Audit Risk & Assurance Committee

Mon 13 June 2022, 13:00 - 14:30

Microsoft Teams

Agenda

1. Preliminary Matters

Verbal *Chair*

1.1. Apologies for Absence

1.2. Declarations of Interest

1.3. Draft Minutes of the Meeting held on 17th May 2022

Attachment *Chair*

1.3 Approved Minutes Audit Committee 17.05.20.pdf (7 pages)

1.4. Committee Action Sheet

Attachment *Chair*

1.4 Audit Committee Action Log - June.pdf (3 pages)

2. Counter Fraud

2.1. To Receive the Counter Fraud Functional Standard Return Declaration 2021/2022

Attachment *Head of Counter Fraud*

2.1 Counter Fraud Audit Committee Report.pdf (27 pages)

3. NWSSP Audit & Assurance - Internal Audit & Specialist Service Unit

3.1. To Receive the Internal Audit Reviews from the 2021/22 Internal Audit Plan

Attachment *Interim Head of Internal Audit*

Reasonable Assurance:

a) Flow Centre

b) Corporate Governance

c) Operational Plan for Resumption of Services

d) Financial Sustainability - **To Follow**

e) Medicines Management (Including Controlled Drugs)

f) NIS Directive

Not Rated

g) Medical Equipment and Devices - **Director of Therapies & Health Science in attendance**

3.1 AB Internal Audit FINAL Assurance Progress Report.pdf (11 pages)

3.1a ABUHB 2021-22 Flow Centre Final Report v3.pdf (19 pages)

3.1b AB 2122-01 - Corporate Governance Final Internal Audit Report.pdf (14 pages)
3.1c AB 2122-21 - Resumption of Services Final Audit Report v2.pdf (15 pages)
3.1d AB 2122-03 - FINAL Internal Audit Report - Financial Sustainability.pdf (20 pages)
3.1e ABHB 2021-22 Medicines Management Final Report for client.pdf (17 pages)
3.1f AB-2122-19 NIS Directive FINAL Report for Client.pdf (16 pages)
3.1g ABUHB Medical Equipment and Devices Final Report v2.pdf (12 pages)

3.2. To Receive the Final Head of Internal Audit Opinion 2021/22

Attachment *Interim Head of Internal Audit*

3.2 ABUHB FINAL Opinion Annual Report 21-22.pdf (36 pages)

4. Final Draft Annual Report & Accounts 2021/22

4.1. To Receive the Audit of Accounts 2021/22 (ISA260)

Attachment *Audit Wales*

4.1 ABUHB FINAL Audit of Accounts ISA 260 2021-22.pdf (24 pages)

4.2. To Review the Final Draft Annual Report 2021/22

Attachment *Director of Corporate Governance*

a) Performance Report (Part 1)

b) Accountability Report (Part 2)

- i. Corporate Governance Report
- ii. Remuneration and Staff Report
- iii. Parliamentary Accountability & Audit Report

4.1 Cover Paper Performance and Accountability Report.pdf (7 pages)
4.2a Performance Report Section v2 (002) recived from RM 6-6-22 reviwed by TV 7-6-22 with comments.pdf (85 pages)
4.2b Accountability Report_Updated Draft_060622_RM.pdf (93 pages)

4.3. To Review the Final Draft Financial Statements 2021/22 (Part 3): including Annual Accounts 2021/22

Attachment *Interim Director of Finance / Assistant Finance Director (Corporate)*

Supporting appendices contained in supplementary Board Book

4.3 Final Accounts paper 2021-22 v2 (002).pdf (3 pages)
4.3 ABUHB 2021-22 Annual Accounts - Final.pdf (76 pages)
4.3 Appendix 2 - Queries raised in the Audit Finance and Risk Committee on 17.05.2022..pdf (2 pages)
4.3 Appendix 3 - Analysis of Expenditure in note 3.2 to the 202122 Annual Accounts.pdf (2 pages)

4.4. To Review the Final Letter of Representation for 2021/22, as included in Audit Wales' ISA260 2021/22

Attachment *Interim Director of Finance*

4.4 Letter of Representation 2021-22.doc.pdf (4 pages)

4.5. To Agree a Recommendation to the Board in respect of the Annual Report and Accounts 2021/22

Attachment *Chair*

4.5 Recommendation to Board from ARAC_Annual Accounts 2021-22.pdf (1 pages)

5. Date of Next Meeting

Verbal *Chair*

Business Meeting
Tuesday 02 August 2022
09:30 - 12:30

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Audit, Risk & Assurance Committee held on Tuesday 17th May 2022 at 9.00am via Microsoft Teams

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Present:

Shelley Bosson	-	Independent Member (Chair)
Richard Clark	-	Independent Member
Katija Dew	-	Independent Member (Third Sector)
Paul Deneen	-	Independent Member
Iwan Jones	-	Independent Member (Finance)

In Attendance:

Glyn Jones	-	Interim CEO
Rani Mallison		Director of Corporate Governance
Simon Cookson	-	Head of Internal Audit
Stephen Chaney	-	Internal Audit
Gwen Kohler	-	Assistant Director of Finance, Procurement & Value
Richard Harries	-	Audit Wales
Rob Holcombe	-	Interim Director of Finance
Estelle Evans	-	Head of Financial Services & Accounting
Dani O'Leary	-	Head of Risk & Assurance
Bryony Codd	-	Head of Corporate Governance
Gwen Kohler	-	Assistant Director of Finance
Louise Wright	-	Independent Member

Apologies:
None

AC 1705/01	**Welcome and Introductions and Apologies for Absence**
	The Chair welcomed everyone to the meeting. Apologies for absence were noted.
AC 1705/02	**Declarations of Interest** There were no Declarations of Interest to record.
AC 1705/03	**Draft Minutes of the Meeting held on 7th April 2022** The Committee accepted the minutes as a true and accurate reflection of the meeting. **AC0704/08, Update on Outpatient Transformation** – The Chair requested confirmation as to when assurance in respect of Job Planning would be presented to the People & Culture, given previous recommendations regarding the need for improvement. **Action: Secretariat**

AC1705/04	**Action Sheet** **AC0302/07, re streamlining for new starters** – Amend to 'in progress'. The Chair requested an outcomes report come back to a future meeting when concluded. **Action: Secretariat**
AC1705/05	**Review of the Draft Annual Report 2021/22** Rani Mallison (RM), Director of Corporate Governance, presented the Committee with the draft Performance Report and Accountability Report for 2021/22, for comment and input. The Committee was informed that the manual of accounts sought to simplify annual reporting in recognition of NHS Wales's ongoing challenges, and that there was no requirement to prepare a separate Annual Quality Statement or Sustainability Report. **Performance Report (Part 1)** Based on the Health Board's main objectives, strategies, and principal risks, the performance section provided a summary highlighting what had been done to deliver and improve the quality of services provided and commissioned by the Health Board to drive further improvements in population health and care. The report was noted as a working draft, with the following areas to be strengthened: - • the availability of end of year performance data had not aligned with the population of the draft report but would be incorporated into the final iteration • An out-turn position against the Annual Plan 2021/22 is being produced but has not been available to date – this is clearly a significant element of the annual report which will need to be included • a section on our strategic partnerships was a work in progress and would be included in the final draft • A condensed shorter public facing summary report would be available for the Annual General Meeting (AGM). Committee members raised the following points for consideration and inclusion in the final iteration of the performance report: - • Throughout the document, there is inconsistency in how the organisation performed in 2021/22 in terms of what was delivered and achieved (refer to the section on Track & Trace as an exemplar) • The report is not structured around the Health Board's priorities. • Where sections refer to reporting periods, clarification was needed as per calendar or financial year. • A glossary of terms should be included. • Reference to recommendations made on the 2020/21 Report should be considered to ensure they are captured. • Evidence should be provided to support statements made. • Reference to the Health Board's engagement approach, listening to feedback and co-production should be

	strengthened. **Accountability Report (Part 2)** The Committee was informed that the Corporate Governance Report, Remuneration and Staff Report, and Parliamentary Accountability and Audit Report were all required to be included in the Accountability Report to demonstrate how the Health Board is meeting its key accountability and reporting requirements. This section of the report, like the performance report, was marked as a working draft. Although the final Head of Internal Audit Opinion was still required for the Annual Governance Statement, an outline conclusion had been included in the draft, which confirmed the following: - • The Health Board remains on 'routine' monitoring as part of NHS Wales Escalation and Intervention arrangements. • The Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. Committee members raised the following points for consideration and inclusion in the final iteration of the accountability report; - • Page 8 & 38- Include the Power of Discharge sub-committee in the structure. • Attachment 1 – Include a table that shows which partner organisation groups/boards Independent Members sit on. • Make clear that Special Advisors are not members of the Board. • Check if Cyber Security had been considered by the ARA Committee in 2021/22 and, if so, include under Items considered by Committees. • Add detail under other employment matters e.g., staff sickness / disciplinaries. • Include end-of-year staff composition data for 2020/21 and 2021/22 to demonstrate gender balance. The Chair questioned whether the figures for remuneration in excess of the highest paid director were correct and asked if this could be checked. **Action: Head of Financial Services & Accounting** The Chair requested that further comments be sent to RM. For ease of reference, any additional insertions or revisions to the final iteration should be highlighted in a different colour. **Action: Director of Corporate Governance** The Committee thanked the Director of Corporate Governance and Interim Director of Finance, and respective teams, for the comprehensive reports.
AC 1705/06	**Review of the Draft Financial Statements 2021/22 (Part 3)** The Draft Annual Accounts were presented by the Interim Director of Finance, who was assisted by the Head of Financial Services &

	Accounting, noting that the accounts were subject to review by Audit Wales. The Committee was informed that the Health Board had met both statutory financial duties and noted the key points below. • The Health Board met its Revenue Resource Limit for the year and delivered a surplus of £249k. • The Capital Resource Limit target of £48.9m was met in 2021/22 with a small underspend of £50k. • The Health Board met its duty to breakeven over a three-year period. • The Public Sector Payment Policy Target was achieved. • The Health Board's Cash Balance reported was £1.7m achieving target. • Pay Schemes value is circa £756k with funding agreed by Welsh Government. Katija Dew (KD), Independent Member, questioned the transparency of overall spending to third-party and private-sector providers. Estelle Evans (EE) agreed to provide a breakdown of voluntary expenditure. **Action: Head of Financial Services & Accounting** The Committee was informed of the reasons for the key movements in the figures between 2020/21 and 2021/22 and noted that an additional £38m in COVID funding received in 2021/22 had driven an increase in costs. During the audit, it was discovered that the annual leave accrual of £19.6m had been incorrectly recorded under non-NHS payables and would be moved to Non-NHS Accruals, as it had been done the previous year. Clinical Negligence claims had risen from £11 million in 2020-21 to £45 million in 2021/22 because of three cases in excess of £5m. A £756k provision in the accounts for scheme pays would result in a regularity qualification in the Health Board accounts; this was identified as an issue for all Welsh Health Boards with scheme pays. External Auditor Richard Harries (RHa), Audit Wales, advised that the qualification's wording would be critical in highlighting the issue as a national issue rather than a Health Board issue. Iwan Jones (IJ), Independent Member, expressed concerns about the pooling of Pay Schemes and inquired how organisations obtain assurance from auditors that the Welsh quantum is correct. IJ noted his similar concerns about provisions and contingencies for irrecoverable debts, and he questioned whether medical negligence assessments should be completed under IFRS9. EE stated that All Wales data had been sent to all Health Boards to identify employees who were enrolled in pay schemes and relied on WG management of schemes. RH agreed that IFRS application against provisions needed to be reviewed at the All-Wales level.

	IJ questioned the efficacy of the four-year revaluation process, which RH offered to discuss outside of the meeting or circulate a briefing note about. Audit Wales confirmed that work would begin centrally in the coming weeks, but also informed the Committee that the Welsh Government is currently looking across the UK to see what needs to happen in between revaluation cycles. Paul Deneen (PD), Independent Member, asked if there was any comparative data with other Health Boards in terms of end-of-year accounts, and raised concerns about energy and medical negligence costs. RM suggested that a board briefing on clinical negligence arrangements be re-arranged for full board sightedness. RM also assured the Committee that the Board's Litigation Group was under review to ensure robust governance alignment with the Board. **Action: Director of Corporate Governance** RH informed the Committee that the estimated energy costs for 2022/23 had increased by circa £12m. Audit Wales confirmed that they were on track to complete audit work in time for the Auditor General to sign the accounts on 15th June 2022. The Committee thanked the Interim Director of Finance for the comprehensive report. The chair requested any additional questions raised outside of the meeting be logged to ensure evidence of sufficient scrutiny. **Action: Interim Director of Finance, Procurement & Value**
AC 1705/06	**Receive Internal Audit Reviews 2021/22** The Committee was informed by Simon Cookson (SC), Head of Internal Audit, that there were 8 outstanding reviews, with several of them completed and one in progress. SC was confident that all reports would be received by the next meeting of the Committee and would be reflected in the final Head of Internal Audit Opinion. Iwan Jones (IJ), Independent Member, questioned how the Committee obtained overall reasonable assurance, noting that several proposed audits had not occurred as planned. Similarly, IJ noted concerns about the recommendations labelled as 'removed too soon.' SC responded that six reviews had been deferred during the year but were reflected in the opinion, and that he was confident that all work would be completed by June 13th. Stephen Chaney (SCh), Internal Audit, explained that recommendations 'removed too soon' were the result of actions that were marked completed by management but had not been fully embedded. SCh assured the Committee that this was less likely to happen now under the new process for audit recommendation tracking and that the tracker had improved significantly in recent months. The Chair expressed concern about the management response in the Care After Death Audit, questioning whether the target date

	was too ambitious, and suggested that management responses be scrutinised in the future to ensure appropriate timelines were given to all recommendations and all resources were identified. This position was acknowledged. The Committee NOTED the Internal Audit Update.
AC 1705/07	**Approval of the Internal Audit Annual Plan 2022/23** Simon Cookson (SC), Head of Internal Audit, confirmed that the Internal Audit Plan 2022/23 had been approved by the Executive Team and noted that two audits had been removed from the draft Plan. Paul Deneen (PD), Independent Member, questioned the two limited assurance reviews and sought assurance on the action plan in place. SCh assured the Committee that limited audits would be followed up to ensure progress. IJ requested sight of the 3-year audit plan cycle to assure the Committee that all Health Board risk areas were being covered. It was agreed that this would be shared at the Committee's meeting in June 2022. The Chair proposed that the programme be shared with members as an aide memoire at the end of each financial year. **Action: Head of Internal Audit** The Committee approved the Internal Audit Plan 2022/23.
AC 1705/08	**Draft Head of Internal Audit Opinion 2021/22** Simon Cookson (SC), Head of Internal Audit, presented the draft Head of Internal Audit Opinion for 2021/22. SC advised the Committee that, as set out in the document, the Board could take Reasonable Assurance that arrangements to secure governance, risk management, and internal control are suitably designed and implemented effectively within the areas under review, but that Continuing Healthcare and the NIS Directive provided limited assurance. The Committee discussed recurring themes that had been identified throughout the course of the year, across a number of audits, including: • Training • Policies and procedures • Record Keeping The Chair suggested that consideration be given to how the Committee sought assurance on progress in these areas. It was agreed that the Chair would discuss this further with the Director of Corporate Governance. **Action: Chair/Director of Corporate Governance** The Chair thanked the Head of Internal Audit and colleagues for their hard work during 2021/22 and for the comprehensive draft report.

AC 1705/09	**External Audit Annual Plan 2022/23** The Committee noted the final External Audit Plan 2022/23.
AC 0604/15	**Date of Next Meeting**
	Monday 13th June 2022 at 9:30am. The Chair requested the meeting be extended by 30 mins.

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	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2022	**AC 0302/07** Bi-Annual Counter Fraud Progress Report	Liaise with ESR workforce colleagues and Shared Services to further streamline the termination/new starter process for managers	**Director of Finance & Procurement & VBHC** **Head of Counter Fraud**	**August 2022**	**In progress.** An outcomes report to come back to a future meeting once finalised
May 2022	**AC1705/05** Review of the Draft Annual Report	The figures for remuneration in excess of the highest paid to be checked for accuracy.	**Head of Financial Services & Accounting**	**13 June 2022** (Next ARA meeting)	**Completed.** Included in Financial Accounts Paper appendix
		Any additional insertions or revisions to the final iteration should be highlighted in a different colour.	**Director of Corporate Governance**	**13 June 2022**	**Completed.** Highlighted in the final report submitted to the Committee.
May 2022	**AC1705/06** Review of the Draft Financial Statements	Provide a breakdown of overall spending to third-party and private-sector providers.	**Head of Financial Services & Accounting**	**13 June 2022** (Next ARA meeting)	**Completed.** Included in Financial Accounts Paper appendix
		A board briefing on clinical negligence arrangements to be arranged for full board sightednesss.	**Director of Corporate Governance**	**September 2022**	To be scheduled for September 2022
		Any additional questions raised outside of the meeting be logged to ensure evidence of sufficient scrutiny.	**Interim Director of Finance, Procurement & Value**	**13 June 2022** (Next ARA meeting)	**Completed.** No additional questions raised.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

May 2022	**AC1705/07** Approval of the Internal Audit Annual Plan 2022/23	Provide a copy of the 3-year audit plan cycle to assure the Committee that all Health Board risk areas are being covered.	**Head of Internal Audit**	**13 June 2022** (Next ARA meeting)	**Completed.** Cycle distributed via email 08 June 2022
May 2022	**AC1705/08** Draft Head of Internal Audit Opinion 2021/22	Discuss how the Committee gain assurance on progress against the recurring themes identified.	**Chair** **Director of Corporate Governance**	**July 2022**	**In progress** To be taken forward via audit recommendation tracking, themes and analysis reporting. Next iteration due July 2022.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Audit, Finance & Risk Committee Monday 13th June 2022 Agenda Item:

Aneurin Bevan University Health Board

Counter Fraud Functional Standard Return declaration for 2021/22

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit Committee. It incorporates the legal declaration in relation to the submission of the above mentioned CFFSR for 2021/22 and the actual CFFSR return itself.			
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 - DoF			
Report Author: Martyn Edwards – Head of Counter Fraud			
Report Received consideration and supported by: DoF			
Executive Team		**Committee of the Board [Committee Name]**	**Audit Committee**
Date of the Report: 31st May 2022			
Supplementary Papers Attached: No			

Purpose of the Report
For Audit Committee information.

Background and Context
This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to comply with the legal components/requirements of the Government Functional Standard for Counter Fraud (GovS 013).

Assessment and Conclusion
A green rating was recorded against all requirements.

Recommendation
This report is intended for Audit Committee information only.

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

Declaration of compliance against the Functional Standard Requirements at the end of March 2022

The annual report must contain one of the declarations listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Commissioner Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2021-22 has been self-reviewed against the Functional Standard Requirements relating to fraud, bribery and corruption, and that the above rating has been achieved.

Organisation	
Accountable Board Member Signature	
Date	

Provider Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2021-22 has been self-reviewed against the Functional Standard Requirements relating fraud, bribery and corruption and Service Condition 24 of the NHS Standard Contract, and that the above rating has been achieved.

Organisation	**Aneurin Bevan University Health Board**
Accountable Board Member Signature	S. A. Bosson
Date	**30th May 2022**

Counter Fraud Functional Standard Return (2021/2022)

ANEURIN BEVAN UNIVERSITY LHB

Your Overall Rating is:

Green

Submitted By:

lcfs1397

Counter Fraud Functional Standard Return (2021/2022)

Overall Rating

Your Organisations overall rating is:

Green

Introduction

The NHS Counter Fraud Authority (NHSCFA) is a Special Health Authority, established on 1 November 2017 and charged with identifying, investigating and preventing fraud within the NHS and the wider health group. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care.

As part of its role, NHSCFA is required to provide annual assurance to Cabinet Office of how the NHS is identifying and mitigating the risk of fraud, bribery and corruption.

The term 'NHS funded services' above refers to any organisation with partial or full NHS funding, currently this includes: NHS Trusts, Foundation Trusts, Ambulance Trusts, Special Health Authorities, Clinical Commissioning Groups, certain Independent Healthcare Providers, Health Boards, NHS Improvement and NHS England.

From April 2022 all NHS funded services are required to provide assurance against the NHSCFA Requirements of the Government Functional Standard GovS 013: Counter fraud. This should be overseen by the organisation's finance director and audit committee and in line with the organisation's existing approach to assurance against counter fraud requirements.

The NHSCFA will support the integration into the NHS and will be responsible for receiving Counter Fraud Functional Standard Returns (CFFSR). The NHSCFA will be engaging with the NHS to review compliance.

A detailed explanation for each of the Government Functional Standard NHSCFA Requirements is given including an indication of what each organisation needs to do to comply with the requirement.

