2022

Document reference: 2813A2022

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

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

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

About this document

1 This document provides the Audit, Finance and Risk Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value for money examinations and the work of our Good Practice Exchange (GPX).

2 We are currently undertaking consultation on our future work programme and would welcome views from the Health Board Consultations | Audit Wales.

3 As part of our national study work looking at the use of equality impact assessments, we're seeking feedback from 'decision makers' who see/ use these assessments to make or approve decisions. In particular, we'd like to hear from independent board members in the NHS Equality impact assessments.

Accounts audit update

4 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
2021 Audit Plan	Completed; presented to the April Committee meeting.
Audit of Accounts Report	Completed and ISA 260 report presented to the June Committee meeting.
Charitable Funds: • 2021 Audit Plan • Audit of Charitable Funds financial statements	Presented to the Charitable Fund Committee on 11 January and to the Board on 26 January 2022

5 We presented a draft version of our Audit of Accounts Addendum Report to the December Audit, Finance and Risk Committee, and have since issued the final version with updated management responses to our recommendations and action implementation dates.

Performance audit update

6 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work completed (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Finance, Audit and Risk Audit Committee
Radiology Services follow-up	Completed and findings presented to the Committee in November 2021.
Structured Assessment 2021	Completed and findings to be presented to the Committee in February 2022.
Annual Audit Report 2021	Completed and to be presented to the Committee in February 2022.

Exhibit 3 – work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
Quality Governance	This work will examine both the operational and corporate	Draft report issued.

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
Executive Leads: Rhiannon Jones, James Calvert and Peter Carr	approach to quality governance, looking at issues such as organisational culture and behaviours, strategy, structures and processes, information flows and reporting.	Planned date for consideration – Audit Finance and Risk Committee – May 2022 / Patient Quality, Safety and Outcomes Committee – June 2022
Orthopaedic Follow up review Executive Lead: Leanne Watkins	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges and consider the impact of the pandemic and orthopaedic service recovery. Therefore, reporting was moved to 2022.	Report being drafted.
Review of arrangements for securing efficiencies Executive Lead: Rob Holcombe	This work will consider whether the Health Board's arrangements for securing efficiencies are robust, including the impact of new ways of working on planned efficiencies.	Reviewing approach to ensure relevance to post-pandemic recovery. Planned date for consideration - to be confirmed.
Unscheduled care arrangements Executive Lead: Leanne Watkins / Rhiannon Jones	This work has been carried forward from the 2020 Audit Plan and will initially look to provide a high-level whole system overview of the unscheduled care. The overview will be informed by the development of an interactive database covering all aspects of the unscheduled	This review was replaced by work on Test, Track and Protect. The review is now recommencing. Data analysis currently being completed.

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
	care pathway. Further work will then be undertaken on specific elements of unscheduled care pathway, with a likely focus on activities to signpost patients to the most to appropriate care setting, and to manage patient flow through the system.	Date for consideration to be confirmed.

Good Practice events and products

7 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

8 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee on 3rd February. Details of future events are available on the GPX Website.

9 In response to the COVID-19 pandemic, we have established a **COVID-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to prompt some thinking and support the exchange of practice. As part of the project, we held a COVID-19 Learning Week in March 2022. The material from the COVID-19 Learning Week, and other related material, is available here.

NHS-related national studies and related products

10 The Audit, Finance and Risk Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts and Public Administration Committee at the Senedd to support its scrutiny of public expenditure.

11 Exhibit 4 provides information on the NHS-related or relevant national studies published in the last 12 months.

12 There were no NHS-related or relevant national studies published since we last reported to the Committee on 3rd February.

Exhibit 4 – Recent NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Joint working between Emergency Services	January 2022
Care Home Commissioning for Older People	December 2021
Picture of Healthcare	October 2021
Taking care of the carers	October 2021
Rollout of the Covid-19 vaccination programme in Wales	June 2021
Cwm Taf Morgannwg Joint Review follow up	May 2021

Audit Wales

24 Cathedral Road

Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

2022 Audit Plan – Aneurin Bevan University Health Board

Audit year: 2022-23

Date issued: March 2022

Document reference:

This document is a draft version pending further discussions with the audited and inspected body. Information may not yet have been fully verified and should not be widely distributed.

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to 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.

Contents

2022 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2022 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic has had an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 While Wales is currently at Coronavirus Alert Level 0, Audit Wales will continue to monitor the position and will discuss the implications of any changes in the position with your officers.

Audit of financial statements

4 I am required to issue a report on the Health Board's financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. I lay them before the Senedd together with any report that I make on them. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report; and
- assess whether other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

5 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

6 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit, Finance and Risk Committee prior to completion of the audit.