The previous NHS specific Standards have been aligned to the new NHSCFA Requirements Mapping of previous NHS counter fraud standards | Government Functional Standards | NHS Counter Fraud Authority (cfa.nhs.uk)

The submission deadline for the CFFSR is the 31 May 2022.

Organisations must ensure that the CFFSR is completed and submitted on or before the deadline.

If you have any questions on the Counter Fraud Functional Standard Return, they can be directed in the first instance to fraudqa@nhscfa.gov.uk

If you are having technical difficulties accessing the CFFSR please contact servicedesk@nhscfa.gov.uk.

Counter Fraud Functional Standard Return (2021/2022)

Organisational information

Name of the organisation

ANEURIN BEVAN UNIVERSITY LHB

This is mandatory for declaration

Annual budget of the organisation

Over £ 1 billion

This is mandatory for declaration

Staff headcount at the organisation including contracted employees

Over 10,000

This is mandatory for declaration

Organisation code

7A6

This is mandatory for declaration

Organisation/provider type

Health Board

This is mandatory for declaration

Co-ordinating Commissioner for this provider

WALES

This is mandatory for declaration

Region

WALES

This is mandatory for declaration

NHS England region

WALES

This is mandatory for declaration

The STP / ICS that the organisation belongs to

WALES

This is mandatory for declaration

Counter Fraud Functional Standard Return (2021/2022)

Personnel information

(Link:) Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management

Robert Holcombe

Remaining characters: 85

This is mandatory for declaration

(Link:) Name of the Local Counter Fraud Specialist

Martyn Edwards

Remaining characters: 86

This is mandatory for declaration

(Link:) Email of the Local Counter Fraud Specialist

martyn.edwards3@wales.nhs.uk

Remaining characters: 72

This is mandatory for declaration

(Link:) Name of the counter fraud provider organisation (including in-house)

In House (Wales)

This is mandatory for declaration

Counter fraud provider type (Link:)

WALES

This is mandatory for declaration

(Link:) Name of the Chair of the Audit Committee / equivalent body

Shelley Bosson

Remaining characters: 86

This is mandatory for declaration

(Link:) Email of the Chair of Audit Committee / equivalent body

Shelley.bosson@wales.nhs.uk

Remaining characters: 73

This is mandatory for declaration

Counter Fraud Functional Standard Return (2021/2022)

Costs and days information

Pro-active days used (Maximum 3 digits)

342

Numerical count, whole number ex. (000)
This is mandatory for declaration

Reactive days used (Maximum 3 digits)

253

Numerical count, whole number ex. (000)
This is mandatory for declaration

Total days used for counter fraud work

595

Numerical count, whole number ex. (000)
This is mandatory for declaration

Cost of counter fraud staffing per financial year - Pro-active

£ 82594.00

Currency, to 2 decimal places ex. (£ 0000000.00)
This is mandatory for declaration

Cost of counter fraud staffing per financial year - Reactive

£ 61101.00

Currency, to 2 decimal places ex. (£ 0000000.00)
This is mandatory for declaration

Total costs for counter fraud work

£ 143695

Currency comma separated, to 2 decimal places ex. (£ 0,000,000.00)

Counter Fraud Functional Standard Return (2021/2022)

Reactive information

Number of referrals received during the most recent financial year

26

Numerical count, whole number ex. (000)
This is mandatory for declaration

Number of cases opened during the most recent financial year

26

Numerical count, whole number ex. (000)
This is mandatory for declaration

Number of cases closed during the most recent financial year

36

Numerical count, whole number ex. (000)
This is mandatory for declaration

Number of cases open as at 31/03/2022

11

Numerical count, whole number ex. (000)
This is mandatory for declaration

Amount of fraud losses identified during the most recent financial year

£ 44374.00

Currency comma separated, to 2 decimal places ex. (£ 0,000,000.00)
This is mandatory for declaration

Amount of fraud losses recovered during the most recent financial year

£ 44374.00

Currency comma separated, to 2 decimal places ex. (£ 0,000,000.00)
This is mandatory for declaration

Amount of fraud losses prevented from reactive work during the most recent financial year

£ 300676.00

Currency comma separated, to 2 decimal places ex. (£ 0,000,000.00)
This is mandatory for declaration

Number of criminal sanctions applied during the year

1

Numerical count, whole number ex. (000)
This is mandatory for declaration

Number of civil sanctions applied during the year

3

Numerical count, whole number ex. (000)
This is mandatory for declaration

Number of disciplinary sanctions applied during the year

20

Numerical count, whole number ex. (000)
This is mandatory for declaration

Counter Fraud Functional Standard Return (2021/2022)

Proactive information

Number of proactive exercises conducted during the most recent financial year

10

Numerical count, whole number ex. (000)
This is mandatory for declaration

Amount of fraud losses identified from proactive exercises during the most recent financial year

£ 0.00

Currency comma separated, to 2 decimal places ex. (£ 0,000,000.00)
This is mandatory for declaration

Amount of fraud losses prevented from proactive exercises during the most recent financial year

£ 0.00

Currency comma separated, to 2 decimal places ex. (£ 0,000,000.00)
This is mandatory for declaration

Amount of fraud losses recovered from proactive exercises during the most recent financial year

£ 0.00

Currency comma separated, to 2 decimal places ex. (£ 0,000,000.00)
This is mandatory for declaration

1: Accountable individual

NHS Requirement 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 to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. N. B. 'Equivalent body' may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation

Your Rating is: Green

Comments:

ABUHB counter fraud, bribery and corruption workplan A/R on counter fraud, bribery and corruption work Progress reports to the A/C & board Best practice professional probity private meetings between LCFS & Independent Board Members Minutes of relevant meetings, action points and records of their execution A/C minutes Standing Orders/Standing Financial Instructions Evidence of the presentation of counter fraud, bribery and corruption information to A/C including functional standard return, annual report of counter fraud work and the counter fraud workplan. Evidence of presentation of NHSCFA Functional Standard to A/C and implementation of recommended remedial action Documentation from the nominations process most recent being LCFS Mr Gareth Lavington in 2020, which is evidence of compliance Documented definition as to status of the Director of Finance as Accountable Individual. DoF is an Executive Director for the ABUHB organisation and the manager of the CF provision

NHS Requirement 1B:

The organisation's non-executive directors, counter fraud champion or lay members and board /governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, 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 standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.

Your Rating is: Green

Comments:

Meeting minutes, decisions, action points and records of their execution A/C minutes evidencing monitoring and evaluation of counter fraud work conducted in compliance with the counter fraud functional standard A/C acknowledgement of LPE's & risk assessments and in particular, actions raised with regard to overpayment of salaries LPE Documentation from the nominations process A nominated Counter Fraud Champion who in addition to promoting fraud awareness, is involved in the appointment of the LCFS Communications to staff directly attributed to the Counter Fraud Champion Counter fraud, bribery and corruption workplan Documentation arising from NHSCFA engagement process e.g. thematic assessment & implementation of FPN's etc. Evidence of implementation of remedial

recommendations made by the NHSCFA on thematic assessment NHS Audit Committee Handbook (relevant sections) Evidence that the Audit Committee Chair has an NHS.net account Annual report on counter fraud, bribery & corruption

2: Counter fraud bribery and corruption strategy

NHS Requirement 2:

The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. (The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)

Your Rating is: Green

Comments:

Evidence of alignment with NHSCFA recommendations in annual report The NHSCFA strategy document NHSCFA Strategy 2020-2023 Counter fraud, bribery and corruption policy referencing the NHSCFA strategy Organisation over-arching strategy referencing the NHSCFA strategy is fully aligned Risk assessment materials - annual report refers Evidence of risk monitoring being conducted A/C & DoF - S.2.15, 2.16, 4.12 & 4.14 Annual Report C/F work plan A/R on counter fraud, bribery and corruption work Fully completed counter fraud functional standard return Relevant meeting minutes, action points and records of their execution Action plan made as part of any NHSCFA engagement - compliance evidence S.4.18 annual report New LCFS appointed Nov 2019, making establishment 2.8 WTE in line with corporate structure. All LCFS fully trained/accredited. Evidence of continuous local proactive risk exercises being undertaken and outcomes managed Evidence of above being reported to Audit Committee

3: Fraud bribery and corruption risk assessment

NHS Requirement 3:

The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy 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 (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.

Your Rating is: Green

Comments:

The NHSCFA strategy document NHSCFA Strategy 2020-2023 Local risk assessment materials Evidence of liaison with risk management staff within the organisation Evidence of risk monitoring being conducted at a senior level Relevant meeting minutes, action points and records of their execution Audit committee minutes Audit reports Counter fraud, bribery and corruption work plan is aligned to the risk assessment and NHSCFA counter Fraud strategy. Progress reports Organisational risk registers GCFP core discipline "Fraud Risk Assessment" Process is fully aligned with the Govt methodology utilising the tools provided by NHSCFA

4: Policy and response plan

NHS Requirement 4:

The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: Green

Comments:

The NHSCFA counter fraud manual resource document 'Template Local Counter Fraud, Bribery and Corruption Policy' The organisation's counter fraud, bribery and corruption policy and response plan The NHSCFA strategy document NHSCFA Strategy 2020-2023 NHS Counter Fraud Manual Standing Orders/Standing Financial Instructions Relevant meeting minutes, action points and records of their execution Materials and supporting evidence to show that the plan has been communicated across the organisation - A/R para's 2.1, 2.2, 2.3, 2.12, 3.7, 3.11, 4.2 refer. Evaluation measures i.e. staff surveys - A /R appendix 3 & para 3.4 refers. Evidence of the review of the plan including subsequent amendments to it where appropriate - A/R para's 2.2, 2.3, 4.2 refer. ABUHB Counter Fraud Bribery & Corruption Policy is up-to-date and fit for purpose and last received Executive review in February 2020. Process aligns with NHSCFA/Gov strategic plan and is current and reviewed in line with local policies

5: Annual action plan

NHS Requirement 5:

The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).

Your Rating is: Green

Comments:

Counter fraud, bribery and corruption work plan Audit committee minutes National and locally based risk assessments - Annual Report para's 4.12, 4.14, 4.17, 4.18, 4.19 & 4.20 refer. NHS Audit Committee Handbook (relevant sections) Other evaluation materials such as reports on proactive exercises Evaluation materials resulting from participation in national exercises A measured reduction in risk or expenditure Documentation arising from any NHSCFA engagement Evidence of the implementation of any recommendations made by the NHSCFA as part of any engagement - Annual Report para's 4.17 & 4.18 refer. Internal audit reports Increased compliance with policies and procedures Examples of where findings have been suggested for policy development Examples of where findings have influenced policy development Staff are given informed and suitably aligned objectives on annual PADR which are reviewed throughout the reporting period to ensure their continued appropriateness.

6: Outcome-based metrics

NHS Requirement 6:

The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.

Your Rating is: Green

Comments:

The NHSCFA strategy document NHSCFA Strategy 2020-2023 NHS Counter Fraud Manual The NHSCFA instructions and guidance on the use of the approve NHSCFA fraud case management system. Approved NHS fraud case management system records Approved NHS fraud case management system weakness records Investigation files Evidence of proactive prevention and detection exercises NHSCFA Benchmarking data Counter fraud, bribery and corruption work plan Audit committee minutes A measured reduction in risk or expenditure NHSCFA circulars NHSCFA's 'Intelligence Alerts, Bulletins and Local Warnings Guidance' Results of thematic engagements Evidence derived from participation in the National Fraud Initiative Clue3 is used to facilitate this work also the predecessor system 'First'

7: Reporting routes for staff, contractors and members of the public

NHS Requirement 7:

The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.

Your Rating is: Green

Comments:

The NHSCFA strategy document NHSCFA Strategy 2020-2023 NHS Counter Fraud Manual The organisation's counter fraud, bribery and corruption policy Links to the NHSCFA online fraud reporting tool https://cfa.nhs.uk/reportfraud - Annual Report para's 3.7, 3.5, 5.28 refer Materials and supporting evidence to show that the incident reporting routes have been communicated across the organisation - Annual Report section 3 is evidence of this Evaluation measures such as staff surveys or sample checks - Annual Report Appendix 3 refers Evidence of the review of the incident reporting routes - Annual Report para's 4.30, 4.31, 4.38 & 5.28 refer Annual Report Section 3 in it's entirety provides full evidence of compliance

8: Report identified loss

NHS Requirement 8:

The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises

Your Rating is: Green

Comments:

NHS Counter Fraud Manual The NHSCFA Investigation Case File Toolkit now incorporated in the NHS Counter Fraud manual The NHSCFA instructions and guidance on the use of the approved NHS fraud case management system. Approved NHS fraud case management system records Approved NHS fraud case management system weakness records Investigation files Evidence of proactive prevention and detection exercises Evidence of review Correspondence with third parties including the Crown Prosecution Service and the NHSCFA All sanctions achieved are recorded as soon as is reasonably practicable Use of NHSCFA Advance Warning process Cases are closed on the approved NHS fraud case management system within one month of the conclusion of a case, with all relevant fields completed. Section 4.17 & 4.20 of Annual Report is evidence of remedial action to system weaknesses which were identified during course of investigation

9: Access to trained investigators

NHS Requirement 9:

The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA 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 commit fraud, bribery or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.

Your Rating is: Green

Comments:

NHS Counter Fraud Manual The NHSCFA counter fraud manual resource document NHSCFA 'Witness statement review template' NHSCFA instructions and guidance on the use of the approved NHS fraud case management system. Approved NHS fraud case management records Investigation files Correspondence with third parties including the Crown Prosecution Service and NHSCFA staff Training records Annual Report para 1.4 outlines accreditation for LCFS's & subsequent nomination with NHSCFA Meeting minutes, action points and records of their execution Evidence that the witness statements are regularly reviewed for compliance and quality Evidence that findings are fed back into improvements IUC's are legislatively compliant The NHSCFA counter fraud manual resource Interview under caution review template Evidence that interviews under caution are regularly reviewed for compliance and quality Training records Annual Report Para's 2.20, 2.22, 6.3, 6.5, 6.6 outlines maintaining core skills/competencies

10: Undertake detection activity

NHS Requirement 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, including local exercises and participation or response to national exercises. Results of this work 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, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.

Your Rating is: Green

Comments:

Results from evaluation activities, for example a measured reduction in risk A/R evidence of liaison with Internal Audit, Corporate Finance, Procurement Services & Payroll Services First/Clue entries Final reports from proactive exercises Final report findings from participation or response to national exercises. Pre-employment controls/checks Evidence that relevant staff have been trained and that training is kept up to date Evidence of proactive exercises A/R para's 4.17 to 4.21 refer Examples of where the results of evaluation and/or audits have led to improvements to pre-employment checking Pre-contract procurement fraud and corruption: (guidance for prevention and detection) Relevant risk assessments Evidence of the review of policies and procedures relating to procurement fraud, bribery and corruption Actioning of NHSCFA FPN's and fraud guidance Awareness on fraud, bribery and corruption risks in the area of Procurement Services invoicing & mandate fraud A/R Para 4.12

11: Access to and completion of training

NHS Requirement 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 all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work.Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.

Your Rating is: Green

Comments:

The NHSCFA strategy document NHSCFA Strategy 2020-2023 Links to NHSCFA's online fraud reporting tool https://cfa.nhs.uk/reportfraud Presentations and their evaluations Intranet, extranet and public website materials Organisation newsletters and team briefs Induction materials Leaflets and posters Evidence of where awareness work has been evaluated and changed to maximise its impact Learning aims and outcomes Staff surveys Work plans Organisational risk assessments Meeting minutes, action points and records of their execution Materials in the NHSCFA's fraud awareness toolkit. This is available at https://cfa.nhs.uk/fraud-prevention/fraud-awareness-toolkit LCFS fraud awareness video film Payslip messages Mandatory requirement on PADR for staff to complete fraud e-learning module Mandatory requirement for fraud awareness input on Corporate Induction Section 3 Annual Report in its entirety Primary care contractor newsletters

12: Policies and registers for gifts and hospitality and COI.

NHS Requirement 12:

The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested.

Your Rating is: Green

Comments:

Bribery Act 2010 (promotion on intranet) The NHSCFA counter fraud manual Bribery Act Guidance Gifts and hospitality policy and declarations Sections 1.4, 4.13, 4.25 & 4.39 A/R Constitution (for NHS foundation trusts) Staff surveys and other evaluation materials Code of conduct declarations Standards of business conduct policy and declarations Relevant clauses in staff contracts of employment Publicity in relation to the code of conduct Evidence of measures to evaluate awareness of the code of conduct among staff, and of changes made to increase it NHS Standard Contract General Condition 27 - Conflicts of Interest and Transparency on Gifts and Hospitality Ethical Standards for Providers of Public Services Continuous engagement with Board Secretary - Section 2.4 A/R NFI 3-way data matches - Companies House versus Payroll versus procurement supplier Continuous ongoing reviews of 'declaration of interest policy' and the 'Policy for Standards of Business Conduct for employees C/F workplan

ACC Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.As the Audit Committee Chair, and in line with the audit committee's responsibility for the strategic assurance and oversight of counter fraud work as described in section 5.6 of the NHS Audit Committee Handbook, I confirm that the information contained in this self review for 7A6 reflects the work reported and considered by the Audit Committee.	acc13424 Fri May 20 17:03:22 BST 2022

DOF - CFO Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for WALES anti-fraud, bribery and corruption. As the responsible member of the executive board or equivalent body I confirm that by ticking this authorisation box the information contained in this self review for 7A6 is correct and complete.	dof14220 Thu May 19 18:23: 20 BST 2022

Declaration

Overall Rating	
Please ensure that this Functional Standard Return has been fully completed. If your director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.	lcfs1397 Mon May 23 08:06: 50 BST 2022

Internal Audit Progress Report

Audit, Risk and Assurance Committee

June 2022

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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 June 2022 Audit, Risk and Assurance Committee;
- present the final 2021/22 Head of Internal Audit Opinion and Annual Report for noting; 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	27
Number of NWSSP audits	3
Number of audits to be reported in 2022/23	2[1]
Number of audits deferred	6

The following reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 17 May 2022:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Financial Sustainability	Reasonable
Operational Plan for Resumption of Services	Reasonable
Medicines Management	Reasonable
Corporate Governance	Reasonable
Medical Equipment and Devices (Position Statement)	N/A
Flow Centre	Reasonable
NIS Directive	Reasonable

Further information over the assurance ratings detailed above is included with Appendix B.

[1] The two audits are CHC – Children and Waste Management

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reasonable assurance reports issued since the last meeting on 17 May 2022.

Financial Sustainability (reasonable assurance)

We completed a review of financial sustainability plans throughout the Health Board, to determine if service areas are giving due consideration to financial sustainability when developing plans. We also considered the budgetary control framework that supports sustainability and savings. Whilst we did not identify any significant matters for reporting, we noted that:

- the Health Board needs to ensure alignment between its Transformation Programmes, IMTP Core Priorities and Priority Programmes; and
- improvements could be made in the development and approval of Transformation Projects, including the need to develop measurement criteria that are SMART and accounting structures that capture the more complex multi-service impact of these projects in support of the approval process.

Operational Plan for Resumption of Services (reasonable assurance)

This audit assessed the actions being completed by the Health Board to maximise capacity and the delivery of services. We found good arrangements, with regular reviews and prioritisation of services across the Scheduled Care Division.

However, we did recommend that the plans incorporate delivery timeframes to help reduce the waiting lists and to develop performance metrics for each service area to assist with the process.

Medicines Management (reasonable assurance)

This review incorporated controlled drugs and we considered two main objectives. The first was the governance of controlled drugs and the second was adherence to the Management of Controlled Drugs Policy. We visited 23 areas across the Health Board (including four theatre sites and 19 wards). Overall, we found no stock count discrepancies and confirmed that staff adopt a professional approach to the management of controlled drugs.

However, we did identify the following areas for improvement, including

- stock takes not being completed weekly in line with policy;
- a lack of evidence over the six-monthly stock checks completed by the Pharmacy Team; and
- the Policy for the Management of Controlled Drugs requires updating.

We recognise that some of the points described above were significantly impacted by the pandemic.

Corporate Governance (reasonable assurance)

Our testing of the Board Assurance Framework (BAF) process covered the most recent reporting cycle of the Health Board from November 2021.

We have audited the BAF process, noting that work is in progress to fully implement and embed supporting processes and procedures.

We did not identify any significant matters for reporting in our review. However, we have identified areas where improvements could be made, commenting on the need for the individual Risk Owners to assess and address any weaknesses or gaps in the assurances being relied upon more effectively.

We also recommended that the engagement of sub-committees of the Board in the BAF process is more formally documented, and that the effectiveness of the BAF process in its entirety is periodically reviewed and reported to the Board.

Medical equipment and Devices (assurance rating not applicable)

At the commencement of the fieldwork testing, we identified that significant progress is still required to update the controls for the management of medical equipment and devices (e.g. medical equipment and devices register(s) and training records). We also confirmed that the delivery milestones for these actions had been set by the Medical Equipment Management Group for delivery during 2022, largely as a result of the recent pressures of the pandemic.