7 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

8 I will also report on your charitable funds' accounts. I will issue a separate Audit Plan for the audit of the Charitable Funds accounts.

9 There have been no limitations imposed on me in planning the scope of this audit.

Audit of financial statement risks

10 The following table sets out the significant risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	We will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business.
Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements. [Insert work to be undertaken as appropriate.
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include accounting for field hospital decommissioning and	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.

Financial audit risks	Proposed audit response
their associated costs; fraud, error and regularity risks of additional spend; valuation (including obsolescence) of year-end inventory including PPE; and estimation of annual leave balances.	
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.
Other areas of audit attention	
There is a risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 11 shows a small deficit. This, combined with the outturns for 2019-20 and 2020-21, predicts a three-year surplus of £276k. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure [(for LHBs and SHAs only) and qualify your regularity opinion]. Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.	We will focus our testing on areas of the financial statements which could contain reporting bias.
Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be	We will review the completeness and accuracy of the disclosures

Financial audit risks	Proposed audit response
considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	

11 In addition to my responsibilities in respect of the audit of the body's statutory financial statements set out above, I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of Whole of Government Accounts.

Performance audit work

12 In addition to my Audit of Financial Statements, I must also satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

13 My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

14 During 2020-21 I consulted public bodies and other stakeholders on how I will approach my duties in respect of the Well-being of Future Generations (Wales) Act 2015 for the period 2020-2025. In March 2021, I wrote to the 44 public bodies designated under the Act setting out my intentions, which include:

- carrying our specific examinations of how public bodies have set their well-being objectives, and
- integrating my sustainable development principle examinations within my local audit programme

15 My auditors are liaising with the Health Board to agree the most appropriate time to examine the setting of well-being objectives.

16 **Exhibit 2** sets out my current plans for performance audit work in 2022.

Exhibit 2: My planned 2022 performance audit work at the Health Board

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2022 structured assessment work will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).
All-Wales Thematic work	As part of my 2022 plan, I intend to undertake an assessment of the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. I will tailor this work to align to the responsibilities of individual NHS bodies in respect of workforce planning. I also plan to use an element of the 2022 audit fee to respond to aspects of service delivery where my insight and knowledge across Wales will provide value to NHS bodies. The exact focus of this work will be confirmed following a broader consultation on my overall programme of audit work for Audit Wales for 2022-23 and beyond (see paragraphs 18 and 19).
Locally focused work	Where appropriate, I will also undertake performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and discussed at the Audit, Finance and Risk Committee.

Theme	Approach/key areas of focus
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

17 In March 2022, I published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through my national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. As we develop and deliver our future work programme, we will be putting into practice key themes in our new five-year strategy, namely:

- the delivery of a strategic, dynamic, and high-quality audit programme; supported by
- a targeted and impactful approach to communicating and influencing.

18 The possible areas of focus for future audit work that we set out in the consultation were framed in the context of three key themes from our Picture of Public Services analysis in autumn 2021, namely: a changing world; the ongoing pandemic; and transforming service delivery. We also invited views on possible areas for follow-up work.

19 We will provide updates on the performance audit programme though our regular updates to the Audit, Finance and Risk Committee.

Fee, audit team and timetable

20 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];

[1] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

21 As set out in our Fee Scheme 2022-23 our fee rates for 2022-23 have increased by 3.7% as a result of the need to continually invest in audit quality and in response to increasing cost pressures. The previous increase to our fee rates was in 2016. The estimated fee for 2022 is set out in **Exhibit 3,** alongside the previous year's actual fees. This year's estimated fee represents a 3.66% increase.

Exhibit 3: audit fee

Audit area	Proposed fee for 2022 (£)[2]	Actual fee for 2021 (£)
Audit of Financial Statements	**£228,176**	**£220,154**
Performance audit work:		
• Structured Assessment	£53,574	£64,237
• All-Wales thematic review[3]	£74,060	£68,807
• Local projects	£30,999	£19,948
Performance work total	£158,634	£152,992
Total fee	**£386,809**	**£373,146**

22 Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

23 Further information on my fee scales and fee setting can be found on our website.

[2] The fees shown in this document are exclusive of VAT, which is not charged to you.

[3] As detailed in the respective audit plans.