Consequently, we were unable to complete sufficient testing to provide an assurance opinion over this area. Whilst this was not a follow-up audit, but rather a full separate review, the previous 2017/18 Medical Equipment and Devices audit (rated limited assurance) should still be considered as our current assurance position.

However, to assist the Audit, Risk and Assurance Committee with an update, we completed walkthrough testing and reviewed the documentation supplied. This has been presented as a Position Statement and has been factored into our findings and conclusions within the Head of Internal Audit Opinion. We also reconciled the status of the previous recommendations raised from the 2017/18 audit and confirmed that the outstanding recommendations were being tracked on the Audit Recommendation Tracking Tool (the 'Tracker').

We have scheduled another full audit of medical equipment and devices in 2023/24 as a part of our three year plan, and progress on our previous recommendations will continue to be assessed within the annual Follow-up of High Priority Recommendations review.

In the meantime, the Health Board should still consider this to be an area of high risk and manage it accordingly.

Flow Centre (reasonable assurance)

As previously reported, the Flow Centre is responsible for the delivery of a service that operates within an area of a high degree of inherent risk. There are strong processes in place, supported by a comprehensive induction and training package. However, there is a high volume of calls each day and often the patients being discussed have complex needs.

We found overall that the arrangements are being followed and are operating as intended.

However, we raised recommendations over the following areas for improvement, including:

- ensuring calls are documented completely and to a consistent standard;
- reviewing and testing the business continuity plan and processing any updates; and
- determining if the Flow Centre is achieving the anticipated benefits.

NIS Directive (reasonable assurance)

We reviewed arrangements in place for the implementation of the NIS (Network and Information Systems) Directive within the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

The matters which require management attention include:

- no retention of supporting information provided to the Cyber Resilience Unit (CRU) as part of the CAF assessment.
- improvement actions have not been fully identified and a plan has not yet been developed.
- there is no regular reporting of cyber security to the Board or a sub-committee, and the risk does not fully articulate the cyber security risk.

4. 2021/22 Head of Internal Audit Opinion

The final 2021/22 Head of Internal Audit Opinion and Annual Report is presented for review and noting the final opinion rating.

The final Head of Internal Audit opinion is reasonable assurance and is based on the outcome of work from the 2021/22 Internal Audit Plan and other relevant information or knowledge regarding the organisation.

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;
- advice on agency invoice processing within the Workforce and OD Division;
- monthly meetings with the Director of Finance and Performance;
- Audit, Risk and Assurance Committee pre-meeting with the Audit, Risk and Assurance Committee Chair;
- meetings with the Chair and Chief Executive;
- review and advice over financial control procedures; and
- liaison with senior management.

6. Recommendation

The Audit, Risk and Assurance Committee is invited to note the above, and note the 2021/22 Head of Internal Audit Opinion and Annual Report.

Appendix A: Progress against 2021/22 Internal Audit Plan

Review	Status	Draft report date	Management Responses received	Rating	Summary of recommendations	Actual ARA Committee [2]
Corporate Governance	Final report	26th April	12th May	Reasonable	2 Medium, 2 Low	June
Risk Management	Final report	7th March	24th March	Reasonable	2 Medium	April
Financial Sustainability	Final report	13th May	1st June	Reasonable	2 Medium, 6 Low	June
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	December
Gifts, Hospitality and Declarations of Interest	Final report	28th July	30th July	Reasonable	2 Medium	August
Clinical Negligence Costs	Final report	8th & 17th November	22nd November	Substantial	1 Medium, 1 Low	December
Putting Things Right	Final report	3rd & 20th September	27th September	Reasonable	2 Medium	October
Charitable Funds	Final report	2nd November	19th November	Substantial	1 Medium	December
Medical Equipment and Devices	Final report	18th May	31st May	N/A	N/A	June

Medicines Management (including Controlled Drugs)	Final report	19th May	1st June	Reasonable	4 Medium, 1 Low	June
Falls Management	Final report	22nd February	14th March	Reasonable	1 High, 1 Medium	April
Datix	Final report	5th May	N/A	N/A	N/A	May
NIS Directive	Final report	8th April	6th May	Reasonable	4 Medium, 1 Low	June
IT System Controls (WRIS)	Final report	8th November	15th December	Reasonable	1 High, 9 Medium	February
Operational Plan for Resumption of Services	Final report	16th May	1st June	Reasonable	2 Medium	June
Flow Centre	Final report	29th April	27th May	Reasonable	4 Medium, 3 Low	June
Pathology	Final report	9th November	24th November	Reasonable	4 Medium, 6 Low	December
Facilities Directorate Review	Final report	23rd March	29th March & 4th May	Reasonable	1 Medium, 3 Low	May
Occupational Health	Final report	27th October	10th November	Substantial	2 Low	December
Tredegar Health and Well Being Centre	Final report	7th October	21st October	Reasonable	4 High, 6 Medium, 2 Low	December
Waste Management	Draft report	29th April	To be reported during 2022/23	Reasonable	11 Medium, 2 Low	August
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	Final report	5th May	N/A	N/A	N/A	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	Final report	Reasonable
Payroll	Final report	Reasonable
PCS Contractor Payments	Final report	Substantial

[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.

Flow Centre
Final Internal Audit Report
June 2022

Aneurin Bevan University Health Board

Contents

Review reference:	AB-2122-22
Report status:	Final
Fieldwork commencement:	9th March 2022
Fieldwork completion:	28th April 2022
Draft report issued:	29th April 2022
Debrief meeting:	4th May 2022
Management response received:	27th May 2022
Final report issued:	27th May 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit
Executive sign-off:	Leanne Watkins, Interim Director of Operations
Distribution:	Paul Underwood, General Manager, Operations
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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

This audit assessed the processes within the Flow Centre Team of Aneurin Bevan University Health Board (the 'Health Board') for:

- ensuring patients are cared for in the right place, at the right time;
- ensuring local co-ordination with other partners; and
- providing a single point of contact for transferring patients into and between hospital sites.

Overview

We have issued reasonable assurance on this area.

As previously reported, the Flow Centre is responsible for a high degree of inherent risk. There are strong processes in place, supported by a comprehensive induction and training package, but it processes a high volume of calls each day and often the patients have complex needs.

The matters requiring management attention include:

- ensuring calls are documented completely and to a consistent standard;
- reviewing and testing the business continuity plan and processing any updates; and
- determining if the Flow Centre is achieving the anticipated benefits.

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.	⇔ 2020/21

Assurance summary[1]

Assurance objectives		Assurance
1	Operational Management	
	a. Patient are fully logged	Reasonable
	b. Patients are prioritised	Substantial
	c. Clinical authorisation is in place	Substantial
	d. CWS is updated	Reasonable
	e. Clinical care during transfer	Substantial
	f. Documentation of decisions	Reasonable
2	Flow centre performance monitoring	Reasonable
3	Flow centre resources / BCP	Reasonable
4	Training and induction	Substantial
5	Complaints / incidents	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Completed and aborted calls	1	Operation	Medium
4	Business Continuity Plan	3	Design	Medium
5	Expected Benefits	2	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 the Flow Centre was completed in line with the 2021/22 Internal Audit Plan. This is the second review of the Flow Centre, with the first completed as part of the 2020/21 Internal Audit Plan (Clinical Futures – Transport, Reasonable assurance).

1.2 Clinical Futures is the key strategic direction within Aneurin Bevan University Health Board (the 'Health Board'). It is the Health Board's plan for a sustainable health care system across the Gwent area. The plan comprises of a number of key pathways which are critical to ensure successful delivery of health care throughout Gwent, following the opening of the Grange University Hospital (GUH).

1.3 This audit specifically focused on the process to:

- transfer patients between hospital sites within the Health Board; and
- direct patients to an appropriate hospital site (e.g. via a GP or paramedic).

1.4 To manage this process, the Health Board created a service area during 2020 and supporting infrastructure, called the ABUHB Flow Centre (the 'Flow Centre'). The majority of patients will be transferred via this process, with clinical authorisation for a transfer required in some instances. However, this transfer process is not appropriate for women in labour, the discharging of patients, patients experiencing a mental health crisis or where an immediate emergency response is required. Alternative procedures are in place for patients that fall into those categories.

1.5 The overall objectives of the Flow Centre are to ensure patients are cared for in the right place at the right time and to provide a central point of contact for the transport / admission of patients to hospital sites.

1.6 The responsibility for identifying the appropriate resource to complete the transfer, the transfer paperwork and the completion of inter-site liaison will be completed by the Flow Centre flight marshals / navigators.

1.7 Welsh Ambulance Service NHS Trust (WAST) maintain a corresponding team, called the WAST Flow Desk Team, who receive requests from the Health Board's Flow Centre and dispatch ambulances and other appropriate vehicles to transfer patients.

1.8 The key risks considered in this review are:

i. patient harm as a result of the delayed transfer of care or inappropriate care during transfer;
ii. increased financial cost due to delays in the transfer of patients;
iii. an increased demand for beds, as patients are not transferred between sites promptly; and
iv. reputational damage as a result of the ineffective transfer of patients between sites.

1.9 This audit did not review the transfer of patients outside of the remit of the Flow Centre. Furthermore, we did not assess the clinical decisions undertaken as part of the transfer process.

We did not test the Datix process for the management of complaints within this audit.

The key focus of this audit was the operational management of the Flow Centre Team, i.e. the processing of a patient transfer request.

2. Detailed Audit Findings

2.1 As identified within the previous audit, the Flow Centre Team (the 'Team') and the supporting processes operate in an area of high inherent risk, where each decision to admit and step down a patient in a timely manner can be critical. Ultimately, the Health Board implemented the service to help deliver patients to the respective hospital sites, to maximise the efficiency of resources and deliver care closer to home.

2.2 We found the number of incidents[2] that took place during October 2020 and December 2021, as part of the transfer process, was 72 - with eight attributed to the Team itself. Each was investigated as part of the Incident Reporting Process and actions implemented, where required.

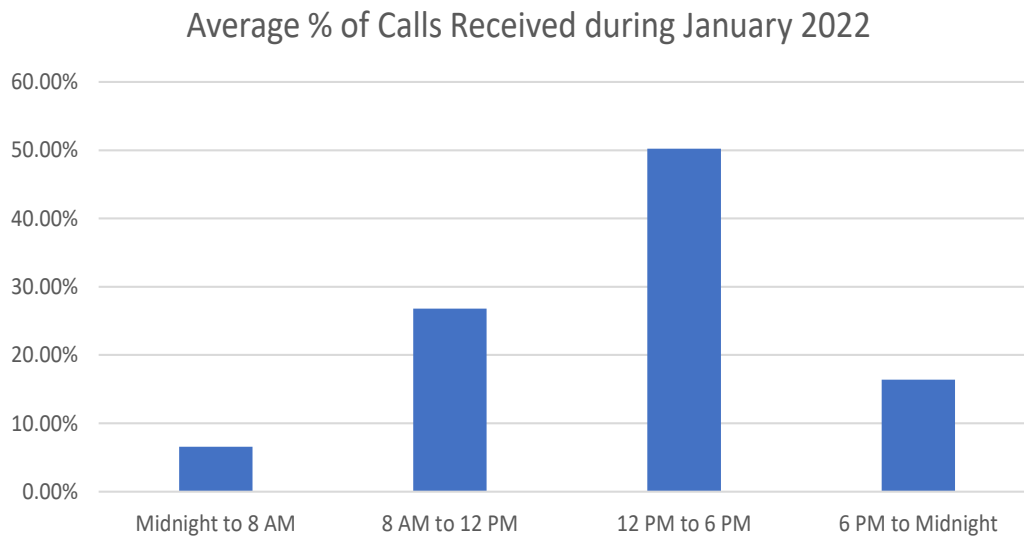
2.3 Table one below illustrates the destination of patients that are processed via the Flow Centre, with less patients being directed to the GUH during January 2022, compared to the previous audit.

Table One: Destination of Flow Centre Referred Patients

Hospital	2021/22 Audit Sample (%)[3]	2020/21 Audit Sample (%)
Grange University Hospital	39.71	51.51
Royal Gwent Hospital	27.99	18.02
Ysbyty Ystrad Fawr	7.39	14.18
Nevill Hall Hospital	16.69	13.39
No hospital (primarily not admitted)	3.9	2.75
Other (direct to ward)	0.92	0.13
St Woolos	1.08	0.01
Ysbyty Aneurin Bevan	1.69	0.01

[2] Where the process has not been adhered to or an unintended result has been achieved e.g. patient transfer delayed.
[3] This includes patients stepping up / down / across between hospital sites.

2.4 Ultimately, the Flow Centre is in place to facilitate the transfer of patients as safely and swiftly as possible over 24 hours each day. The graph below details the profile of the call times received during January 2022.



2.5 During January 2022, 5,280 patients were processed through the Flow Centre. The table below provides the total number processed through each route:

Category	Total Processed
Step across between sites	418
Step down across sites	646
Step up across sites	251
Pre-hospital streaming – GP	2,680
Pre-hospital streaming – WAST	1,285
Total	5,280

2.6 From the 418 (7.91%) patients stepped across between hospital sites, 87 patients were recorded as 'did not arrive' at their correct destination. This may be for a variety of reasons including lack of beds.

2.7 To deliver the service, 18.84 WTE staff are allocated to the Team, including flight navigators, registered nurses and consultant cover.

2.8 We reviewed the work rosters and found that staff have been allocated appropriately for each respective shift. However, we were informed that on a couple of occasions, last minute absences arose, which provided staffing challenges. Typically, this occurred during the night shifts.

2.9 Overall, we continue to recommend that the Health Board undertakes a cost / benefit analysis to ensure that the Flow Centre is delivering the expected benefits e.g. improved patient outcomes / reduced number of bed days.

Audit objective 1a: patients are fully logged into the system promptly and marked as 'closed' when processed

2.10 All calls are automatically assigned a reference number, with details inputted onto the database as the call is received. Once a patient has been transferred the call is marked as 'closed', We selected a sample of 20 patients and a further three patients that were stepped-up between hospital sites, to determine if this took place. We found no issues arising.

2.11 We also reviewed the entire referral data for January 2022 (5,280 patients) and found that 211 referrals had not been marked as 'closed' (mission completed). Of these, 89 were 'advice only' calls, with the 122 (2.31%) remaining calls not marked as completed during January 2022. This has been raised within **matter arising one.**

2.12 Furthermore, we found the transfer of 126 patients was aborted, of this total the reason recorded was marked as:

- 'other' for 46 patients;
- 'stood down – no reason provided' for four; and
- the reason was left blank for 11 patients.

Overall, 61 of 126 patients did not have a reason recorded for cancelling / stepping down their transfer / admission. When an individual no longer requires a transfer and is aborted, the reason should be recorded, to ensure the rationale can be identified and that patients are not removed from the system in error. This has been included within **matter arising one.**

Conclusion:

2.13 We confirmed that calls are logged onto the system in real-time and marked as 'closed' when complete. However, we found the quality of the information inputted can be improved further. Therefore, we have provided reasonable assurance for this objective.

Audit objective 1b: the prioritisation process is completed for each patient request received

2.14 The screening process, completed during the processing of a transfer, records existing medical conditions and current symptoms. A 'clinically accepted transfer time' is assigned to each call, where a transfer is required. Patients that are stepped up to the Grange University Hospital (GUH) are prioritised. In addition, for patients that are stepped up to another hospital, a three way process is completed, with the Flow Centre and the responsible clinicians at each hospital site (transferring from and to) involved. In the event of an emergency, the calling of 999 is adopted, to minimise any delay.

2.15 Within our sample of 23 patients, we confirmed that the priority of the patient is identified. There were no issued identified.

Conclusion:

2.16 As no issues were identified, we have provided substantial assurance for this objective.

Audit objective 1c: appropriate clinical authorisation is in place for each patient

2.17 Within our sample, we tested to ensure appropriate clinical authorisation was in place, prior to the transfer of a patient. As part of our sample, four patients were stepped up (from a total of 251 for January 2022). Prior to the transfer, a clinician from both hospital sites is required to agree upon the step up of the patient. We confirmed that this was taking place, although on occasion it was difficult to identify the applicable form.

2.18 If a step down is required, then an SBAR form is completed, to assist with the process. Within our sample, four patients were stepped down. All documentation was present.

Conclusion:

2.19 We have provided substantial assurance for this objective as no issues were identified.

Audit objective 1d: patient details from transfer requests are uploaded into the respective Clinical Workstation (CWS) record

2.20 We selected a sample of 23 patients from January 2022 to determine if all of the necessary patient's records were uploaded onto CWS. We confirmed that they had all been included on CWS, except for one patient that had been stepped up. This has been included within **matter arising two**.

Conclusion:

2.21 We have provided reasonable assurance for this objective.

Audit objective 1e: patients receive appropriate clinical care during their transfer to another hospital site

2.22 A patient is assessed as to their level of clinical care, including:

- critical care level;
- Covid-19 infection present;
- intubation requirements; and
- IV fluids and infusion pump requirements etc.

This is completed as part of the transfer checklist. We tested the completion of this within our sample tested and found no issues.

This also includes their infection risk. We found 209 patients were identified as an infection risk (including Covid-19), prior to their transfer.

Conclusion:

2.23 We have provided substantial assurance for this objective.

Audit objective 1f: decisions are sufficiently recorded

2.24 Within our sample of 23 patients, we found a variety of detail in the Transfer Form completed. Whilst we did not find any examples of screening responses that were inappropriately completed, some records were more comprehensive than others. We have raised this as **matter arising two.**

Conclusion:

2.25 Due to the improvements that could be undertaken to improve on the overall quality of records, we have provided reasonable assurance for this objective.

Audit objective 2: the Flow Centre performance and partnership arrangements

2.26 We reviewed performance data detailing the time and day of call centre contact, volume of calls, and the pre-streaming volume to each hospital location across a 24 hour period. Whilst the information provides an overview of the volume, key performance indicators have still not yet been implemented. Therefore, we have raised an amended version of recommendation three from the previous audit (Clinical Futures – Transport – 2020/21 – 40). This has been included as **matter arising three**.

2.27 The Team is based at WAST's South Wales headquarters and frequently hold meetings to discuss issues as they arise. In addition to this, the Team has access to C3 Radius (call handling system) alongside WAST, to help manage patients on the system.

Clinical and operational issues that arise are managed in partnership with WAST.

Conclusion:

2.28 As work has not been fully completed on performance indicators, we have provided reasonable assurance for this objective.

Audit objective 3: the Flow Centre resources, including the development of business continuity arrangements

2.29 The workforce roster number is 18.84 WTE, with one nurse and flight navigator covering the night time shift (20:00 to 8:40). The call volume (based on January 2022) is 18.3%. However, within that total, nearly 3% of the calls relate to the time between 7:00 and 8:40, thus c.15% of calls are received from 20:00 to 07:00 – approximately 2.5 calls per hour (on average across the month). The workforce roster is reasonable for this call volume, but only when it is fully resourced for the entire shift. It is important that arrangements are agreed in

advance that set out the steps to follow if there is an unexpected resource issue. This is included within **matter arising four.**

2.30 We reviewed the resourcing for the daytime shifts and found no further issues to report.

2.31 As the Flow Centre is a pivotal service throughout the Health Board, we examined the business continuity arrangements in place. We found a comprehensive business continuity plan (BCP) in place. However, it does not appear to have been updated since the last audit, with comments on the draft BCP still present. Indeed, the review date is set as 30th November 2020 (although, we believe this is an error and should read 30th November 2021). Nonetheless, the BCP is the same version as the previous audit.

We were also informed that the BCP has not been tested. Therefore, our previous recommendation remains. See **matter arising four.**

Conclusion:

2.32 Whilst the resourcing is adequate for the current call volume, the business continuity arrangements should be improved, with testing of different scenarios and an up-to-date plan. We have provided reasonable assurance for this objective.

Audit objective 4: training and induction for all staff

2.33 The process for training and induction remains the same as for the previous review. As the service is critical for the transfer of patients there is a very comprehensive training package in place. This includes:

- an induction programme;
- scenario testing;
- pathway training e.g. abdominal pain;
- video training of C3 Radius (WAST call handling software);
- testing of common scenarios and process requirements;
- numerous presentations covering topics including active listening through to which CWS forms to use; and
- shadowing a more experienced member of staff.

We confirmed that the previous process remains in place. There are no recommendations to raise.

Conclusion:

2.34 The training and induction package is key to ensure staff adhere to the approved process and are able to screen patients effectively. There is a high level of underlying risk with new starters, who are not familiar with the process. There is

a comprehensive training package and assessment of staff at the end of induction. Therefore, we have provided substantial assurance for this objective.

Audit objective 5: appropriate management of complaints / incidents

2.35 We tested to ensure that complaints / incidents are investigated and resolved. We found that each incident is reviewed, and lessons learnt where required. This is completed as part of the Datix process (not tested as part of this audit), but the process remains the same as last year. However, we recommend within **matter arising five** that the expected benefits are reviewed to ensure they are being achieved in line with expectations, after taking into account the impact from incidents that arise.

Conclusion:

2.36 As we have not identified any benefits realisation review, we have provided reasonable assurance for this objective.

Appendix A: Management Action Plan

Matter arising 1: Recording Completed and Aborted Calls (Operation)	Impact
We found that 122 calls (from 5,280) had not been marked as complete on the database, thus increasing the risk that patient transfers may be delayed or no longer required. Requests for transfers into a hospital or the stepping up / down / across of patients are automatically recorded onto the database. Each patient is tracked until the transfer is complete or for another appropriate reason (e.g. patient is too ill). On occasion, a transfer has to be aborted. To complete this process, a reason should be recorded. We reviewed the call data for January 2022 and found that 61 of 126 patients that had their transfer aborted did not have a reason recorded.	Potential risk of: • Patient transfers not processed efficiently. • Reasons for the non-transfer of patients are not recorded. • Patient transfers may not be complete.

Recommendations	Priority
1.1 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	Medium
1.2 The Flow Centre Team should close all calls on the system once complete.	Medium

Management response	Target Date	Responsible Officer
1.1 The Flow Centre Team have performed regular audits throughout the year and learning outcomes identified. This recommendation features on our regular 1:1s with individuals, staff weekly updates and will be a focus over the next few months in line with this audits recommendation. Assurance is given via the Operations Structure and Urgent Care Divisional meetings with a monthly frequency and contain a feedback loop to ensure learning is disseminated to the teams.		
Flow Navigator audit tool to be created	30/05/2022	Service Manager (USC)

	Key area of focus for our Flow Navigator Auditor over the next 2 months	30/07/2022	Service Manager (USC)
1.2	This audit has highlighted a key learning outcome regarding the process followed when closing calls on the system and the loophole associated with the system used for recording the referral (Nugensis).		
	Learning identified and training provided to staff	30/06/2022	Flow Centre Nurse
	Key area of focus for our Flow Navigator Auditor over the next 3 months	30/07/2022	Flow Centre Nurse

Matter arising 2: Screening Information (Operation)	Impact
We reviewed a sample of 23 patients and found that the information inputted into the Transfer Forms varied in detail and completeness. Whilst the requirements of each patient are unique, within the sample there were examples of comprehensive audit trails documented. However, this was not consistent across the entire sample reviewed. We also found that a request to step up to the GUH had been received for one patient within the sample, but the details had not been uploaded onto CWS.	Potential risk of: • Relevant medical information not be readily available to view.

Recommendations	Priority
2.1 The Flow Centre Team should establish the required level of information to be documented on the Transfer Form for each patient screened and all forms should be uploaded onto CWS.	Low

Management response	Target Date	Responsible Officer
2.1 In the past 3 months an internal audit performed by the department highlighted further evidence of this practice and an action plan has been implemented to improve this area of practice.		
Clinical audit tool to be created	30/06/2022	Flow Centre Nurse
Initial audit to be completed – 5% of Flow Nurse workload	30/08/2022	Flow Centre Nurse
Learning identified and training provided to staff	30/09/2022	Flow Centre Nurse

Matter arising 3: KPIs (Design)	Impact
We reviewed a range of performance data, which is used to align the workforce roster to the volume of calls received. However, key performance indicators have not yet been developed. Operational performance should be monitored and assurance provided to an appropriate sub-committee of the Board. This information should also be taken into account when reviewing the level of benefits that the Flow Centre process is expected to deliver.	Potential risk of: • Poor performance not being identified. Anticipated benefits of operating the Flow Centre may not be achieved.

Recommendations	Priority
3.1 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	Low

Management response	Target Date	Responsible Officer
3.1 With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID.		
Create operational KPI for Pre-Hospital Screening	30/07/2022	Service Manager (USC)
Create clinical KPI for Intersite transfer service	30/07/2022	Flow Centre Nurse
Review the clinical and operational model of the Flow Centre	30/09/2022	Service Manager (USC)

Matter arising 4: Business Continuity Plan (Operation)	Impact
We reviewed an initial draft of the business continuity plan. This was comprehensive and contained action cards for multiple continuity events, with high level instructions in place. However, this was the same draft as reviewed within the 2020/21 audit of Clinical Futures – Transport, where we raised a recommendation to update the plan and to undertake regular testing. Whilst it details key attributes of an appropriate continuity plan it would benefit from more specific / step-by-step instructions to utilise in the event of a continuity event. For example, the Flow Centre Team has identified a location to operate from in the event of a loss of premises, but identifying who would occupy which seat in advance would reduce the decision making required during an emergency. Periodic test runs against different continuity events would help identify improvements, familiarity and additional detail in the plan required. Furthermore, there should be details documented of steps to take in urgent situations, to prevent a continuity event from occurring. For example, unexpected staff absence during a night time / weekend shift, where staff resource is already low.	Potential risk of: • Delays in recovering from a continuity event. • Staff unaware of what is required during a continuity event.

Recommendations		Priority
4.1	We recommend that the Flow Centre Team review and update the business continuity plan, where required.	Medium
4.2	We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	Low

Management response		Target Date	Responsible Officer
4.1	The business continuity plan is being reviewed and updated currently.	30/06/2022	Service Manager (USC)
4.2	A planned test of the business continuity plan will be initiated by the target date	30/08/2022	Service Manager (USC)
	An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	Service Manager (USC)

Matter arising 5: Expected Benefits (Design)	Impact
As raised in the 2020/21 Clinical Futures – Transport audit, the Flow Centre is an integral part of an overall patient centred system of care. The objective is to direct patients to an appropriate hospital site for their care requirements. By operating a centralised critical care hospital, patients are 'stepped-up' and 'stepped-down' as and when required. This enables critical care beds to become free sooner and to maximise patient throughflow. One benefit of this is the maintenance of less critical care beds, as patients are transferred to more appropriate environments as they recover. This leads to reduced staffing requirements and other associated costs. It is important that the original objectives and projected benefits of the service are continually assessed against the costs incurred. This is to ensure that the anticipated benefits are being achieved.	Potential risk of: • The Flow Centre not achieving the expected benefits, impacting patient flow within the Health Board. • There is an increased risk to patient care. • There is an increased financial cost.

Recommendations	Priority
5.1 The Flow Centre Team should provide assurance to an appropriate committee or group of the delivery of the expected benefits.	Medium

Management response	Target Date	Responsible Officer
5.1 The Flow Centre has been operational for a period of time that will enable an effective review of the service projected benefits and assurance to the objectives given. With recent changes in clinical and operational leadership of the Flow Centre a focus will be to review the service by the target date.	30/08/2022	Service Manager (USC)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Corporate Governance

Final Internal Audit Report

June 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

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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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.

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Executive Summary

Purpose

To evaluate the Board Assurance Framework (BAF) process and supporting arrangements that are embedded within Aneurin Bevan University Health Board governance structure.

Overview

Our testing of the BAF process covered the most recent BAF reporting cycle of Aneurin Bevan University Health Board (ABUHB) made in November 2021.

We have audited the BAF process, noting that work is in progress to fully implement and embed BAF processes and procedures and that a stable developed BAF process is yet to be delivered given that BAF reporting commenced in 2021.

We did not identify any significant matters for reporting in our review. We have noted areas where improvements could be made, commenting on the need for the individual Risk Owners to more effectively assess and address any weaknesses or gaps in the assurances being relied upon.

We also recommended that the engagement of Committees of the Board in the BAF process is monitored as procedures are embedded, and that the effectiveness of the BAF process in its entirety is periodically reviewed and reported to the Board.

Other recommendations 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 See page 2

Assurance summary[1]

	Assurance objectives	Assurance
1	An up-to-date Board Assurance Framework (BAF) is in-place	Substantial
2	The effectiveness of the BAF is assessed on a regular basis	Reasonable
3	Key sources of assurances (internal and external) are identified, recorded and regularly reviewed	Reasonable
4	Assurance / Control gaps are identified, formally documented, and fully addressed	Reasonable
5	Prompt action is undertaken to address residual strategic risk outside of the Health Board's risk appetite	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Assurance Weaknesses and Gaps	4, 5	Operation	Medium
2	Assurance Mapping	3	Design	Low
3	Board Committees' Engagement in the BAF Process	3	Design	Low
4	Review of the Effectiveness of the BAF Process	2	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 Corporate Governance review was undertaken in line with the 2021/22 Internal Audit Plan. The review sought to determine if a Board Assurance Framework (BAF) and supporting arrangements are embedded within Aneurin Bevan University Health Board (the 'Health Board').

1.2 The BAF comprises strategic risks and is aligned to the Health Board's strategic objectives and the risks which prevent the Health Board from achieving its strategy. Risks impact across the Health Board in their scope and impact.

1.3 A revised Risk Management Strategy and Framework was launched in September 2021, which is still being embedded throughout the Health Board. The BAF has linkages to the Health Board's Risk Management Framework and with the Quality Assurance Framework to provide a robust structure that enables the Health Board to focus on the threats to its most important objectives.

1.4 The key risk considered in this review is that insufficient assurance is provided to the Board which may lead to the non-achievement of strategic objectives, and associated potential patient harm, financial loss, and/ or reputational damage to the Health Board.

1.5 Wider risk management aspects have been covered in a separate Internal Audit report AB-2122-02 entitled Risk Management issued in February 2022 and the scope of this audit has been limited accordingly to avoid duplication.

1.6 The Health Board implemented BAF reporting in 2021 with six monthly reporting to the Board in May and November 2021. This audit has focused on the November 2021 reporting cycle, post the adoption of the revised Risk Management Strategy and Framework.

2. Detailed Audit Findings

Audit objective 1: An up to date BAF is in place, setting out how key strategic risks are managed

2.1 A review of Board and Committee minutes and papers identified that the Health Board reviewed draft BAF documentation in early 2020. Detailed feedback was received by the Board from the Chair of Audit, Risk and Assurance Committee and the Special Financial Adviser to the Board. The Board approved the BAF, as noted in the minutes of the Board held on 25 March 2020, however as a consequence of the Covid-19 pandemic resources were reallocated and the BAF process was suspended.

2.2 Subsequently, the Board endorsed the BAF as noted in the minutes of the meeting of the Board held in May 2021. The endorsed BAF is now in place and establishes

how key strategic risks, described within the Health Board as principal risks, are managed.

2.3 No matters arising have been raised under this audit objective.

Conclusion:

2.4 An up to date BAF is in place, setting out how key strategic risks are managed. No matters for reporting were identified, therefore we have provided **substantial assurance** over this area.

Audit objective 2: The effectiveness of the BAF is assessed on a regular basis

2.5 Whilst the Audit, Risk and Assurance Committee is charged with seeking assurance that there is an effective framework for the management of strategic, clinical and operational risks i.e. those risks likely to directly impact achieving the Health Board's Integrated Medium Term Plan and strategic objectives, and that the effectiveness of the framework is regularly reviewed, the Committee is not specifically required to report on compliance with, and the effectiveness of, the BAF process.

2.6 Given that the BAF process is in its first year, and is evolving over time, there is value in providing the Board with periodic assurance that the BAF process is implemented and operating. Such a report provides the opportunity for the Board to note an assessment of compliance with the BAF process and the effectiveness of the process to deliver the BAF's stated purpose, that being to provide clarity on the internal assurances that the Board requires and whether the Board can be satisfied that risks are being managed appropriately and that the organisation is on track to achieve its stated objectives.

2.7 As the BAF process evolves further in 2022, and develops a more stable structure, the Board should be provided with periodic papers on the effectiveness of the BAF process, commenting on compliance, its fitness for purpose and the engagement of Risk Owners, Executive management, Board Committees and the Board in the BAF process as defined. This has been raised as matter arising four in Appendix A.

Conclusion:

2.8 Currently the BAF process has not been assessed and reported to the Board, with no reference for such a review being noted in the BAF May 2021 process document endorsed by the Board in that month. Whilst no significant matters for reporting were identified, there is a need to establish a periodic BAF review process reporting to the Board, therefore we have provided **reasonable assurance** over this area.

Audit objective 3: Key sources of assurances (internal and external) are identified, recorded and regularly reviewed

2.9 A review of the BAF reporting cycle for November 2021 identified that the Board was presented with a BAF paper including an appendix detailing the individual principal risks. For each principal risk, key sources of assurances had been identified and recorded and are to be provided to the Audit, Risk and Assurance Committee and the Board every six months for review.

2.10 Each principal risk has a dedicated, named Risk Owner with reference made to Committee Assurance, listing those Committee(s) that have an interest in each principal risk, as it impacts their respective area of oversight.

2.11 To ensure that the Health Board is aware of, and understands, its most significant risks which could impact upon the delivery of its objectives and priorities it is the responsibility of Board and Committees to review the principal risks that threaten the achievement of these objectives and priorities.

2.12 A review of the minutes and papers of those Committees named was performed. The level of engagement of the Committees in the BAF process varied and was not evidenced in a consistent manner. However, we confirmed that programmes (ten in total) of work over the key priorities identified within the IMTP are underway, with a lead Executive responsible for each.

2.13 The Committees' Terms of Reference have recently been reviewed, revised and approved by the Board and comment on Committees' oversight responsibilities. In addition, Committees now receive Committee Risk papers at each meeting that include detailed BAF information. We have noted the work done in this area and the need to ensure the Committees' BAF oversight processes are fully embedded. This has been raised as matter arising three in Appendix A.

2.14 In addition, it was noted that there is no assurance map maintained at a Health Board level that can facilitate an overview across the individually reported principal risks. Such a record would allow a corporate governance view of assurances, in particular the identification of instances where specific assurance may be being relied upon in more than one principal risk area, and the assessment of the consistency of assurances being sought across the Health Board's principal risks. This has been raised as matter arising two in Appendix A.

Conclusion:

2.15 Whilst key sources of assurance are identified and recorded, and are to be regularly reviewed by the Board, there is a need to clarify the role of Committees in any review of principal risks and the processes to be followed. Whilst no significant matters for reporting were identified, there is a need for clarity, therefore we have provided **reasonable assurance** over this area.

Audit objective 4: Assurance / Control gaps are identified, formally documented, and fully addressed

2.16 The review, as noted in para 2.9 above, also identified that for each principal risk, key sources of assurances had been identified and recorded, and where gaps were identified these were also detailed.

2.17 However, each principal risk reported did not indicate that the assurances listed had been assessed and rated, there being no reference to any weaknesses in the assurances currently being relied upon. In addition, there was no reference to actions required to address weaknesses in existing assurances or those gaps in assurances reported.

2.18 There are opportunities to improve the value to be gained from the BAF process in the delivery of reduced risk exposure to the strategic objectives of the Health Board, by being able to demonstrate the level of confidence in the assurances currently being relied upon and addressing any identified weakness or gaps. These have been raised as matter arising one in Appendix A.

Conclusion:

2.19 Whilst no significant matters for reporting were identified, there is an opportunity to gain greater confidence in the assurances being sought, assessing their effectiveness and addressing any weaknesses, together with any gaps in assurance detailed in the individual principal risk reports, therefore we have provided **reasonable assurance** over this area.

Audit objective 5: Prompt action is undertaken to address residual strategic risk outside of the Health Board's risk appetite

2.20 The review also identified that for each principal risk, the risk appetite was disclosed together with risk actions, consistent with the risk appetite structure detailed in the BAF May 2021 process document endorsed by the Board in that month. It was noted that all principal risks reported had a current risk score in excess of the target risk appetite for each risk reported and had not reported any change in 2021.

2.21 However, we raised a recommendation in respect of the point above within the Risk Management audit (2021-22 – 02, rated reasonable assurance) and concluded that the risk appetite should be reviewed.

Conclusion:

2.22 All principal risks reported currently have a risk score in excess of the risk target and there is a need to more clearly align required actions to reduce risk scores. We have not raised any additional recommendations in this audit and as with the Risk Management audit we have provided **reasonable assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Assurance Weaknesses and Gaps (Operation)	Impact
Board Assurance Framework (BAF) reporting to the Board in 2021 contained an appendix listing the twelve principal risks to the strategic objectives of the Health Board. A review of the BAF process, as evidenced by the individual principal risk reports presented to the then Audit, Finance and Risk Committee (now the Audit, Risk and Assurance Committee) in October 2021 and the Board in November 2021 identified the following instances and opportunities to improve the level of confidence to be gained from the BAF process in the delivery of reduced risk exposure to the strategic objectives of the Health Board: i Risk Owners are not reporting any assessments of the effectiveness of the disclosed assurances being relied upon; ii Risk Owners have identified gaps in assurance in some instance but not commented on their significance and whether action is required, or not; and iii Risk Owners have not reported action plans, and progress in their implementation, to address weaknesses or gaps in assurance. In addition, some individual principal risks had more than one risk appetite action attributed such as treat/terminate or treat/transfer or tolerate/treat/transfer. The lack of focus makes it hard to understand the relevance of risk mitigating actions and the significance of associated assurances being sought.	Potential risk of: • Reduced effectiveness of the BAF process • Ineffective oversight and decision making • Reputational damage to the Board • Adverse impact on delivery of the Board's strategies and performance

Recommendations	Priority
1.1 We recommend that the Health Board assesses the effectiveness of those assurances on which reliance is being placed, and report their findings or gaps identified as part of the BAF reporting structure. Where gaps are identified action plans should be developed and monitored for progress.	Medium

Management responses	Target Date	Responsible Officer
1.1 The Health Board accepts this recommendation as part of the iterative development of the Board Assurance Framework. Work to address this recommendation is planned during May/June 2022 and a revised BAF incorporating a robust assessment of assurances will be included. Assurances will be RAG rated and identified gaps will have associated plans to improve the position, monitored by the Audit, Risk and Assurance Committee.	July 2022	Director of Corporate Governance, Head of Corporate Services, Risk and Assurance

Matter arising 2: Assurance Mapping (Design)	Impact
BAF reporting to the Board in 2021 contained an appendix listing the twelve principal risks to the strategic objectives of the Health Board. For each principal risk listed, detail is provided of the assurances being relied upon. However, there is no aggregation of this information into a Health Board level assurance map. There are advantages in maintaining such an assurance map. It allows identification of instances where specific assurance may be relied upon in more than one strategic risk area and to facilitate an assessment of the consistency of assurances being sought across the Health Board's principal risks.	Potential risk of: • A lack of coordinated assurances, with potential overlapping and / or missing assurances not being identified • Reputational damage to the Board • Adverse impact on delivery of the Board's strategies and performance

Recommendations	Priority
2.1 We recommend that the Health Board completes an assurance mapping exercise to record all assurances being sought in relation to those principal risks reported under the BAF process. The exercise should be regularly reviewed to identify any missing and / or the accuracy of the assurance.	Low

Management responses	Target Date	Responsible Officer
2.1 The Health Board accepts this recommendation and actions to undertake this are outlined in recommendation 1. The Health Board has established processes in place to review the BAF at least twice yearly with all principal risks reported to executive team, relevant committees and to the Board at each meeting.	July 2022	Director of Corporate Governance, Head of Corporate Services, Risk and Assurance

Matter arising 3: Board Committees' Engagement in the BAF Process (Design)	Impact
Each principal risk reported under the BAF process has an allocated risk owner with reference made to a specific sub-committee, as providing assurance over the principal risk. A review of the principal risks reported to the Board in November 2021 all referred to one or more of the following sub-committees of the Board: Patient, Quality, Safety and Outcomes Committee; People and Culture Committee; and Audit, Finance and Risk Committee, (name changed to Audit, Risk and Assurance Committee in 2022). A review of Board Committee papers presented in 2021 identified that it was unclear whether monitoring of assurances sought for each principal risk was required to be undertaken and challenged by the committees. For example, there were no assessments of the assurances presented, and, where assurance gaps had been reported, there were no action plans detailed and approved to resolve weaknesses in existing assurances and fill assurance gap. The Committees' Terms of References reviewed at the time of the audit did not comment on the role and responsibilities of the committees regarding the BAF process where specific principal risks have been allocated to them. We acknowledge that the Committees' Terms of Reference were subsequently reviewed with revisions made and approved in March 2022 and that they comment on generic risk management responsibilities. In addition, the Committees now receive Committee Risk papers at their meetings that include detailed BAF information.	Potential risk of: • Ineffective oversight and decision making • Reputational damage to the Board • Adverse impact on delivery of the Board's strategies and performance

Recommendations	Priority
3.1 We recommend that the Health Board continues to monitor the embedding of the BAF related risk management oversight responsibilities of the Committees to ensure that: 1 the Committee Risk papers form the basis of the six monthly BAF reporting to the Audit, Risk and Assurance Committee and the Board; and, 2 appropriate oversight is provided by each Committee on reported BAF activity.	Low

Management response	Target Date	Responsible Officer
3.1 The Health Board accepts this recommendation and plans to include strengthened assurance mapping arrangements and assessments for the next iteration of the Board Assurance Framework (BAF).	July 2022	Director of Corporate Governance, Head of Corporate Services, Risk and Assurance

Management response (continued)	Target Date	Responsible Officer
In addition to this, the template reporting for Board and Committees is due to be reviewed, it is proposed that incorporated into this review will be the ability to cross reference each Board and Committee report to the BAF to make explicitly clear where papers address and provide assurance against a principal risk.		