Audit team

24 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Richard Harries	Audit Director (Financial Audit), and Audit Wales Engagement Director for the Health Board	07789 397018	Richard.Harries@audit.wales
Dave Thomas	Audit Director (Performance Audit)	029 20320604	Dave.Thomas@audit.wales
Tracy Veale	Audit Manager (Financial Audit)	07919 217438	Tracy.Veale@audit.wales
Andrew Doughton	Audit Manager (Performance Audit)	07812 094642	Andrew.Doughton@audit.wales
Neall Hollis	Audit Lead (Financial Audit)	029 20320657	Neall.Hollis@audit.wales
Nathan Couch	Audit Lead (Performance Audit)	029 20320658	Nathan.Couch@audit.wales

25 There is one potential conflict of interest that I need to bring to your attention. Nathan Couch's wife is Senior Nurse within the Unscheduled Care Division at the Health Board. Appropriate restrictions on audit practice have been identified to mitigate any audit independence risks arising from this.

Timetable

26 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2022 Audit Plan	February to April 2022	April 2022
Audit of Financial Statements work: • Audit of Financial Statements Report • Opinion on Financial Statements	January to June 2022	June 2022
Performance audit work: • Structured Assessment • All-Wales thematic work • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Audit Wales

24 Cathedral Road

Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Report Title	**Audit Wales WHSSC Committee Governance Arrangements – Update**	**Agenda Item**	HB to complete
Meeting Title	HB Audit Committee	**Meeting Date**	HB to complete
FOI Status	Public		
Author (Job title)	Committee Secretary & Head of Corporate Services, WHSSC		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services, WHSSC		

Purpose of the Report	The purpose of this report is to provide the Health Board's Audit Committee with an update on progress against the recommendations outlined in the Audit Wales "WHSSC Committee Governance Arrangements" report.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s)

Members are asked to:

- **Note** the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, and
- **Note** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report.

AUDIT WALES "WHSSC COMMITTEE GOVERNANCE ARRANGEMENTS" REPORT – UPDATE

1.0 SITUATION

The purpose of this report is to provide the Health Board's Audit Committee with an update on progress against the recommendations outlined in the Audit Wales "WHSSC Committee Governance Arrangements" report.

2.0 BACKGROUND

In 2015, the Good Governance Institute (GGI) and Healthcare Inspectorate Wales (HIW) undertook two separate governance reviews for WHSSC which highlighted issues with WHSSC's governance arrangements. The GGI highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. HIW) conducted a review of clinical governance and found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

Since then, considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in Welsh Government's "A Healthier Wales", the Auditor General for Wales felt it was timely to undertake a review WHSSC's governance arrangements.

The Audit Wales review into Committee Governance arrangements at WHSSC was undertaken between March and June 2020, however as a result of the COVID-19 pandemic, aspects of the review were paused, and re-commenced in July. A survey was issued to all Health Boards and the fieldwork was concluded in October 2020.

The scope of the work included interviews with officers and independent members at WHSSC, observations from attending Joint Committee and sub-committee meetings, feedback from questionnaires issued to Health Board Chief Executive and Chairs and a review of corporate documents.

The findings were published in May 2021 in the Audit Wales Committee Governance Arrangements at WHSSC report.

The report outlined 4 recommendations for WHSSC and the 3 recommendations for Welsh Government.

HB Audit Committees received an update on progress against the recommendations in August/September 2021, and this report provides a further update on progress, and outlines feedback received from Audit Wales at the Joint Committee held on the 18 January 2022.

3.0 ASSESSMENT

3.1WHSSC Management Response

The report outlined 4 recommendations for WHSSC and progress against the actions outlined within the management response have been monitored through the WHSSC Integrated Governance Committee (IGC).

The IGC received updates on progress on the 12 October and 13 December 2021 noted the positive progress made and endorsed the tracker for submission to the Joint Committee.

The Joint Committee received the updated tracker report and an update from Audit Wales on the progress made against the recommendations on the 18 January 2022 and noted:

- that Audit Wales thought the WHSSC response to the recommendations was comprehensive and well thought out and that they were particularly pleased to note there had been ongoing oversight and scrutiny of progress by the Integrated Governance Committee (IGC), and
- that the only area for concern was around pan Wales recovery planning due to the ongoing volatile environment as a result of the pandemic.

The Joint Committee noted that majority of actions had been completed and there were only three areas of partial compliance in relation to:

- **R3b page 12** – relating the appointment of an AMD for Public health – despite proactive efforts to recruit, we have been unable to fill the position,
- **R4a page 14 and R4b page 18** – stakeholder engagement exercise to develop a new specialised services strategy – The timetable for this is being revised in response to the system pressures related to the current wave of the pandemic and the letter from the CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities.

3.2 Welsh Government Management Response

The report outlined 3 recommendations for Welsh Government (WG) and progress against the WG management responses is monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief Executive.