Matter arising 4: Review of the Effectiveness of the BAF Process (Design)	Impact
The BAF process has only recently commenced in 2021 with BAF reporting to the Board in May and November 2021. The papers presented to the Board have commented on the evolving nature of the BAF process and that it is expected to continue to develop. At the time of the audit the BAF process had not reached a steady state, for example not all individual principal risk reports had been completed in full. Whilst the Audit, Risk and Assurance Committee is responsible for seeking assurance that there is an effective framework for the management of strategic, clinical and operational risks i.e. those risks likely to directly impact achieving the Health Board's IMTP and strategic objectives, and that the effectiveness of the framework is regularly reviewed, the Committee is not specifically required to report on compliance with the BAF process. As the BAF process evolves further in 2022, and develops a more stable structure, there is benefit in the Board requesting a paper on the effectiveness of the BAF process, commenting on compliance, its fitness for purpose and the engagement of risk owners, Executive management, committees and the Board in the BAF process.	Potential risk of: • Reputational damage to the Board • Adverse impact on delivery of the Board's strategies and performance

Recommendations	Priority
4.1 We recommend that the Health Board develops a periodic report commenting on compliance / the effectiveness of the BAF process and reports this to an appropriate committee.	Medium

Management response	Target Date	Responsible Officer
4.1 The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	April 2023	Director of Corporate Governance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Operational Resumption of Services
Final Internal Audit Report

June 2022

Aneurin Bevan University Health Board

NWSSP Audit and Assurance

Contents

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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.

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This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit, Finance & Risk Committee.

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Executive Summary

Purpose

We evaluated the adequacy of the systems and controls in place for the operational resumption of services.

Overview

We have issued reasonable assurance on this area. We found good arrangements in place, to ensure a consistent approach to clearing the backlog of appointments caused by the impact of the pandemic. Alongside the service level plans is a divisional overview to prioritise services as required, and regular reporting of referral to treatment (RTT) waiting lists.

The matters requiring management attention include the:

- Updating of plans to reflect the delivery profile of actions and key milestones i.e. the timeframe to reduce the waiting lists to pre-pandemic levels.
- Development of performance metrics to monitor the progress / effectiveness of individual plans / actions taken.

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

Limitation of Scope

We have not provided assurance over whether the plans are reducing the waiting lists at the maximum pace possible, but instead whether the actions and controls in place are appropriate in the circumstances.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved	Not Applicable – first review

Assurance summary[1]

Assurance objectives		Assurance
1	Welsh Government's requirements	Substantial
2	Guidance requirements	Reasonable
3	Monitoring of Plans	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Review of Action Plans	2	Design	Medium
2	Performance Information	3	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 On 16th March 2020, in response to the unprecedented challenge associated with the COVID-19 pandemic, the IMTP process for NHS Wales was paused. The Welsh Government subsequently adopted a quarterly COVID-19 operating framework with Health Boards required to develop operational plans describing their response to the pandemic and the delivery of essential and routine health services.

1.2 A report to the Board of Aneurin Bevan University Health Board (the 'Health Board') on 16th December 2020 set out the revised planning framework and guidance for NHS Wales, issued by the Welsh Government (24th September 2020) which, inter-alia, made it clear that these plans should not be a set of 'new' plans; but instead, they must build on the quarterly planning discipline which NHS Wales has so far adopted for 2020/21. This included confirmation that the IMTP process had been paused and replaced by Quarterly Operational Plans in response to the pandemic.

1.3 The Quarter 3 & 4 Plan (the 'Plan') was submitted to the Welsh Government in line with the guidance issued on 19th October 2020 but was marked as draft pending Board consideration and approval, which was subsequently given.

1.4 The Health Board's report stated that having completed the immediate response to the pandemic and the Adapt and Sustain phases the Health Board was entering the third phase - 'COVID-19 and Winter'. The Plan described how the Health Board would cautiously re-establish elements of routine services whilst ensuring it has the capacity to respond to the pandemic, winter pressures and maintain essential services. The Plan had been developed in the context of the four harms[2] and shaped by providing equal weighting to each, in order to minimise health inequalities across the system.

This Plan describes how the Health Board will meet the unprecedented, combined challenges of:

- ensuring the capacity to respond to COVID-19, consistent with the modelling scenarios set out by Welsh Government;
- ensuring capacity to maintain essential non-COVID-19 services and meet the demand of winter pressures; and
- commissioning an early opening of the new 470 bed Grange University Hospital, together with the reconfiguration of services in the remaining local general hospitals to enable greater resilience for key services during the winder period.

Furthermore, the Plan is structured around:

- the continuing response to COVID-19 (including infection prevention and control);

1. Harm from Covid itself; Harm from reduction in non-Covid activity; Harm from overwhelmed NHS and social care system; and Harm from wider societal actions / lockdown.

- essential services and key quality and safety issues;
- support plans for care homes and social care interface;
- preparing for winter;
- capacity plans, including operational and surge plans;
- digital and new ways of working;
- workforce plans;
- financial implications;
- risks to delivery and mitigation (including EU Transition); and
- mechanisms for stakeholder engagement.

1.5 On 20th May 2021, the Health and Social Services Minister set out plans for a £100m investment to kick-start the health and care system's recovery from the pandemic with a commitment of an extra £1bn to support the recovery plan.

1.6 The initial allocation to the Health Board was £17m for projects to increase capacity in planned care, diagnostics, therapies and mental health.

1.7 The fieldwork testing was significantly delayed by the emergence of the Omicron variant during December 2021, in addition to winter pressures. Consequently, we assessed information supplied to us by this date, with further supporting information supplied during February 2022. We reviewed the latest metrics available to update our conclusions.

1.8 The risks considered in this review include:

- planned performance is not achieved;
- the resumption of services plans are not being adhered to resulting in patient harm;
- financial and reputational implications associated with the failure to achieve the plans;
- inadequate controls in place to systematically identify, assess and manage risks;
- inadequate support arrangements to raise awareness and monitor performance;
- insufficient sharing of best practice amongst the divisions to raise awareness and mitigate risks across the organisation; and
- there is a lack of assurance to the Board over the plans being delivered.

1.9 We have not provided assurance over whether the plans will clear the entire backlog in a specified time period, but rather we have assessed whether the Health Board has undertaken appropriate steps to maximise capacity to reduce the referral to treatment (RTT) waiting times.

2. Detailed Audit Findings

Audit objective 1: Plans delivered for all key services

2.1 Overall, we found good arrangements, including regular reviews and the introduction of alternative actions by management, when required. However, and as expected, the pandemic significantly limited the capacity available for services to resume (during testing elective capacity ranged from 75% to 80%).

2.2 We found that the Health Board set out a process to implement the Welsh Government's requirements across all service areas. In particular, during June 2020 all services were to complete and submit a Service Framework Checklist (the 'Checklist').

2.3 The purpose of the Checklist was to provide clarity on the restarting of urgent elective services, based on the principles outlined in the Welsh Government's 'Covid-19 NHS Principles Framework for Hospitals'.

2.4 We reviewed a sample of Checklists (Urology, Dermatology, Trauma and Orthopaedic, amongst others) and found that the Welsh Government requirements were actively incorporated.

2.5 We also confirmed that the Checklists are reviewed at a divisional level to ensure a consistent approach and prioritisation of resources throughout. This was undertaken at the Divisional Management Team meetings, where the restarting of services has been a key focus since July 2020.

2.6 Furthermore, we found that comprehensive reporting was in place to ensure all services were considered at the Outpatient Service Group (the 'Group') meetings.

Conclusion:

2.7 We have provided **substantial assurance** for this objective, as there is coverage of all service areas, with each regularly tracked by delivery volume.

Audit objective 2: Guidance requirements incorporated into the planning process

a. Consideration over which services are prioritised

2.8 We found that the prioritisation of services is discussed at the Group meetings with additional action scheduled for patients over '100% past their target date'. Examples identified include treatment at private providers (notably St Joseph's Hospital), 'Attend Anywhere', increasing capacity (where possible), virtual appointments and the validation of waiting lists to target clinical priorities, with health risk factors applied.

2.9 Furthermore, the first section to be completed within the Checklist is the prioritisation of patients, based on clinical priorities. All Checklists are considered across the division and performance data measuring waiting lists is utilised to re-prioritise capacity.

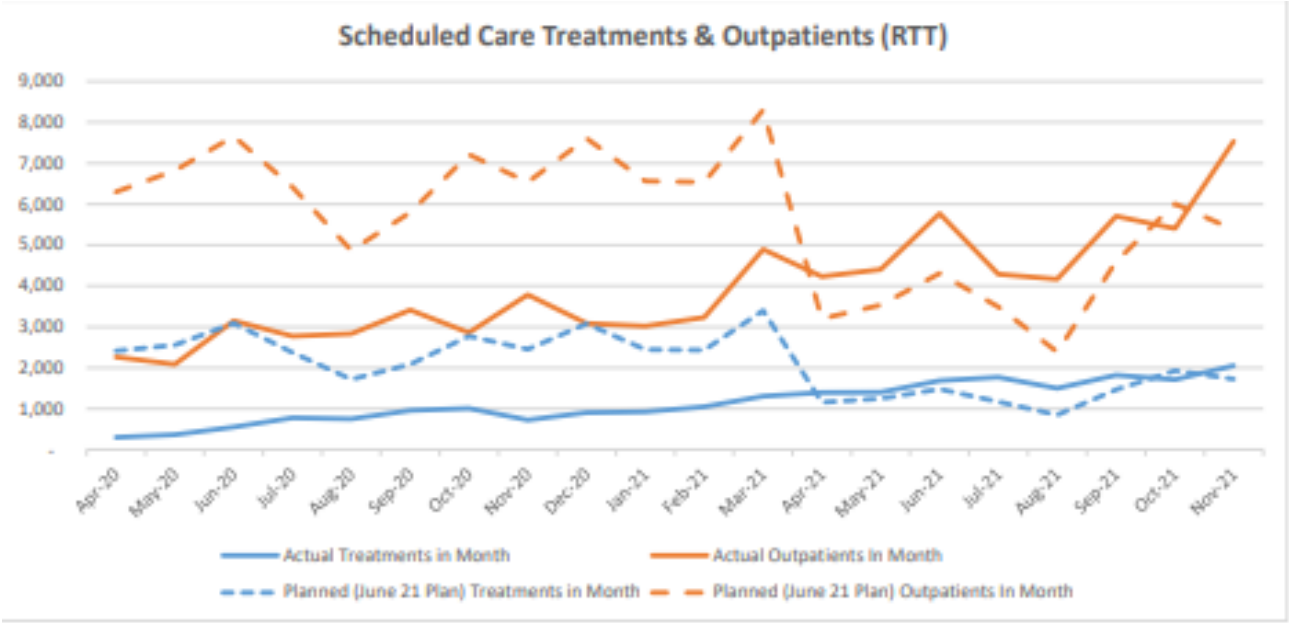
2.10 The Health Board's Clinical Recovery Group oversees the priority of patients, which is based on clinical needs rather than a time-based approach (except where patients have been waiting more than 52 weeks). To achieve this, performance metrics were introduced to measure the number of patients awaiting a clinical assessment date and where they are currently on a waiting list.

b. Whether plans are deliverable

2.11 We tested to determine if the plans were profiled for delivery to clear the backlog of treatment / referrals. However, with significant pressure caused by the pandemic, during September 2021, elective capacity remained at 75% (January 2022 – 80%) of pre-pandemic levels.

2.12 The delivery of capacity is determined by demands across the Health Board, impact from the pandemic, workforce and theatre availability etc. However, during November 2021, individual service recovery plans were initiated to increase capacity, with increases in output within Trauma and Orthopaedic (+87 patients), Urology (+73 patients), General Surgery (+58 patients). These were delivered through the use of surge beds, waiting list initiatives and core time. This has been funded through Covid-19 recovery funding (£11.2m within Scheduled Care).

2.13 Furthermore, the separation of GUH from eLGH sites has enabled a degree of elective surgery to continue throughout the pandemic. The delivery of the plans has enabled the Health Board to deliver above planned output, as shown in the graph below. With the onset of the Omicron Variant, the delivery, as expected started to decrease again.



2.14 However, whilst there has been an increase in capacity, we have not tested to determine if the plans could or should be delivering a higher output level. Instead, we examined the controls in place around the process to maximise output capacity.

2.15 Ultimately, there is still a great distance to recover, with the waiting list figures as at February 2022:

	Mar-20	Dec-21	Feb-22
New Outpatient Waiting List	74,673	113,866	113,904
Inpatient Waiting List	7,289	9,478	10,165
Daycase Waiting List (incl Endoscopies)	18,325	23,594	23,151
Radiology Waiting List	15,051	10,180	11,803

We have raised this as **matter arising one**.

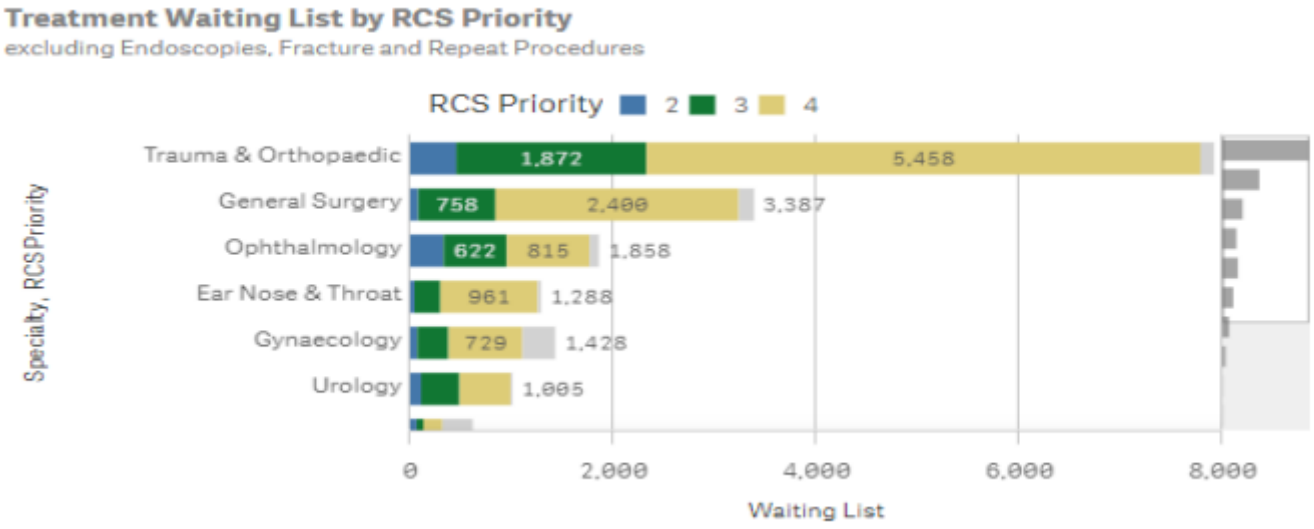
c. Approval of plan arrangements

2.16 Individual plans are reviewed and approved by service and senior managers within the directorates / divisions. We confirmed for a sample selected that this had been completed. There is an ongoing review of the appropriateness of the arrangements.

2.17 We also confirmed that whilst the Gold, Silver and Bronze Command Structure was in operation, reporting of the restarting of services took place via this route too.

d. Patient centred care

2.18 The Royal College of Surgeons (RCS) issued guidance over the prioritisation of patients that are most at risk from harm. We confirmed that the Health Board applied this criterion to the waiting list and patients were assigned a risk rating of either P2 (highest), P3 or P4. We confirmed that 13% of patients were identified as P2. The graph below illustrates the allocation between the specialities.



e. A consistent approach

2.19 As referenced above in paragraph 2.2, the approach taken across all service areas is through the completion of the Checklist, which encompasses the requirements set out by the Welsh Government. We reviewed our sample selected to determine if this was consistently applied. We identified no issues.

Conclusion:

2.20 Whilst the plans are achieving an increased capacity, we cannot provide complete assurance that the plans will deliver and reduce the waiting lists to pre-pandemic levels in the shortest amount of time possible. However, we can provide **reasonable assurance** that the actions undertaken to prioritise the restarting of services are appropriate in the current climate.

Audit objective 3: Plans are regularly monitored, with assurance provided to the Board.

2.21 Each service area regularly tracks the impact of the plans through the Divisional Performance Highlight Reports. This is updated on a weekly basis and tracks actual versus planned delivery. We reviewed a sample of these for each service area tested and found no issues.

2.22 The performance of capacity delivery is incorporated into the Integrated Performance Report and reported to the Board on a regular basis. However, whilst waiting times and volume (in particular RTT delivery) are regularly reported to the Board, there is no reporting on performance of the expected delivery at a service level basis. This would help provide assurance to the Board of the effectiveness of the plans underway and to identify specific areas of improvement required.

2.23 This could be further enhanced with delivery matched to the proportion of RCS priority ratings awaiting treatment. This would help provide a triangulation of key risks throughout the number of patients awaiting treatment. We have raised the above points as **matter arising two.**

Conclusion:

2.24 We have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter arising 1: Review of Action Plans			Impact
We found plans that set out, at a high level, projections for clearing the waiting list of treatments required, which is based on capacity. However, they do not provide details of a general timeframe / milestones to achieve the clearance required. During the pandemic, this would have been very difficult due to shifting challenges. However, as the operational pressures reduce, the Health Board should develop plans setting out a revised timeframe, across each service area of the return to pre-pandemic waiting list levels.			Potential risk of: • Waiting lists increasing further, due to insufficient capacity to maintain and service the backlog of patients. • Patient harm due to delayed treatment.
Recommendations			**Priority**
1.1	The Health Board should review and update service delivery plans to set out the revised delivery timeframes for addressing the current backlog of RTT waiting lists.		**Medium**
Management response		**Target Date**	**Responsible Officer**
1.1	Ongoing work using SFN data in collaboration with Planning to determine the modelling requirements. We will update monthly trajectories in line with the quarterly update process agreed with the IMTP	July 2022 (following Qtr 1 submission)	Director of Operations (Interim) /Director of Planning, Digital and IT

	Plans assessed weekly against trajectories – reported monthly to Executive team and Board via the Integrated Performance report		

Matter arising 2: Performance Information	Impact
We found regular reporting of delivery to the Board and monitoring at a divisional level. However, the Performance Report does not include delivery against expected planned output aligned to individual service plans (i.e. are they successfully achieving the desired results) or whether the plans / actions are on target with the timeframe to bring the waiting lists back to pre-pandemic levels. There is comprehensive reporting regarding waiting list volumes, waiting times, initiatives underway, but no reporting is undertaken over effectiveness of planned actions. Whilst the pandemic has impacted considerably, as services resume towards full capacity there is an opportunity to profile increased delivery and monitor the success of actions completed. This may also serve as a source of assurance to the Board that appropriate action and results are being delivered over the resumption of services.	Potential risk of: • Waiting lists increasing further, due to insufficient capacity to maintain and service the backlog of patients. • Patient harm due to delayed treatment. • Actions undertaken may not be the best use of resources available.

Recommendations		Priority
2.1	The Health Board should review the current performance reporting for the resumption of services and incorporate metrics to monitor the effectiveness of actions undertaken and the profile of the overall reduction of the waiting lists.	**Medium**

Management response		Target Date	Responsible Officer
2.1	Performance is measured weekly actual v planned and set against the agreed trajectories as per IMTP	End of June 2022	Director of Operations (Interim) / Director of Planning, Digital and IT

	Weekly performance meetings reinstated with Divisions and chaired by the Director of Operations		

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Financial Sustainability
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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Contents

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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 review the key financial management controls within Aneurin Bevan University Health Board (the Health Board), including the development and monitoring of the savings required for financial sustainability.

Overview

We have provided **reasonable assurance** over the area under review.

Whilst we did not identify any significant matters for reporting, we noted that:

- the Health Board needs to ensure alignment between its Transformation Programmes, IMTP Core Priorities and Priority Programmes; and
- improvements could be made in the development and approval of Transformation Projects, including the need to develop measurement criteria that are SMART and accounting structures that capture the more complex multi-service impact of these projects in support of the approval process.

All matters arising are detailed in Appendix A.