An update was received from Welsh Government on the 15 December 2021 advising that the advice on the NHS Executive was still being considered by the Minister for Health & Social Services.

During the meeting on the 18 January 2022 Audit Wales advised that they had written to the Chief Executive NHS Wales, and an initial response letter had been received setting out a high level overview of actions to be taken in response to the recommendations. The report had been considered by Senedd Cymru's Public Accounts and Public Administration Committee (PAPAC) following which the Chair of that Committee has written to the Director General/Chief Executive NHS Wales requesting an update on progress which is awaited.

3.3 Governance & Risk

Following the Joint Committee's approval of the tracker report on the 18 January 2022 the document has been shared with the NHS Wales Board Secretaries in HBs for inclusion on HB Audit Committee agendas in February/March 2022 to ensure that all NHS bodies are able to maintain a line of sight on the progress being made, noting WHSSC's status as a Joint Committee of each HB in Wales.

A further update on progress will be given to the Joint Committee and HB Audit Committees in summer 2022.

Risk management is a key element of developing WHSSC's services and risk assessments are undertaken as required.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, and
- **Note** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report.

Governance and Assurance	
Link to Strategic Objectives	
Link to Integrated Commissioning Plan	**-**
Health and Care Standards	Governance, Leadership and Accountability Safe Care Effective Care
Principles of Prudent Healthcare	Only do what is needed Reduce Inappropriate Variation
Institute for HealthCare Improvement Quadruple Aim	Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	The Management responses outline activities to strengthen and develop WHSSC's impact on quality, safety and patient experience.
Finance/Resource Implications	Some improvement actions may require the application of additional resources.
Population Health	There are no specific population health implications related to the activity outlined in this report.
Legal Implications (including equality	There are no specific legal implications related to the

& diversity, socio economic duty etc)	activity outlined in this report. There are no adverse impacts concerning equality and diversity or the socio economic duty.
Long Term Implications (incl WBFG Act 2015)	The WHSSC management responses take into consideration the long-term impact of decisions, to support better working with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
Report History (Meeting/Date/ Summary of Outcome	Integrated Governance Committee 13 December 2021 – Supported Joint Committee – 18 January 2022 - **Approved**
Appendices	Appendix 1 - WHSSC Audit Wales Governance Report Tracker – Jan 2022

Recommendations from the Audit Wales Report
Welsh Health Specialised Services Committee Governance Arrangements

Audit Tracker– Update January 2022

In May 2021, Audit Wales published the "Welsh Health Specialised Services Committee Governance Arrangements"[1] which found that the governance, management and planning arrangements at WHSSC have improved, however the impact of COVID-19 will require a clear strategy to recover key services and that the Welsh Government's long-term model for health and social care 'A Healthier Wales', and the references made to WHSSC should be re-visited.

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response was presented to the Joint Committee on the 13 July 2021. Progress against actions to address the recommendations will be monitored through the Integrated Governance Committee (IGC).

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Quality governance and management				
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.				
a) We will include in our routine reports to Joint Committee (JC) on quality, performance and finance a section highlighting key areas of concern to promote effective focus and discussion.	Sept 2021	Director of Finance Director of Nursing & Quality Director of Planning	As a consequence of the COVID-19 pandemic the routine reports on activity, quality and financial performance presented to each Joint Committee (JC) meeting have evolved to include additional detailed analysis of the position and any key points to promote effective focus and discussion. For 2021 the position is very stable with an improving underspend position.	Completed

[1] Welsh Health Specialised Services Committee Governance Arrangements (audit.wales)