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	Service areas have sustainable budget plans, with effective monitoring and scrutiny in place, with savings plans / arrangements identified if required to produce a balanced budget	Reasonable
2	Where financial sustainability is not achieved, a process of escalation and recovery (consistent with the Budgetary Control Policy) is completed to identify the underlying reasons and to redress the funding balance over an appropriate timescale	Substantial
3	Financial oversight of strategic / transformational projects is in place to maintain a sustainable position for the Health Board	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
4.1	Alignment of Transformation Projects to IMTP Core Priorities and Priority Programmes	3	Design	Medium
4.2	Measurement criteria and accounting structures for Transformation projects	3	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 Aneurin Bevan University Health Board (the Health Board) has historically received a funding allocation from the Welsh Government of circa £1.4 billion per annum.

1.2 During 2020/21, the Health Board completed significant transformation projects, both in response to the pandemic and relating to the implementation of its Clinical Futures strategy.

1.3 For 2021/22, the funding from Welsh Government has increased significantly to address cost pressures incurred due to the Covid-19 pandemic and support future recovery. The funding allocation for 2021/22 was circa £1.6 billion.

1.4 Prior to the pandemic, recurrent savings of £33m were planned for 2020/21. Whilst this process was temporarily restricted by the effects of the pandemic, it was expected to resume within the next financial year. However, as the impact of the Covid pandemic rolled into 2021/22, the underlying recurrent deficit position is expected to remain constant at circa £21 million, with any cash savings being used to support services in year. Reduction in the recurrent deficit position is planned for 2022/23.

1.5 The key risks considered in this review are:

- increased financial costs due to insufficient / inappropriate planning;
- insufficient funding for large transformational projects, including Clinical Futures;
- increased patient waiting times, due to insufficient funding for some service areas;
- decisions undertaken without sufficient financial scrutiny;
- longer term financial plans are not developed in a rigorous manner; and
- corrective action for currently unsustainable services is not taken in sufficient time to ensure their sustainability.

1.6 This audit has focused on the 2021/22 financial year, reviewing the budgetary process and the savings plans in place, and assessing the approval, planning and establishment of those transformation projects approved in 2021/22 for implementation in 2022/23 as part of the Integrated Medium-Term Plan (IMTP) process.

2. Detailed Audit Findings

Audit objective 1: Service areas have sustainable budget plans, with effective monitoring and scrutiny in place, with savings plans / arrangements identified if required to produce a balanced budget

2.1 The latest approved IMTP for 2019/20 – 2021/22 was submitted to Welsh Government by 31st January 2019. The Board received an overview of the document which was supported by Service Change Plans and supporting appendices, including a detailed Quality Assurance and Improvement Plan. The Director of Finance, Procurement & Value advised that the Welsh Government expectation was of financial balance across the 3 years.

2.2 Due to the pandemic, Welsh Government suspended the process for annually refreshing the IMTP in 2020/21 and 2021/22. In 2021/22 the Health Board was entering its third year of the last approved IMTP. Welsh Government requested an Annual Plan for 2021/22 in place of a refreshed three-year IMTP.

2.3 A draft plan was submitted to Welsh Government following review by the Board on 24th March 2021. The Health Board set a revenue budget prior to the beginning of 2021/22, in accordance with its Standing Financial Instructions, allocating resources based on delivering the priorities within the Annual Plan.

2.4 The Board formally approved the Final Annual Plan for 2021/22 at its meeting held on 28th July 2021.

2.5 As the Health Board moved into a pandemic response and recovery phase, there was uncertainty around the level of funding for the second half of 2021/22. Service and workforce plans continued to be flexed to meet service demands, spending plans were being adjusted, and the delivery of savings required was, in part, dependent on the service changes planned as part of delivering the Annual Plan priorities. On this basis, the Board agreed to review revenue budgets, including associated funding and spend plans, on a quarterly basis in 2021/22.

2.6 The Annual Plan included comment in the financial section noting that the financial plan is based on a financial assessment of the service and workforce plans developed for 2021/22 and that it assumes the delivery of financial balance within available funding, recognising the increased risk of delivering savings not achieved during the 2020/21 financial year as well as the ongoing savings requirement.

2.7 The current Budgetary Control Policy (the Policy) and Financial Control Procedure, issue 3, (the FCP) was approved by the Audit Committee and issued in July 2019. It is due a review by the document owner (Director of Finance, Procurement & Value) by July 2022.

2.8 Our review of budgetary processes adopted by the Board, the Executive, directorates and divisions during 2021/22 identified that, due to the pandemic, the budget monitoring and reporting processes in the divisions had been flexed by the

various directors. Whilst it was evident that appropriate controls were in place given the circumstances, the processes adopted were not fully compliant with the FCP:

a. **Budget acceptance not always evidenced:** We verified that the original 2021/22 budgets were communicated to Executive Directors and each Executive Director had formally confirmed acceptance. However, for the subsequent quarterly budget revisions, we noted that the communication and acceptance of delegated budgets was not always evidenced in accordance with the FCP, being substituted by an informal monthly revision process between budget holders and their Business Partner Accountants and formal Board approval of the quarterly revised annual budget.

b. **Automated Finance Business Information (FBI) application:** the FCP does not include reference to the automated processes now provided by the FBI application, in terms of providing budget holders with actual and budgetary data.

c. **Financial review not always formally evidenced due to lack of meeting minutes:** for one of the two divisions sampled, whilst meeting agendas are used, the Divisional Management Team (DMT) has not maintained minutes of its meetings during the pandemic; and

d. **Clarity in the virement process:** whilst virements were not common in 2021/22, we identified that a major reallocation of services between divisions was approved at Executive Board but not formally reported to the Board, there being a lack of clarity in the FCP as to whether such virements require formal reporting.

2.9 Whilst control was evident in these instances, any revision to the Policy and FCP needs to allow for the flexibility that may be required in certain circumstances to ensure that control can be exercised in these events. This has been raised as matter arising one in Appendix A.

2.10 We undertook a review of the training provided to newly appointed budget holders. A process exists to ensure that, when budget holders are established on Oracle, they are invited to a Health Board budgetary control presentation. However, we noted that the FBI Overview Session Attendance List provided listed 42 new budget holders, of whom 14 were reported as not having attended the training, despite their line managers being informed of non-attendance. There is a need to strengthen this process to ensure that attendance is the norm and not seen as optional. This has been raised as matter arising two in Appendix A. Whilst budget holders may not always attend the training, support is provided through the Business Partner Accountants (BPAs), and we note that the main budget holders are all Executive Directors who are all experienced budget holders.

2.11 As 2021/22 progressed, the Health Board noted that the forecast year end 2021/22 underlying recurrent financial position (to be carried forward into 2022/23) was a deficit of £20.8m. This is consistent with the underlying position brought forward from 2020/21, indicating that the underlying financial position of the Health Board is not improving or planned to improve in 2021/22. All funding is being used for in year cost pressures and the underlying recurrent financial pressure the Health Board faces is, therefore, not reducing. To achieve this balance, recurrent savings of £13.6m are required, as reported in the Director of Finance Procurement & Value's report to the Board. These savings comprise of many plans across the Health Board.

2.12 We reviewed the monitoring and reporting processes for savings plans and noted that, whilst the Financial Performance Reports to the Board contain analysis around savings delivery, this section could be enhanced to provide greater oversight and accountability going forward – further detail is provided in matter arising three.

2.13 Savings are not separately budgeted for, with savings embedded in existing operational budgets. Whilst savings plans are monitored and reported on within the divisional management information (MI) reporting mechanism each month, the savings plans information in the MI is not integrated with the rest of the MI reporting. We have commented on the need to report savings analysed by key generic savings activities across the Health Board - further detail is provided in matter arising three.

Conclusion:

2.14 Three matters arising have been reported in this area: the current Budgetary Control Policy and Financial Control Procedure review (low priority), training of newly appointed budget holders (low priority), and greater integration of savings plans within the budget structure (low priority). Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: Where financial sustainability is not achieved, a process of escalation and recovery (consistent with the Budgetary Control Policy) is completed to identify the underlying reasons and to redress the funding balance over an appropriate timescale

2.15 Our review of a sample of two divisions identified that the actual 2021/22 cumulative position and forecast for year-end at the time of our audit (March-April 2022) reflected budget underspends. This has reduced the pressure on the divisions to deliver savings targets and, as such, less focus has been given to the delivery of savings than in previous years. This position may not be repeated in future years, therefore, going forward, greater focus will be required on the reporting and monitoring of savings plans and for identified underachievement to be actively addressed in a timely manner.

2.16 We were able to verify that savings plan performance was included within the monthly budget holder MI for both divisions. We also discussed with the two divisional BPAs how overspends would be managed. However, due to the underspend position of both divisions, we could not undertake testing around actions taken in response to overspends or the escalation process for significant underspends.

Conclusion:

2.17 There is an established process for the monitoring, reporting and addressing overspends which threaten financial sustainability, although we could not test the process for addressing underspends as we did not identify any during the audit. No matters for reporting were identified in this area. Noting the limited scope of testing we were able to undertake, we have provided **substantial assurance** over this audit objective.

Audit objective 3: Financial oversight of strategic / transformational projects is in place to maintain a sustainable position for the Health Board.

2.18 Ten Transformation Projects have been approved by the Executive Board as part of the 2022/23-2025/26 IMTP planning process, with projects due to be implemented in 2022/23. Our review of two of the Transformation Project processes in the approval and development phase has identified the following four issues that have been raised as matter arising four in Appendix A.

a. **Alignment with priorities:** In addition to the Transformation Projects, the Health Board's Health System Leadership Group (HLSG) was working on IMTP Core Priorities, and its Project Management Office has presented Priority Programmes as part of the evolving Clinical Futures programme in 2021/22. These two key sources for driving change need to be reviewed to ensure that they are aligned and that Health Board priorities are consistently represented.

b. **Ensuring fully developed projects specifics prior to approval:** Some of the Transformation Projects are complex in nature, with costs and benefits spread across more than one Health Board service (sometimes this also crosses divisional boundaries). For the projects sampled, the following were being determined after the Health Board had approved the project:

   i. SMART criteria for measuring success; and

   ii. accounting structures and principles.

   In some cases, costs may be incurred in one service area and benefits arise in other service areas, requiring a Health Board view of such projects. There is a need to develop project specifics further as part of the approval process.

c. **Expectations on project purpose:** Transformation Projects are not primarily being driven by obvious budgetary cash savings. Benefits of

improved efficiency of service and improved patient and staff experiences are also key drivers behind the approval of these projects, together with the opportunity for related additional cost avoidance. Transformation Projects need to be financially sustainable with agreed sources of funding comprising redeployment of existing budgets and/or specific non-recurrent funding.

d. **Short-term funding for projects:** There is an inherent risk that elements of non-recurrent funding of Transformation Projects may not be forthcoming in future years. Any decision to continue projects without an identified recurring source of income risks financial sustainability in future years. Where resources are limited, there may be a need to prioritise Transformation Projects, requiring the ability to compare projects.

Conclusion:

2.19 The approved Transformation Projects have been supported by papers that summarise the cost and benefits (cash and non-cash) but the complexity of the impact of such projects requires the development of a well-defined measurement and accounting structure which allows for projects to be compared and contrasted, as well as being able to monitor progress against a target of "what success looks like". Transformation Projects are not solely savings plans but offer improvement in services to patients and staff that may result in greater efficiencies and the possibility of future cost avoidance. One medium priority matter has been raised on the four structural issues noted above. Noting the limited testing we were able to undertake (due to the Transformation Projects not yet being implemented), we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Update of Budgetary Control Policy and Financial Control Procedure (Design)	Impact
Budgetary Control Policy (the Policy) and Financial Control Procedure (FCP), issue 3, is due for review by the document owner, the Director of Finance, Procurement & Value, by 19 July 2022. Whilst appropriate controls were in place throughout the period under review, our review of budgetary control practices identified instances where the divisions were not always fully compliant with the FCP due to processes being flexed by the directors during the pandemic. Instances noted included: **Budget acceptance not always evidenced:** The FCP requires budget delegations to be evidenced by letters that cascade down form the Chief Executive to budget holders, with acceptance letters being returned up the structure to acknowledge and accept delegations made. In 2021/22, due to the inherent uncertainty in funding, the Board took the prudent approach to review, update and approve the annual budget each quarter. Whilst we verified that the original 2021/22 budgets were formally acknowledged via budget acceptance letters from the Executive Directors, we identified that the delegation letter and acceptance process was not always completed for the subsequent quarterly annual budget updates. Instead, budget holders were informed through the monthly finance meetings with their BPA and the Board approved the quarterly updates to the annual budget. **Automated FBI application:** The FCP does not reflect the current automated FBI application that provides budget and actual information to each budget holder, making compliance with the FCP impractical. **Financial review not always evidenced due to lack of meeting minutes:** for one of the two divisions sampled, whilst meeting agendas are used, the Divisional Management Team (DMT) has not maintained minutes of its meetings during the pandemic; and **Clarity in the virement process:** Whilst there was little evidence of virements occurring during the year in the sample Divisions reviewed, it was noted that a virement relating to the transfer of services between directorates during 2021/22 had been discussed and approved at Executive Board level but the budget amounts had not been reported in detail or the Board informed, as detailed in the document.	Potential risk of: • non-compliance with FCPs potentially resulting in loss of financial control.

Recommendations	Priority
1.1 The upcoming review of the Budgetary Control Policy and Financial Control Procedure, issue 3, should consider establishing effective control procedures that allow for practical compliance across the Health Board and that	Low

any accepted deviation from defined procedures is documented, such that authorisation of such changes is defined and communicated. Areas for consideration include:

1.1.1 whether the formal budget delegation and acceptance letter process applied to the initial annual budget needs to be applied to any significant budget changes made during the financial year;
1.1.2 should the monthly budget review and reporting processes reflect the specific needs of each division / directorate, given an assessment of the variation in budget risk between the divisions; and
1.1.3 whether each virement requires formal approval by the Board or could delegation of authority be given to the Executive Team with the subsequent notification to the Board, subject to appropriate financial limits.

The full findings of this review should be considered when the documents are reviewed.

Management responses		Target Date	Responsible Officer
1.1.1	Delegation of such large £'s during the year is relatively recent and became apparent during Covid due to late notice of confirmation and receipt of funding. We would normally expect to issue delegation letters only at the start of the financial year, when the vast majority of budgets are delegated, recognising that these are at a point in time, there will always be subsequent changes as new funding is agreed. The delegation is approved by the CEO and the expectations of managing that budget are clear in the initial letter and FCP's. The FCP will be reviewed and revised to reflect the clarity of this process.	August 2022	Assistant Finance Director Financial Planning / Head of Governance
1.1.2	The Board financial report includes an overview of each budget head. 'FBI' provides the standard ABUHB Budget holder reports in detail. No action proposed.	N/A	N/A
1.1.3	The budget is delegated through the Board and CEO to the Executive, to deliver the agreed priorities. There should be no need to refer changes to the Board as they have already delegated the authority of its management. However, where there are significant changes to the proposed usage which are outside of agreed priorities and delegation arrangements, there is an expectation that the Board is notified and potentially approval sought. Continuous review of proposed significant budget changes is to be performed as part of normal financial control and reporting. We will implement a reporting process for budget virements in excess of £250k to Board.	On going (from June 2022)	All Assistant Finance Directors

Matter arising 2: Provision of Budget Holder Training (Operation)	Impact
Budget related training is provided at various occasions, including within the Finance induction for all new starters and specific budget related training for new budget holders. Our review of the record of those offered training in recent months compared to those who had subsequently attended training indicated that take up was low. Our review of the FBI Overview Session Attendance List provided identified 42 new budget holders, of whom 14 were reported as not having attended training. We understand line managers are informed of any non-attendance. Not all new budget holders necessarily need to attend this training to be proficient, for example they may already be an experienced budget holder. Additionally, Business Partner Accountants (BPAs) can assess individual budget holder capabilities and provide one-to-one support where necessary. However, training requirements (and the delivery thereof) need to be more closely controlled and evidenced so that assurance can be provided that all budget holders are proficient in the budgetary control process.	Potential risk of the budget process not operating as defined due to lack of understanding of staff potentially resulting in: • poor financial control limiting ability of management to address issues and make informed decisions in year, impacting service delivery and sustainability; and, • medium and longer-term planning based on historic budgetary views that are flawed.

Recommendations	Priority
2.1 The Director of Finance, Procurement & Value should ensure that the budgetary control training provided is appropriate and that each staff member receives an adequate level of training to address their needs and fulfil their role. This should include the inclusion of budgetary control training in staff PADRs (where appropriate), monitoring attendance at budgetary control training sessions, and clear, documented justification where a budget holder does not need to attend the training (for example, if they had significant budgetary control experience in a previous role).	**Low**

Management responses	Target Date	Responsible Officer
2.1 Financial and budget training is part of induction training sessions and FBI training is provided in addition to encouraging budget holders to attend. Non attendance reports are provided to line managers and Business Partner Accountants teams to follow up. Reminders will be sent to all budget holders and line managers to ensure attendance	August 2022	Assistant Finance Director (PCMH) / CPD and Training Lead

at budget training. Consideration will be given to proposing budget training be made a mandatory course, possibly on ESR or another platform.

Matter arising 3: Savings Plans (Design)	Impact
Whilst the Financial Performance Reports to the Board contain analysis around savings delivery, this reporting could be enhanced to provide greater oversight and accountability around savings plans going forward. Current reporting focuses predominantly on achievement of the overarching savings targets, but could, for example, be expanded to provide details of divisional performance. Greater emphasis could also be placed on achievement to date, alongside consideration of forecast savings. Savings are not separately budgeted for, with savings embedded in existing operational budgets which are monitored and reported on. Review of forecast savings plans against actual delivery of savings is not managed wholly within the budgetary process, requiring evaluation of savings plans to be performed by Business Partner Accountants and then separately reported as part of Divisional MI reporting. Whilst savings plans are monitored and reported on within the Divisional MI reporting mechanism each month, the savings plans information in the MI is not integrated with the rest of the MI reporting. A review of a sample of divisions identified that the actual 2021/22 cumulative position and forecast for year-end reflected budget underspends, reducing the pressure to deliver savings plans to reach targets or overachieve. Such a financial position may not be repeated in future years requiring greater focus on the reporting and monitoring of the delivery of actual savings forecast throughout each quarter and for any identified underachievement to be actively addressed in year. As noted in the previous paragraph, to support the delivery of a financially sustainable position the Health Board will need to deliver recurrent savings into the future from 2022/23 onwards to offset the forecast recurrent deficit of £21m at 31st March 2022.	Potential risk of: • as cost pressures increase in future years, delivery of a balanced recurrent cost funded budget and associated savings plans will become more challenging, resulting in a greater likelihood of an annual deficit and associated increase in patient waiting times and reduced services.

Recommendations	Priority
3.1 Going forward, the Director of Finance, Procurement & Value should consider enhancing / expanding the Board reporting around the delivery of savings plans, as pressure to deliver a sustainable balanced budget becomes ever increasing.	Low
3.2 Whilst savings are not separately budgeted for, the Director of Finance, Procurement & Values should consider the reporting of savings achieved analysed by key generic savings activities across the Health Board. For example, an analysis of savings planned and achieved from the more effective management of variable pay costs across the Health Board, or the avoidance of additional costs as a result of efficiencies achieved.	Low

Management response	Target Date	Responsible Officer
3.1 Savings information is provided in summary in the Board Financial Report, in addition the appendix provides a line by line analysis. The Finance & Performance Committee will receive a more detailed savings analysis as part of regular agenda updates, including analysis of recurrent, non-recurrent and delivery performance.	July 2022	Assistant Finance Director – Financial Planning
3.2 See response to 3.1 above.		

Matter arising 4: Transformation Projects (Design)	Impact
Ten Transformation Projects have been approved by the Executive Board as part of the current IMTP process and are due to commence in 2022/23. Our audit work identified the following: **Alignment with priorities:** In addition to the Transformation Programmes, the Health Board's Health System Leadership Group was working on IMTP Core Priorities, and its Project Management Office has presented Priority Programmes as part of the evolving Clinical Futures programme in 2021/22. These two key sources for driving change need to be reviewed to ensure that they are aligned and that Health Board priorities are consistently represented. **Ensuring fully developed project specifics prior to approval:** At the time of the audit, none of the Transformation Projects had gone live although enabling actions had been taken. Some of the Transformational Projects are complex in nature, with costs and benefits spread across Health Board services. It was not evident that "what success looks like" had been defined for each project, with SMART criteria for measuring projects and the accounting structures being developed after projects had been approved. In some cases, costs may be incurred in one service area and benefits arise in other service areas, requiring an overarching Health Board view of such projects. However, it was noted that Transformation Projects are to be formally reviewed at the end of 2022/23 with a view to their continuance, amendment or cancelation as appropriate. There is a need to develop project specifics further as part of the approval process. **Expectations on project purpose:** Transformation Projects are not primarily being driven by obvious budgetary cash savings. Benefits of improved efficiency of service and improved patient and staff experiences are also key drivers behind the approval of projects, together with the opportunity for related additional cost avoidance. Expectation that Transformation Projects will deliver immediate, measurable improvement in the Health Board budget needs to be managed. Whilst project cash outlays are established, the ability to identify and evaluate the impact of benefits from a non-cash budget perspective are far more complex. **Short-term funding for projects:** Upfront funding of Transformation Projects has been part secured from the Welsh Government, albeit as part of an annual funding process, there being no guarantees of repeat funding in future years. Transformation Project commitments are therefore to be established on an annual basis and this may adversely impact staff recruitment numbers and quality, and may result in more expensive, shorter term resource costs. However, it was noted that Transformation Projects are to be formally reviewed at the end of 2022/23 with a view to their continuance, amendment or cancelation and that this may require the Health Board to prioritise projects if sustainable available funding sources are not identified in 2023/24.	Potential risk of: • Transformation Projects not being aligned with Priority Programmes of Clinical Futures development, resulting in dysfunctional activity; • Projects not being subject to SMART criteria limiting objective assessment of benefits realisation; and • Short-term funding of transformational change limits effective medium- and longer-term planning and threatens financial sustainability if funding streams are not identified in future years.