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			In addition, to ensure effective governance we have reviewed the structure of the committee report template for routine reports (including for quality, performance and finance) and have updated it to include a section on governance, quality and risk which specifically captures key areas of concern to promote effective focus and discussion. This ensures effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients. This will be used from January 2022 onwards. The new template was considered by the Corporate Directors Group Board (CDGB) in September and in November 2021, and was considered by the Integrated Governance Committee (IGC) on the 12 October and will approved by them on the 13 December 2021. The JC received a detailed presentation on "Recovery" at its meeting on the 7 September 2021 which focussed on quality, performance and finance and which highlighted key areas of risk and	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			concern. The presentation was also given to the Management Group (MG) sub committee on the 23 September 2021 for assurance.	
b) We will develop a revised suite of routine reports for JC that will include elements of the activity reporting, that we introduced during the pandemic, and will take into account the quality and outcome reporting that is currently being developed by Welsh Government (WG).	Mar 2022	Director of Finance Director of Nursing & Quality Director of Planning	As a consequence of the COVID-19 pandemic the routine reports on activity, quality and financial performance presented to each JC were reset to include more explicit, measurable intentions to measure achievement against. This includes detailed analysis of the position and any key points to promote effective focus and discussion. Detailed activity performance reports are prepared on a monthly basis and provide qualitative information and quantitive data to the JC and MG. The reports detail delivery by provider and specialty against historic performance and waiting times. Prospectively activity reports will also include performance compared to provider agreed recovery plans and waiting list profiles. A presentation dashboard format of the waiting times position has been agreed and details variation from agreed activity delivery, referral rates and overall waiting lists whenever possible.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			The activity dashboard will evolve and align to the quality and outcome reporting that is currently being developed by Welsh Government (WG). The WHSSC Commissioning Assurance Framework (CAF) was considered by the JC in May 2021 and approved in September 2021. Assurance against the CAF is achieved through service specifications, Service Level Agreement (SLA) and performance monitoring through the Quality and Patient Safety Committee (QPS) and the Integrated Governance Committee (IGC).	
c) We will encourage members of the JC to engage in consideration and discussion of key areas of concern that are highlighted.	Sept 2021	Chair of WHSSC	The Joint Committee received a detailed presentation on "Recovery" at its meeting on the 7 September 2021 which focussed on quality, performance and finance and which highlighted key areas of risk and concern. The Recovery presentation encouraged wide-ranging discussion and it was agreed that structured highlight reports will be presented to the JC from November 2021 onwards. Following on from the recovery discussion WHSSC have requested further detailed plans from providers as	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			additional detail was required from HBs in some areas. As part of WHSSC's commitment to improving the effectiveness and efficiency of the Joint Committee and WHSSC we have embarked on a development programme, which included the JC participating in an equity workshop in May 2021, and there are plans for further development sessions to review the Integrated Commissioning Plan (ICP) and to revisit equity going forward.	
d) We will include routinely at JC an invitation for an oral report to be delivered by, or on behalf of, the Chair of the WHSSC Quality & Patient Safety Committee (Q&PSC) based on the written report from the Chair of Q&PSC.	Sep 2021	Chair of WHSSC/ Committee Secretary	Each JC meeting receives a Chairs assurance report from each of the sub-committees which provides an update on the business discussions of each sub-committee meeting. Each relevant chair is asked to present the Chairs report and to outline any salient points during the JC meeting. The Chair of WHSSC invites the Chair of the Quality & Patient Safety Committee (QPSC)/and or the Director of Nursing and Quality as Executive lead to provide a verbal update based on the written report at each JC meeting.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Programme Management				
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.				
a) Building Programme Management competency/capacity A number of new staff have recently joined WHSSC in senior positions in the planning team who bring with them strong programme and project management skills. There are 'lunch and learn' sessions planned to share this approach, and the use of common templates is embedding, it is anticipated that this approach will grow programme management competency and capacity within the organisation. The approach is already starting to embed in the way the planning team operates, with programme management approaches already applied to the two strategic pieces committed to through the 2021 ICP (namely paediatrics and mental health) and to the management of the CIAG prioritisation process. Common templates apply to highlight and exception reporting, risk logs and timelines/milestones.	Nov 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of new commissioned services including: • undertaking a recruitment exercise to appoint 3 dedicated Project Manager roles (2 generic PM roles and one to specifically support Traumatic Stress Wales (TSW)), The posts work as part of the PMO hosted within the planning directorate to share learning, skill and competencies, as well as integrating a project management approach across WHSSC, • the PM roles will review our existing programme management methodology, and introduce new specific templates for project initiation, project highlight reports, risk assessments and project closure reports,	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			• develop a project management training package, • provide project highlight updates to JC. Programme Management arrangements are now in place for all new programmes of strategic work (e.g. Paediatrics and Mental Health).	
b) Programme management on WHSSC commissioned services. Programme arrangements have previously been used for strategic service reviews and the development of the PET (positron Emission Therapy) business case. We will further develop this approach as outlined above, i.e. through a common approach to programme management across the organisation and to and the use of common templates. These will become the basis of reporting through programme structures and as necessary to Joint Committee.	Nov 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of new commissioned services including: • the programme management arrangements for the All Wales Positron Emission Tomography (PET) Programme demonstrate how WHSSC has developed and strengthened its approach to programme management and the Programme Business Case (PBC) for the project was approved by HBs and endorsed by Welsh Government (WG) Ministers on the 25 August 2021. The All Wales PET Programme Board will utilise its governance structure and reporting arrangements to provide ongoing assurance on	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			progress and it is proposed that it reports into the JC going forward, • we have appointed 3 dedicated Project Manager roles. The posts work as part of the PMO hosted within the planning Directorate to share learning, skill and competencies, as well as integrating a project management approach across WHSSC, • the PM roles will review our existing programme management methodology, and introducing specific templates for project initiation, project highlight reports, risk assessments and project closure reports, • developing a project management training package, • providing project highlight updates to JC. With increased project and programme management capacity and competency, this structured approach will be adopted consistently for all future major projects.	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
c) HB Commissioned Services – when services are not the sole responsibility of WHSSC, and where the senior responsible officer is outside of WHSSC, we will contribute to the programme arrangements, offering clarity about the role of WHSSC and the scope of the responsibilities it has within the programme. We will seek to deliver against any key milestones set, and report progress, risk and exception accordingly.	Oct 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of projects for new commissioned services. Each project has its own specific terms of reference outlining the purpose and scope of the project, and including the membership and roles and responsibilities. Where services are not the sole responsibility of WHSSC we ensure that the membership includes representatives from Health Boards (HBs), professional groups etc and that the project plan includes measurable milestones with regular reports on progress being presented to the reporting sponsor, for example the JC.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Recovery Planning				
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.				
a) Managing backlog of waits whilst reducing harm i. Introduction of real-time monitoring and reporting of waiting times to Management Group and Joint Committee ii. Review of recovery plans with Welsh provider Health Boards, iii. Regular Reset and Recovery meetings with services to monitor performance against plans. Significant variance from plans will be managed through the WHSSC escalation process iv. Introduction of the WHSSC Commissioner Assurance Framework (CAF), v. Workshop with Joint Committee members on how to deliver 'equity' in specialised services. Report shared with HBs and WG.	Sep 2021 Jul 2021 From Apr 2021 In Place	Director of Finance Director of Nursing & Quality Director of Planning	i. Real time monthly monitoring and reporting of waiting times are presented to the MG on a monthly basis and to each JC meeting through regular performance reports, which include trend analysis and information on comparisons to support effective performance management, ii. WHSSC have discussed recovery plans with Welsh providers through Service Level Agreement (SLA) meetings and received recovery positions from each of the welsh providers of tertiary services. There was an initial delay in receiving the recovery plans, and some detail is still awaited, iii. WHSSC hold regular Reset and Recovery meetings with services	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			to monitor performance against plans. A joint Executive to Executive meeting has been agreed between WHSSC, CVUHB, SBUHB and BCUHB, in order to discuss the welsh position across the plans and where necessary identify alternate pathways or welsh patients. Any Significant variance from plans will be managed through the WHSSC escalation process, discussed with the relevant provider and reported to the QPS Committee and the JC, iv. The final Commissioning Assurance Framework (CAF) was formally approved by the JC on the 7 September 2021 and is supported by a Performance Assurance Framework, Risk Management Strategy, Escalation Process and a Patient Engagement & Experience Framework, v. Following on from a discussion at JC in February 2021, as part of WHSSC's commitment to improving the effectiveness and efficiency of the Joint Committee and WHSSC we have embarked	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			on a development programme, which included the JC participating in an equity workshop in May 2021. The findings of the workshop were shared with HBs and Welsh Government.	
b) Potential impact and cost of managing hidden demand. i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported to the WG Planned Care Board and HBs to inform non- WHSSC commissioned pathway development. ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact.	In place Q3/Q4 2021-22	Director of Finance Director of Nursing & Quality Director of Planning Medical Director	i. The introduction of demand monitoring comparing historical levels for high volume specialities is routinely undertaken and the findings are reported to the WG Planned Care Board and HBs to inform non- WHSSC commissioned pathway Development. Demand monitoring continuously features as part of the ICP process, board presentations to HBs and through strategic reviews highlighting variations in access using data systems, ii. Despite proactive efforts WHSSC have not been able to appoint an Associate Medical Director for Public Health and alternative models are being explored.	Partially Completed
c)Financial consequences of services that were commissioned and under-delivered as a result of COVID-19	In Place	Director of Finance	Information pertaining to the financial consequences of services that were commissioned and under delivered as a consequence of COVID-19 are	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
i. This information is already captured through our contract monitoring process and compared against the national block contract framework implemented to maintain income stability through COVID-19. This will inform future planned baselines and contract negotiation, where the negotiation is within our control. WHSSC is working with contracted providers across Wales and England to establish their specialised recovery trajectories and where appropriate will secure recovery funding from WG to direct to providers for recovery performance if above established contracted baseline levels.			monitored through block contracts which remain in place during 2021-22 with the position reviewed for 2022-23. The planned position for 2022-23 will be return to cost and volume contracting to ensure full incentives to deliver commissioned volumes. WHSSC are fully participating in the English recovery incentive process with additional funding secured from Welsh Government.	
d) Reporting Analysis We will review and analyse the business intelligence gathered from the actions outlined in points a, b and c above and use the real-time and historical data to inform our decision making on managing existing, and developing new specialised commissioned services. We will report our analysis and outcomes to the Joint Committee, Welsh Government and the Management Group as appropriate.	Sept 2021	Director of Finance Director of Nursing & Quality Director of Planning	We have reviewed and analysed the business intelligence gathered from real-time monitoring and reporting of waiting times, demand monitoring compared to historical levels for high volume specialties and contract monitoring and developed a full information reporting system which provides monthly updates on delivery against historic activity levels, delivery against recovery plans, referral levels against plan and waiting list positions.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			We report our analysis and outcomes to the JC, Welsh Government and the MG as appropriate.	
Specialised Services Strategy				
R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient • outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer); • where alternative interventions provide better outcome for the investment (change); currently commissioned, which should continue.				
a. Embrace New Innovations i. We will continue to utilise our well-established horizon scanning process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery, ii. We will continue to develop our relationship with NICE, AWMSG and	Jul 2021 Q3	Managing Director Director of Finance Director of Nursing & Quality	i. The dual processes of horizon scanning and prioritisation is firmly embedded in WHSSC's commissioning practice and has been applied successfully since 2016. The process helps ensure the NHS in Wales effectively commissions' new and innovative treatments that are both clinically and cost effective, and are made available in a timely manner.	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