Recommendations		Priority
4.1	The Health Board should ensure clear alignment between its Transformation Projects, IMTP Core Priorities and Priority Programmes.	Medium
4.2	Before Transformation Projects are put forward for review and approval, the Health Board should ensure that SMART criteria for measuring a project's development and "what success looks like" are defined, and the accounting structures to be applied to record each project are documented and subject to review.	Medium
4.3	The Health Board should ensure that Transformation Projects are expressed as financially sustainable with identified funding from redeployment of existing budgets and/or non-recurrent funding sources.	Low
4.4	There is an inherent risk that elements of non-recurrent funding of Transformation Projects are not forthcoming in future years. Any decision to continue projects without an identified recurring source of income risks financial sustainability in future years. Therefore, the Health Board should consider developing a clear mechanism to compare projects to allow for clear decision making where funding resources are limited and there may be a need to prioritise Transformation Projects.	Low

Management response		Target Date	Responsible Officer
4.1	Agreed. Implemented as part of IMTP 22/23 – 24/25	Actioned	N/A
4.2	Agreed. Each Programme should have benefits criteria agreed by its own Programme Governance and signed off by the Clinical Futures Programme Board (HSLG). The SRO should lead the development of the benefits measures with support from business partners and programme leads	July 2022	Clinical Futures Director
	Finance Leads to be allocated to IMTP priorities programmes. Accounting of efficiency and savings progress to be captured in financial management information packs.	July 2022	Interim Director of Finance and Procurement

4.3	Agreed in principle. Recommendations from programme workstreams will be considered through organisation planning, reporting and governance arrangements ultimately to Executive Team and the Board.	June 2022	Executive Programme Leads
4.4	Agreed. A prioritisation process to support resource allocation as part of IMTP development is being developed by the Executive team for consideration by the Board.	June 2022	Interim Director of Finance and Procurement

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Medicines Management
Final Internal Audit Report

June 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

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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.

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Executive Summary

Purpose

The review sought to provide Aneurin Bevan University Health Board ('the Health Board') with assurance that there are adequate arrangements in place for the management, administration and storage of controlled drugs.

Overview

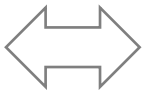
We have issued reasonable assurance on this area.

The matters requiring management attention include:

- ward stock takes not being completed weekly in line with policy;
- the Pharmacy Team not achieving 100% compliance with six monthly stock checks in line with policy; and
- Policy for the Management of Controlled Drugs requiring updating.

Other recommendation points are included within the detail of the report. Overall, we reconciled 109 drugs across 23 areas at five different Health Board sites, with no stock count exceptions noted. Although there are areas for improvement, we found staff undertake their responsibility for the management of controlled drugs professionally.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 Incorporated into the Divisional Audit - Unscheduled Care Wards (2016/17)

Assurance summary[1]

Assurance objectives		Assurance
1	Governance	Reasonable
2	Controlled drugs policy	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
2	Policy for the Management of Controlled Drugs update	2	Design	Medium
2	Weekly controlled drug stock takes	2	Operation	Medium

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

3	Omnicell guidance	2	Design	Medium
4	Pharmacy stock reconciliations and expired drugs	2	Operation	Medium

1. Introduction

1.1 The Medicines Management review was completed in line with the 2021/22 Internal Audit Plan. The Medicines Act 1968 was published to provide a framework for the management of drugs. In addition to this legislation, some medicines are also governed by the Misuse of Drugs Act 1971 and associated regulations such as the Misuse of Drugs Regulations 2001. Medicines that are listed in Schedules 1-5 of the Misuse of Drugs Regulations 2001 (and subsequent amendments) are known as 'controlled drugs'.

1.2 Aneurin Bevan University Health Board (the 'Health Board') has a Policy for the Management of Controlled Drugs (the 'Policy'). It establishes the standards of practice to be adopted by all Health Board staff on the procedures relating to the safe and secure handling and storage of controlled drugs.

1.3 The Chief Executive has overall responsibility for the management of medicines in the Health Board. This responsibility has been delegated to the Health Board's Medical Director.

1.4 The key risks considered in this review are:

- lack of policies and procedures that outline the arrangements and responsibilities for controlled drugs;
- ineffective controls leading to missing drugs / theft; and
- lack of oversight of incidents / issues relating to controlled drugs within the Health Board.

1.5 As part of the audit, we reviewed a range of speciality wards at multiple hospitals across the Health Board. The hospitals and corresponding wards visited include:

- Royal Gwent Hospital – Wards C7 West, C6 East, D2 West, D5 West, C4 East;
- Grange University Hospital – Wards A0, B0, CCU, ACU (B2), C3, C4, and Theatres 6, 7, 8, Recovery;
- Nevill Hall Hospital – Wards 4/3, 4/4/, 3/3, Minors;
- Ysbyty Ystrad Fawr – Wards 2/2 Bargoed, Birth Centre; and
- Ysbyty Aneurin Bevan – Wards Tyleri, Carn Y Cefn.

2. Detailed Audit Findings

Audit objective 1: Governance for the management of controlled drugs

2.1 The Gwent Controlled Drugs Local Intelligence Network (the 'Group') is responsible for sharing intelligence regarding the use and potential abuse of controlled drugs (CDs) that are purchased or ordered, prescribed, dispensed, handled and administered within the Health Board's geographical region.

2.2 We reviewed the terms of reference (ToR) of the Group. We found that it stated meetings will be held quarterly at the discretion of the Chairperson, but no less

than three times per year. However, due to the Covid-19 pandemic and a change in Medical Director, there had been a gap between January 2020 and September 2021. During this time, the Medicines Safety Officer and the Senior Primary Care Pharmacist still received Datix alerts.

2.3 Meetings have now recommenced and are quarterly.

2.4 Roles and responsibilities of the Group were noted in the ToR as well as setting out information regarding the Chair, how the membership was comprised, and what the quoracy requirements are. We reviewed meeting minutes against the requirements of the ToR.

2.5 Meetings were quorate at the January 2020 and 2022 meetings, but not at the September 2021 meeting. The ToR states a representative from the Police must be in attendance, but no representative was present at this meeting. However, an update to the meeting had been provided by the Police which was delivered by the Senior Primary Care Pharmacist. We have raised this as **matter arising 1**.

2.6 We identified from minutes that the Group maintains actions logs and this is noted as good practice. We would recommend that the requirements for both minutes and action logs be included within the ToR, when next reviewed. We have raised this within **matter arising 1.**

2.7 We analysed the aims and objectives of the Group and compared them to the agenda items in meetings to consider how they were delivering their objectives. There were examples of subjects discussed that indicated coverage of the key objectives stated in the ToR. Additionally, we noted the review and discussion of individual incidents and themes at the January 2022 Group meeting we attended. From observing this meeting and reviewing the minutes and summary tabs of Datix spreadsheets, we confirmed that the Health Board identifies themes, trends and patterns of incidents.

Conclusion:

2.8 Although there has been some non-compliance with the ToR, individual incidents and themes are discussed at the Group meetings in sufficient degree, therefore, we have provided **reasonable assurance** over this objective.

Audit objective 2: Adherence to the Health Board's controlled drugs policy

Policy

2.9 There is a Policy for the Management of Controlled Drugs (the 'Policy') in place which is available to staff via the intranet. This is in date and is not due for review until November 2023. The Policy sets out the standards of practice to be adopted by all Health Board staff on the procedures relating to the safe and secure handling and storage of controlled drugs.

2.10 Although the policy is in date, due to changes in practices since the pandemic and the opening of the new Grange University Hospital the Policy will be reviewed this financial year (2022/23). We identified some non-compliances with the Policy. At the next review date of the Policy, the Health Board should review the Policy to see if all of the content remains relevant. We have raised this as **matter arising 2**.

2.11 The results of our compliance testing with the Policy are noted below (total of 19 wards). The four Theatre areas have been dealt with in a separate table. Red grading is less than 50% compliant, amber is 51-75% compliant and green is 76-100% compliant.

2.12

Policy Reference (Wards Testing)	**Sample % compliant**
13.1 – controlled drugs keys held on their own	0%
12.1 – red ink used for stock reconciliation	32%
16.0 – only one register should be used at a time	89%
6.4 – appropriate stock levels are maintained	N/A – no standard stock levels kept
10.1 – the order book must be kept in a locked place	63%
14.0 – where possible patient-controlled drugs should be stored on a separate shelf	0%
14.0 – [patient] details should be recorded in the back of the controlled drugs register	68%
12.1 – Balance checks of all stock must be carried out at least once every week	74% - but all completed within one month
13.2 – Registers must be bound (not loose leaf) with sequentially numbered pages	100%
13.1 – Keys for the controlled drugs cupboard must be held on the person of the designated person in charge	100%
12.1 – Reconciliation of register balances…carried out…a minimum of every six months by pharmacy staff	79% **- matter arising 4**

2.13 Where the non-compliances are rated red above, we understand that this may be due to the practicalities of the work environment, for example a lack of space or keeping the controlled drugs key with other keys for ease of use. Overall, these non-compliances pose minimal risk, such as not marking when a stock count was completed in red ink. Therefore, we have not raised a specific finding regarding this.

2.14 We also reviewed compliance with the Policy within the Theatres service area, based at the GUH. Three theatres were selected, along with Theatre Recovery. The compliance rate for Theatres is noted below:

2.15

Policy Reference (Theatre Testing)	**Sample % compliant**
13.1 – controlled drugs keys held on their own	100%
12.1 – red ink used for stock reconciliation	100%
16.0 – only one register should be used at a time	100%
6.4 – appropriate stock levels are maintained	N/A – no standard stock levels kept
10.1 – the order book must be kept in a locked place	75% - not in Theatre Recovery
14.0 – where possible patient-controlled drugs should be stored on a sperate shelf	N/A
14.0 – [patient] details should be recorded in the back of the controlled drugs register	N/A
12.1 – Balance checks of all stock must be carried out at least once every week	100% - they are carried out twice daily
13.2 – Registers must be bound (not loose leaf) with sequentially numbered pages	100%
13.1 – Keys for the controlled drugs cupboard must be held on the person of the designated person in charge	100%
12.1 – Reconciliation of register balances…carried out…a minimum of every six months by pharmacy staff	0% - matter arising 4

Controlled drugs stock testing

2.16 12.1 within the Policy states that checks of all stock must be carried out at least once every week by two authorised staff and then that check documented and signed by both staff. Across all sites tested there was a compliance rate of 78% for weekly stock checks.

2.17 Across the 23 areas visited we reconciled 109 drugs throughout these areas to the Controlled Drugs Register. Our sample compliance findings are below:

2.18

Stock reconciliation testing	**Sample % compliant**
Controlled drugs register fully complete	100%

List of controlled drugs at front of register	100%
Two authorised staff complete register	100%
Running balance maintained for each controlled drug	100%
Entries reconcile	100%

2.19 We identified no issues when completing our sample reconciliation testing across the five sites.

Omnicell

2.20 The areas tested used either a controlled drugs cabinet (i.e., a locked cabinet that is manually opened) to store drugs or an automated medication cabinet, called an Omnicell that also contains other non-controlled drugs.

2.21 Where an Omnicell is used, authorised staff can access the controlled drugs via fingerprint technology rather than keys. Two fingerprints are required for the removal of controlled drugs (the user and a witness). The name of the controlled drug is typed into the Omnicell keypad and then the required drawer where the drug is held flashes green and unlocks. Inside the draw are compartments each holding separate drugs, the required compartment flashes green once the draw is opened.

2.22 We noted issues with some staff using the Omnicell machines on their wards. We observed some non-substantive staff, who had access to the Omnicell machine, who were unaware how to adequately use the automated system. We witnessed staff ignore the clear green flashing lights identifying where the required drug was being stored, with some staff trying to pull open locked draws and opening up multiple compartments within drawers before locating the requested drug.

2.23 We identified an Omnicell machine on one ward registering 15 discrepancies. We queried this with the Ward Manager who suggested that an update to the machine had been causing issues and a lack of time meant the discrepancies had not been investigated. An Omnicell stock discrepancy with a controlled drug (Morphine Sulphate ampoules) had been noted by the Ward Manager on the day of our testing (but prior to us arriving at site).

2.24 18 ampoules had been listed in the Omnicell machine, but only nine were available. After checking the Controlled Drugs Book (the required legal document for control drug records), it was confirmed that the figure of nine was correct and the Omnicell machine was adjusted down. No further investigation had taken place.

2.25 When on site we counted the number of ampoules available and confirmed the Controlled Drugs Book and Omnicell machine were then consistent. If used correctly, the Omnicell machine quickly directs a user to the medication inventory and potential drug diversion issues that need attention i.e. creating a clear audit trail and nullifying the need for hard-copy controlled drugs books to be used.

2.26 We requested the Ward Manager to print out a report of all the Morphine Sulphate drug movements from the Omnicell, as we wanted to investigate the discrepancy previously found. However, the Ward Manager was unable to do this. We requested a member of Pharmacy to assist with this process, but they were also unable to print off the required report (Ward C6 East, Royal Gwent Hospital).

2.27 There is a knowledge gap within the Health Board over how to maximise the full potential of an Omnicell machine within the wards. This, however, has already been recognised. We were informed that the Principal Pharmacy Technician - Systems Manager has developed a basic Omnicell user guide. We understand this will be added to Sharepoint this year so staff can access when first using an Omnicell machine to understand its full functionalities. We have raised this as **matter arising 3.**

2.28 It should be noted that when completing the sample stock checks of controlled drugs within the Omnicell machines throughout the Health Board sites, no discrepancies were identified.

Pharmacy

2.29 12.1 in the Policy states that the Pharmacy Team should undertake their own six-monthly audits of wards/departments to check that the controlled drug balances are correct. If any discrepancies are found, these should be reported to the Ward Sister and the Pharmacist responsible for the area should investigate.

2.30 From the clinical areas visited, we identified four wards where there was no evidence that the Pharmacy Team had undertaken a stock reconciliation at the minimum of six-month intervals. We noted that the process for completing the six-month stock checks was inconsistent across the sites visited. This has been raised as **matter arising 4**.

2.31 Additionally, we noted a number of wards holding expired controlled drugs. Each expired drug identified during testing was adequately labelled to warn staff from using them.

2.32 There is a risk that expired controlled drugs stored within the controlled drugs cabinet may be accidentally used for patient treatment causing unintentional patient harm. This has also been included within **matter arising 4.**

Conclusion:

2.33 Although there are areas for improvement around compliance with the Policy, as there were no instances of stock imbalances during our sample testing, we have provided **reasonable assurance** over this objective.

Appendix A: Management Action Plan

Matter arising 1: Quoracy (Operation)	Impact
We reviewed the terms of reference (ToR) of the Gwent Controlled Drugs Local Intelligence Network (the 'Group') to identify the requirements of the Chair, how the membership was comprised, and what the quoracy requirements are. We then reviewed meetings against the requirements of the TOR. Meetings were quorate at the January 2020 and 2022 meetings, but not at the September 2021 meeting. The ToR states that a representative from the Police must be in attendance, but no representative was present at this meeting. Therefore, the meeting went ahead without being quorate. Minutes are maintained after each Group meeting. We identified from minutes that the Group maintains actions logs and this is noted as good practice.	Potential risk of: • There is a risk that if the Group meets when the meeting is not quorate, binding decisions cannot be made. This may lead to delays in responses to controlled drug incidents.

Recommendations	Priority
1.1 Management should review the terms of reference (ToR) for the Gwent Controlled Drugs Local Intelligence Network, including its quoracy requirements. Meetings that are not quorate should either be deferred or recognised at the start of the meeting ensuring those in the meeting understand the implications of this. The requirement to complete minutes and action logs after each meeting should also be added to the ToR.	Low

Management response	Target Date	Responsible Officer
1.1 The terms of reference of the Gwent CDLIN will be reviewed and updated as requested at the next CDLIN on 1st August 2022. 1. The TOR will be updated to remove need for Police representation at each member. 2. To recognise any non-compliance with quoracy requirements at the start of any meeting. The implications of this to be noted in the minutes. 3. To add the requirement to complete minutes and action logs after each meeting will be added to the TOR.	August 2022	Senior Primary Care Pharmacist

Matter arising 2: Policy update (Design)	Impact
There is a Policy for the Management of Controlled Drugs in place. This is in date and is not due for review until November 2023. The Health Board confirmed that although the Policy is in date, due to changes in practices since the pandemic and the opening of the new Grange University Hospital, the policy will be reviewed this financial year. Through our testing we identified examples of non-compliance with the Policy. At the next review date of the Policy, the Health Board should consider whether all sections of the Policy remain relevant. Stock takes of controlled drugs should be completed by ward staff on wards at least once a week. There were four wards in our testing where this did not happen, although these wards had completed stock checks within the previous month.	Potential risk of: • Policy becoming impractical and not taking into consideration the environment in which staff operate e.g. lack of storage space. • Increased risk of drugs being able to be misappropriated / misused if regular stock takes are not completed.

Recommendations	Priority
2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	Medium
2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policy and confirm the areas of non-compliance identified as part of this review have been rectified.	Medium

Management response	Target Date	Responsible Officer
2.1 The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy.	March 2023	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services

	Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version. The use of red pen on the wards is to make stock checks more visible. The practicality of this will be reviewed. Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock. The policy will also include a description of the audit framework that will provide assurance the policy is being followed.		
2.2	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance. The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	March 2023	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services

Matter arising 3: Omnicell (Design)	Impact
We noted issues with staff utilising Omnicell machines on their wards. We observed some non-substantive staff who had access to the Omnicell machine and who were unaware how to adequately use the automated system. Furthermore, we witnessed staff ignoring the green flashing lights, identifying where the required drug was being stored. We also found some staff trying to pull open locked draws and opening up multiple compartments within drawers before finding the requested drug. There is a lack of knowledge throughout the Health Board over how staff can maximise the use of an Omnicell machine's capabilities. This, however, has already been recognised. The Principal Pharmacy Technician - Systems Manager has developed a basic Omnicell user guide. This will be added to Sharepoint this year so staff can access when first using an Omnicell machine to understand its full functionalities	Potential risk of: • Drugs not being appropriately accounted for due to lack of knowledge in using an Omnicell machine. • Drugs being misappropriated / misused and not investigated due to an inability to use Omnicell.

Recommendations	Priority
3.1 Management should continue as planned to add the Omnicell user guides to Sharepoint and direct staff to this learning material. The guides should be useful to the front end user and also to Ward Managers regarding the reporting capabilities within an Omnicell machine.	Medium

Management response	Target Date	Responsible Officer
3.1 There are user guides for both end and superusers provided by Omnicell. The Principal Pharmacy technician at RGH has developed basic user guides for the wards which detail the common functions with picture guides. These are available on the wards, but staff cannot always find them. The plan is to add them to SharePoint and signpost staff to them. Short training videos are also to be developed which will be uploaded to YouTube. QR codes will be placed on the side or front of the cabinet and linked to the videos which will show staff how to maximise the Omnicells functionalities.	August 2022	Head of Pharmacy - Operational Services / Principal Pharmacy Technician – Systems Manager

Matter arising 4: Pharmacy stock reconciliations and expired drugs (Operation)	Impact
From the clinical areas visited, we identified a number of wards where the Pharmacy department had not undertaken a stock reconciliation at the minimum of six-month intervals. Additionally, we noted a number of wards holding expired controlled drugs. Each expired drug identified during testing was adequately labelled to warn staff from using them.	Potential risk of: • without six monthly stock reconciliations by Pharmacy, the Team will not be compliant with the Policy and areas where controlled drugs may be being misappropriated / misused, go unidentified.