HTW in relation to the evaluation of new drugs and interventions, iii. We will engage with developments for digital and Artificial intelligence (AI), iv. We will continue our regular dialogue and knowledge sharing with the four nations' specialised services commissioners, v. We will continue to build upon our existing relationships with the Royal Colleges, vi. We will continue to develop our work on value-based commissioning, vii. We will develop a communication and engagement plan to support and inform the strategy. viii. As previously agreed with Joint Committee a stakeholder engagement exercise will be undertaken to gain insight on long-term ambitions and to inform how we shape and design our services for the future. This will inform the Specialised Services Strategy and the supporting the 3 year integrated commissioning plan.	2021-22 In Place Dec 2021 Dec 2021	Director of Planning	Horizon scanning identifies new interventions which may be suitable for funding, and prioritisation allows them to be ranked according to a set of pre-determined criteria, including clinical and cost effectiveness. This information when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP). A horizon scanning exercise was undertaken by the Medical Directorate between January and May 2021, which informed the new Interventions Prioritisation Panel on the 20 July 2021, and the Clinical Impact Advisory Group (CIAG) prioritisation day on the 3 August 2021, ii. WHSSC continues to develop its relationships including: a. Three members of the WHSS team are current members of NICE appraisal committees (AC – TA committee A; ID – TA committee D; SD – HST committee). AC is also Chair of the NICE Welsh Health Network,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			b. WHSSC has a built a strong working relationship with HTW. A MoU was signed in 2018 (currently being updated) and WHSSC is represented on their Assessment Group, Appraisal Group and Stakeholder Forum. A joint proposal to support all Wales policy development of HTW guidance was supported by MG in June and the HTW Executive Board in July 2021. Funding for two posts (Project Manager and Admin) to support this work is now being sought from WG c. WHSSC also has a close working relationship with AWMSG, focused mainly on medicines management and horizon scanning. A MoU is now being developed between WHSSC and AWMSG to formalise these links and to share knowledge and expertise. The appointment of a WHSSC Medicines Management Pharmacist (due to start January 2022) will	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			further strengthen this partnership. iii. We continue to engage with developments for digital and Artificial intelligence (AI) iv. We continue to attend the four nations' specialised services commissioners meetings, v. We continue to build upon our existing relationships with the Royal Colleges, vi. We continue to develop our work on value-based commissioning, vii. We have developed a communication and engagement plan to support and inform the strategy which will be presented to the CDGB in January 2022, viii. It was previously agreed with Joint Committee that a stakeholder engagement exercise would be undertaken in December 2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			system pressures related to the current wave of the pandemic and the letter from Judith Paget CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities.	
b. Approach to Review of Services will be considered in strategy engagement **i.** The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and undertake a value based services assessment to assess if existing services are still categorised as specialised, ii. We will continue to undertake our annual prioritisation panel with HB's to assess new specialised services that could be commissioned, iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services, iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the	Sept 2021 March 2022	Director of Finance Director of Nursing & Quality Director of Planning	i. The draft new specialised services strategy: a. It was previously agreed with Joint Committee a stakeholder engagement exercise would be undertaken in December 2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the system pressures related to the	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
development of an outcome manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.			current wave of the pandemic and the letter from Judith Paget, CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities. b. On the 28 September 2021 the WHSSC executive team met with Improvement Cymru (IC) to discuss and explore potential options for them to support WHSSC in developing its new specialist services strategy and WHSSC agreed to hold a Quality Improvement workshop facilitated by IC in January 2022 and to develop improvement and audit days with nursing teams with a view to undertaking our own internal competency assessment to drive improvement, and considered predictive modelling for interventions, and international collaborative networks,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			c. WHSSC are required to agree annually those services that should be planned on a national basis and those that should be planned locally (section 1.1.4 WHSSC SO's), to support this, following a discussion at the JC 7 September 2021 a workshop was held with the MG on the 25 November 2021 to evaluate the commissioning of services. MG members were requested to submit expressions of interest to evaluate specific commissioned services in order to evaluate the merits of the service being commissioned locally at HB level or through WHSSC. d. A recovery workshop was held with the MG on the 16 December 2021 to discuss recovery Planning and Quality and Outcome Improvement for Patients. ii. The annual prioritisation panel with HB's to assess new specialised services that could be commissioned was held on the 20 July 2021,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			iii. The process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services was undertaken between January and May 2021 and informed the prioritisation panel on the 20 July 2021, iv. We have investigated opportunities for strengthening our information function through internal re-organisation and investment and have strengthened the staffing model of the information function to enable more timely information. The WHSSC staffing structure has been reviewed to include a senior outcomes commissioner to design outcome systems and monitor and report outcomes.	
Welsh Government Recommendation - Independent member recruitment				
R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: I am aware there have been challenges in securing nominations from health boards			<u>WG update received 15/12/21</u> WHSSC are in discussions with WG on the IM remuneration and time commitment issues and a report was	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.			presented to the Chairs group in October 2021 requesting their views. The Chair of WHSSC and the Committee Secretary meet with WG officials on a monthly basis to progress the IM remuneration discussions. A progress report will be presented to the Joint Committee on the 18 January 2021.	
Welsh Government Recommendation - Sub-regional and regional programme management				
R6 This is linked to Recommendation 2 made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi- partner programme management arrangements are in place from concept through to completion (i.e. early in the development through to post-implementation benefits analysis).				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened.			<u>WG update received 15/12/21</u> This is linked to R2 and an update will be received in due course.	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.				
Welsh Government Recommendation - Future governance and accountability arrangements for specialised services				
R7 A Healthier Wales included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner			<u>WG update received 15/12/21</u> Welsh Government have advised that the advice on the NHS Executive is still being considered by the Minister. The Public Accounts and Public Administration Committee has written to the Director General/Chief Executive NHS Wales following her recent appearance before them to ask for an update on the WHSSC Audit Wales Reports recommendations 5, 6 and 7 and a	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate. In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.			response will be issued in due course.	

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Terms of Reference & Operating Arrangements

Version: Approved

Date: March 2022

Document Title:	Audit, Risk & Assurance Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Current version:	Approved
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

1. INTRODUCTION

1.1 Section 2 of Aneurin Bevan University Health Board's Standing Orders (referred to in this document as 'ABUHB or the 'Health Board') Standing Orders provides that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance Committee** (referred to throughout this document as 'the Committee'). The Committee has been established in order 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.

1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

2.1 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'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisations activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

- a progress report from the Head of Internal Audit summarising:

  ✓ work performed (and a comparison with work planned);
  ✓ key issues emerging from the work of internal audit;
  ✓ management response to audit recommendations;
  ✓ changes to the agreed internal audit plan; and
  ✓ any resourcing issues affecting the delivery of the objectives of internal audit;

- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings);

- management assurance reports;

- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
  - use of single tender waivers;
  - extensions of contracts:
  - writing off of losses; or
  - the making of special payments;

- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;

- the internal audit strategy;

- the Head of Internal Audit's Annual Opinion and Report;

- quality assurance reports on the internal audit function;

- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;
- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Experience, Quality & Safety Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and

- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit, Risk & Assurance Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer

- Director of Finance, Procurement and VBHC
- Director of Corporate Governance

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Office of the Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held as a minimum on a **Bi-Monthly basis** (six times per year) and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.4 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how

attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g. interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public 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 in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- appropriate escalation of concerns.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

The Board and Board Committee Handbook provides detailed guidance on the conduct of the Committees business.

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.