Recommendations	Priority
4.1 The Pharmacy Team should comply with the relevant Health Board policies and SOPs for controlled drugs, in particular the removal of expired controlled drugs and the completion of six-monthly stock reconciliations (which should all be completed in a consistent manner). Where compliance with the policy cannot be achieved, for example due to resourcing, an agreed temporary deviation from the Policy should be agreed and approved at an appropriate Group.	Medium

Management response	Target Date	Responsible Officer
4.1 A full review will be conducted into the Pharmacy processes relating to 6-monthly CD stock reconciliations to determine the extent of the issue and to provide assurance of compliance. The Pharmacy Team will input into the Management of Controlled Drugs Policy, with the potential to visit the mechanism of how expired drugs are reported to Pharmacy, to ensure a more robust system with auditable records is available in the future.	September 2022	Head of Pharmacy - Operational Services

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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NIS Directive (Cyber Security)
Final Internal Audit Report

June 2022

Aneurin Bevan University Health Board

Contents

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Committee:	Audit and Corporate Governance 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 Service Strategy and Terms of Reference, approved by the Audit, Finance & Risk Committee.

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Executive Summary

Purpose

Review arrangements in place for the implementation of the NIS (Network and Information Systems) Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

Overview

We have issued reasonable assurance on this area. The matters which require management attention include:

- No retention of supporting information provided to the Cyber Resilience Unit (CRU) as part of the CAF assessment.
- Improvement actions have not been fully identified and a plan has not yet been developed.
- There is no regular reporting of cyber security to the Board or a sub-committee, and the risk does not fully articulate the cyber security risk.

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	CAF completion and maintenance of evidence	Reasonable
2	Accurate self-assessed position supported by evidence	Substantial
3	Improvement plan implementation	Reasonable
4	Governance	Limited

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
2	Assessment Evidence	1	Operation	Medium
3	Improvement Plan	3	Operation	Medium
4	Costs	3	Operation	Medium
5	Reporting and Risk	4	Operation	Medium

1. Introduction

1.1 Our review of the Network and Information Systems (NIS) Regulations (the 'Regulations') was completed in line with Aneurin Bevan University Health Board's (the 'Health Board' or the 'organisation') Internal Audit Plan for 2021/22. The review sought to provide the Health Board with assurance that there are effective processes in place to manage the risks associated with the Regulations.

1.2 Cyber security and resilience is the protection of computer systems and networks from the theft of or damage to their hardware, software, or electronic data, as well as from the disruption or misdirection of the services they provide.

1.3 The Regulations are a core piece of legislation relating to cyber security and was brought into UK law during May 2018 from the EU NIS Directive, with the intention to raise levels of cyber security and resilience of key systems across the European Union.

1.4 At the core of this piece of legislation is the aim to drive improvement in the protection of the network and information systems, which are critical for the delivery of digital services and essential services in the UK. These regulations require bodies to have processes in place to protect themselves from attack, detect potential intrusions and react appropriately when intrusions occur.

1.5 Although cyber security is not a devolved matter, the Welsh Government (WG) is the competent authority for the NIS in the case of essential health services in Wales.

1.6 Within NHS Wales, Digital Health and Care Wales (DHCW) takes a leading and coordinating role for the maintenance and improvement of cyber security on behalf of the WG. They are responsible for establishing the compliance framework for operators of essential services, which includes defining the scope of the regulations, reporting thresholds, and processes for reporting and dealing with cyber incidents. Individual NHS organisations which fall within scope must adopt and comply with these arrangements.

1.7 The potential risks considered in the review were as follows:

- poor or non-existent stewardship in relation to cyber security;
- failure to comply with regulations such as the NIS Regulations; and
- loss of data or services and inappropriate access to information.

2. Detailed Audit Findings

Objective 1: a process exists for completion of the self-assessment and maintenance of appropriate evidence.

2.1 Foundation work on the Cyber Assessment Framework (CAF) was undertaken by the ICT Cyber Team Leader to identify the critical systems within the Health Board. This process used the service catalogue in place, however there was a lack of understanding from system owners over what comprised a critical system. The decision was therefore made to undertake a single assessment of the core underlying ICT infrastructure of the Health Board.

2.2 The Health Board's Cyber Security Team Leader undertook the completion of the CAF. We note that there was only limited involvement of the system owners, and this was at the critical system identification stage as noted above. The output was not shared with system owners, although we note the intent to move the CAF to a system level in the future and involve owners accordingly. **See Matter Arising 1 at Appendix A**.

2.3 There is a review process in place for the CAF assessments. The outcomes were taken to senior technical ICT staff and the Chief Nursing Information Officer, and were also reviewed prior to submission by the Interim Chief Technology Officer, acting as Chief Digital Officer.

2.4 Information to support each CAF response was provided through discussions with the Cyber Resilience Unit (CRU), where required. The CRU did not specifically request evidence in the form of documentation as part of the assessment, and as such the assessment responses do not have supporting information.

2.5 The national guidance states that the self-assessment will be repeated annually. The lack of recorded information and clarifications sought from the CRU may hinder the timeliness and efficiency of future iterations particularly if key individuals leave the Health Board. **See Matter Arising 2 at Appendix A.**

Conclusion:

2.6 Significant work was undertaken by the Cyber Security Team to prepare and complete the self-assessment, and there was a process for review of the assessed position. However, evidence and records of discussions have not been appropriately retained for future iterations of the CAF. Consequently, we have provided **reasonable** assurance for this objective.

Objective 2: the self-assessed position is accurate and supported by evidence.

2.7 As part of this review, we conducted interviews with the Cyber Security Team Leader.

2.8 During this review, as noted above, there was no retention of evidence and so we were unable to fully evaluate the Health Board's self-assessed position. However, we tested a sample of four objectives within the CAF to ensure appropriate scoring and discussed the position. The four objectives related to:

- A1.b Roles and Responsibilities;
- B5.a Resilience Preparation;
- C1a Monitoring Coverage; and
- C2.b Proactive Attack Discovery.

2.9 Using our professional judgement, information gleaned from interviews and update reports, we consider the self-assessment to be an accurate reflection of the Health Board's current cyber security position. We note some minor areas where the assessment does not fully reflect the narrative, however the basis of the assessed position was discussion with the CRU.

Conclusion:

2.10 Whilst we consider the self-assessed position to be accurate, as noted above, we were unable to verify this through evidence. However, discussion confirmed the appropriateness of the self-assessed responses. Consequently, we have provided **substantial** assurance for this objective.

Objective 3: an improvement plan is in place to improve the cyber security position within the organisation and is being implemented appropriately.

2.11 Whilst a formal improvement action plan is not yet in place, due to the Health Board awaiting the outcome of the CAF from the CRU, actions to meet the gaps in the CAF are being identified and collated into an improvement plan for cyber security. **See Matter Arising 3 at Appendix A.**

2.12 We note that resolution of the gaps in the CAF Section A, Managing Security are being addressed following the outcome of a review into the Digital Governance Structure in the Health Board by Templar Executives. The outcome of this review contained recommendations regarding the establishment of a revised governance framework which are being taken forward.

2.13 The recommendations from the Templar review were accepted by the Health Board, and funding was granted in order to move the actions forward.

2.14 We further note that there is ongoing work to develop a full cyber security plan, with a cyber services plan in draft. In addition, work to include remediation actions from the National Institute of Standards and Technology (NIST) framework in a full Health Board work plan is ongoing.

2.15 At present the costs associated with implementing a cyber work plan which would enable the Health Board to demonstrate that it is meeting the requirements of the legislation are not known, with no assessment of the costs of individual actions and no mechanism to enable these actions to be prioritised and reported to Committee or Board. **See Matter Arising 4 at Appendix A**.

Conclusion:

2.16 Initial progress has been made to identify gaps in compliance and recommendations to improve the current cyber security position. Work is ongoing to make improvements, in particular relating to the governance weaknesses identified in section A of the CAF. Although at present there is no full improvement plan in place and the associated costs are not fully defined. Accordingly, we have concluded **reasonable** assurance for this objective.

Objective 4: there is monitoring and reporting of the progress of the improvement plan and gaps in compliance to an appropriate governance group.

2.17 We note that there is some reporting of cyber security, and to an extent NIS, to the Audit, Finance and Risk Committee as part of the risk reporting. However, there is no regular, formal reporting on cyber security which fully sets out the position to a Board level group.

2.18 In addition, although we note that there is a risk which relates to cyber security on the organisation risk register, this does not fully articulate the risk associated with poor cyber security, or the potential financial risk associated with non-compliance with the NIS Regulations. **See Matter Arising 5 at Appendix A**

2.19 We note that the Health Board is aware of the requirement to establish a revised governance structure for digital and this is being taken forward as noted above.

Conclusion:

2.20 There is regular reporting of cyber security as part of the risk management framework to the Audit, Finance and Risk Committee. However, this reporting does not fully set out the cyber security position and risk. Accordingly, we have provided **limited** assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: System Owner Involvement (Operation)	**Impact**
There was only limited involvement of the system owners in the completion and review of the Cyber Assessment Framework (CAF).	Potential risk of: • Loss of clarity over the cyber security framework
Recommendations	**Priority**
1.1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	Low

Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	Date of next NIS CAF assessment (Dec 22)	Chief Digital Officer

Matter Arising 2: Assessment Evidence (Operation)		**Impact**
The Cyber Assessment Framework (CAF) responses do not have supporting information relating to the discussion with the Cyber Resilience Unit (CRU) or evidence in place in order to facilitate future iterations.		Potential risk of: • poor or non-existent stewardship in relation to cyber security.
Recommendations		**Priority**
2.1 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Management will ensure that during any future self-assessments records of discussions and information supplied to the CRU will be captured and available for internal or external review.	Date of next NIS CAF assessment (Dec 22)	Chief Digital Officer

Matter Arising 3: Improvement Plan (Operation)		**Impact**
Whilst improvement objectives have been identified following the completion of the self-assessment, a complete Improvement Action Plan has not yet been developed.		Potential risk of: • poor or non-existent stewardship in relation to cyber security; • failure to comply with regulations such e.g., NIS Regulations
Recommendations		**Priority**
3.1 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 NIS Improvement Plan is already being developed by the Cyber Team. The completed plan will be presented for management review and sign off. Currently ABUHB are still awaiting the publication of CAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being developed.	July 2022	Chief Digital Officer

Matter Arising 4: Costs (Operation)	**Impact**
At present the costs associated with implementing a cyber work plan which would enable the Health Board to demonstrate that it is meeting the requirements of the legislation are not known, with no assessment of the costs of individual actions and no mechanism to enable these actions to be prioritised and reported to Committee or Board.	Potential risk of: • poor or non-existent stewardship in relation to cyber security; • failure to comply with regulations such e.g., NIS Regulations
Recommendations	**Priority**
4.1 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structure and relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance framework to support Risk Management within the Health Board.	September 2022	Chief Digital Officer

Matter Arising 5: Reporting and Risk (Operation)	**Impact**
There is no regular, formal reporting on cyber security which fully sets out the position to a Board level group. In addition, although we note that there is a risk which relates to cyber security on the organisation's risk register, this does not fully articulate the risk associated with poor cyber security, or the potential financial risk associated with non-compliance with the NIS Regulations.	Potential risk of: • poor or non-existent stewardship in relation to cyber security; • failure to comply with regulations such e.g., NIS Regulations
Recommendations	**Priority**
5.1 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security. 5.2 The risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliance with NIS.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
5.1 ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting. 5.2 As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	Further engagement with Templar May-July with subsequent dates for completion to be confirmed	Chief Digital Officer

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Medical Equipment and Devices Final Position Statement Report

June 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

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Fieldwork completion:	11th May 2022
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Debrief meeting:	28th April 2022
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Final report issued:	1st June 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit
Executive sign-off:	James Calvert, Medical Director Peter Carr, Director of Therapies and Health Science
Distribution:	Alex Scott, Assistant Director, Quality and Patient Safety Richard Stubbs, Risk Manager
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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

This audit planned to assess the maintenance of the electronic medical devices and equipment (EBME) database and the management of other medical equipment / devices and associated training requirements. The audit objectives were consistent with the 2017/18 Medical Equipment and Devices audit (rated 'limited assurance'), which has allowed a high level review of progress to be completed.

Overview

The impact of the pandemic and the ongoing situation with the Datix system changes, training needs and Scan4Safety has meant that ongoing work against the audit objectives is still underway, with progress still required to address the limited assurance rating raised within the previous audit.

At this stage, we are unable to complete sufficient testing in a timely manner to provide full assurance over each audit objective. Therefore, we have provided a position statement on each objective, with an update included on the previous recommendations raised within this area, which are being managed via the Audit Recommendation Tracking Tool.

Overall, there has been progress made since the last audit, with the introduction of the electronic asset tagging system and actions are being tracked via the Medical Equipment Management Group. The next step will be to identify all relevant medical equipment and devices and to monitor / update the locations accordingly. A dedicated resource is in place to manage this process and co-ordinate the training requirements. However, the previous 2017/18 Medical Equipment and Devices audit (rated limited assurance) should still be considered as our most recent assurance position, with the risk continuing to be managed accordingly.

Report Classification

		Trend
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.	

Assurance summary[1]

	Assurance objectives	Assurance
1	Policies & procedures	
2	Inventory & listing	
3	Planned Maintenance	
4	Equipment related incidents & Datix	
5	Training	

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

1. Introduction

1.1 The planned review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that operational procedures are compliant with Health Board corporate policies. In particular, the audit objectives were developed to ensure that the recommendations raised from the 2017/18 Medical Equipment and Devices audit (rated 'limited' assurance) were implemented.

1.2 The term medical device includes all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. This audit will focus on electromedical equipment e.g. bladder scanners or infusion pumps.

1.3 The Electronic and Biomedical Engineering (EBME) department maintains a medical equipment database to record the service and maintenance history of equipment. Electromedical equipment included within this database are currently tagged with a barcode asset label.

1.4 The Health Board has implemented a radio-frequency identification (RFID) system to assist with the management of assets, including medical equipment and devices. Benefits of this process are expected to include:

- the tracking of equipment;
- the location of tagged equipment to assist with maintenance and device safety recalls;
- reporting capabilities;
- an audit trail to assist with the verification of equipment; and
- the ability to interface with the Health Board's existing medical equipment database (Medusa) and Fixed Asset Register (RAM 4000).

1.5 The risks considered in the review are as follows:

- reporting capabilities responsibilities and processes described within the policies and procedures are not adhered to, resulting in patient harm
- financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

1.6 During the audit we identified that the management of medical equipment and devices still remains in a transitional phase, significantly impacted by the pandemic and in particular the early opening of the Grange University Hospital (GUH).

1.7 At the time of the audit, the majority of the actions on the Medical Devices Workplan were not yet scheduled to be completed (with three of five dates recorded as from the end of June 2022 onwards). Furthermore, a RAG rating of 'amber' or 'red' was assigned to each of them. Whilst we observed progress underway (as summarised in Section 2 below), there is still considerable work to complete to implement each of the previous recommendations.

1.8 As implementation of the actions has not progressed as anticipated, we have provided an interim report on the progress made to date. We have not provided

assurance over each objective, but rather an indication of the direction of travel for progress underway. We confirmed that each of the recommendations from the 2017/18 audit are still being actively managed, as required.

2. Detailed Audit Findings

Audit objective 1: policies and procedures are in place for the management of medical devices and equipment, which are reviewed and up-to-date.

2.1 The Management of Medical Devices Policy (the 'Policy') is owned by the Risk Manager and was issued in April 2018 with a review date set for December 2022.

2.2 It is consistent in style, format and content with other Health Board policies detailing responsibilities of all equipment users from the Chief Executive downwards.

Conclusion:

2.3 We note that the policy is up-to-date and ratified and can confirm that the action for finding five from the previous audit has been completed and closed correctly.

Audit objective 2: the current inventory listings of medical devices and equipment are regularly maintained, with location details recorded.

2.4 The Medusa Database (the 'Database') was set up following the previous audit to address the lack of a central register, which was raised as a recommendation within finding one. The Database has the capability to provide full administrative control over the management of electromedical devices. It has therefore satisfactorily completed that aspect of the audit recommendation.

2.5 The location of a medical device is set by the EBME Team when the equipment is first entered onto the database and released to its operational area. We note two areas of good practice, in that the location recorded is a compound code and is appropriately defined and another example where new equipment is not released to the operational areas until it has been checked by the EBME Team and recorded on Medusa.

2.6 However, for the database to be kept accurate, operational practices are required to deal with the transfer between locations and to ensure that the inventory listing remains accurate. Findings one and three of the previous audit referred to the lack of such processes and the associated recommendation is still being progressed (recommendation one on the Audit Recommendation Tracking Tool (the 'Tracker')).

2.7 Consequently, without the procedures for documenting equipment transfers, there are incubators on the database shown as being located at the Royal Gwent Hospital, but they currently reside at the GUH.

Conclusion:

2.8 The Medusa database has the capability to provide accurate location information on all equipment that is registered on it. However, for that to happen, further

processes are required to support the Policy, with the records updated accordingly. These actions will also address the previous recommendations raised.

Audit objective 3: there is an established process and schedule to ensure medical devices and equipment are maintained and kept in an appropriate state of repair.

2.9 We note that the Medusa database can fully support all maintenance scheduling and reporting functionality for any piece of equipment recorded on it by setting a maintenance schedule for each item.

2.10 Where the equipment has a planned maintenance schedule, and that maintenance is to be carried out by the EBME Team, this has happened. However, if there is no maintenance required, or the maintenance is to be performed by the supplier under a maintenance contract, no schedule has been entered.

2.11 Consequently:

- the service contracts cannot be effectively monitored using Medusa, and the EBME Team are reliant on the suppliers confirming that the work is complete; and
- the planned maintenance side of the database cannot be reconciled to the entire database to confirm all machines have been included.

2.12 We noted that Medusa can facilitate time-based scheduling of work coming due, and scheduled work that is overdue. This functionality is not currently being used by the EBME Team to oversee work done and planned.

2.13 Service reports and records, both internally produced by the EBME Team, and supplied by suppliers as part of the service contracts are easily stored on the Database. The Database also has the facility to provide a complete service history on any item of equipment that has a maintenance schedule.

Conclusion:

2.14 The Medusa service scheduling functionality is not being utilised to its fullest extent at this time. This does increase the risk that equipment may be out of service for longer than is necessary.

Audit objective 4: all adverse incidents, involving medical devices and equipment are recorded on the Datix incident reporting system and investigated in a timely manner.

2.15 All incidents of every type within all Health Boards in Wales have to be recorded on Datix. Equipment related incidents is a selectable option for the incident type.

2.16 The previous audit found that there was no overall control of Datix reporting (finding four) and issued a broad recommendation that the Health Board should set up management practices around the system to confirm all incidents are investigated and reported in a timely manner

2.17 We noted from a Datix report that the option is used with 53 'equipment related' incidents recorded for ABUHB acute hospitals for October to December 2021. Examination of those incidents suggests the policy is being followed across all sites.

2.18 Incident review and management oversight in the Health Board is performed by the Quality and Patient Safety Team, who monitor incidents to closure and determine if escalation is necessary.

Conclusion:

2.19 Datix use for incident reporting is embedded across the Health Board, although we did not test if all relevant incidents have been reviewed and investigated within this audit.

2.20 However, we identified that the recent changes to the Datix version have yet to be fully implemented, but work is currently underway.

Audit objective 5: where required, staff are provided with training before using medical devices and equipment.

2.21 Although ESR can support the recording of training completion, related to specific types of equipment, at present this is not being comprehensively used.

2.22 Furthermore, the Medical Devices Workplan (the 'Workplan'), agreed by the Medical Devices Management Group in March 2022, includes training as one of its key themes. Therefore, whilst training continues as previously, the strengthening of the controls to manage this process have not yet been fully implemented.

2.23 The Workplan has set out a timeframe as the end of June 2022, for a plan utilising ESR to be developed. However, this is expected to be a long term project. A delivery date has not yet been established to roll out a process for cascade training throughout the Health Board.

Conclusion:

2.24 The process for managing training requirements is still not yet fully implemented.

Overall Summary:

2.25 Overall, we confirmed that work is still in progress to implement the recommendations from the 2017/18 internal audit and to incorporate the requirements of the 2021 Managing Medical Devices guidance issued by the Medicines and Healthcare products Regulatory Agency.

2.26 We assessed the progress of each recommendation raised previously and tested to ensure that the Tracker accurately reflects the current position. Table One below provides an update on the progress of the recommendations and whether any additional action is required to track or address the recommendation.

2.27 We found that the Tracker incorporates two recommendations that will fully implement the three partially implemented recommendations that were raised in the previous audit. Within Appendix A we have summarised the previous recommendations that remain outstanding, together with details of the current position.

Table One: Status of Previous Recommendations Raised from 2017/18 Audit

Previous Recommendation Reference	Progress Completed (full, partial)	Reference on Recommendation Tracker	Additional Action Required to Address Recommendation
Medical equipment and devices register (high)	Partially complete	48 / R1	None
Training (high)	Partially complete	48 / R2	None
Loaned / on-loan equipment (medium)	Partially complete	48 / R1	None
Incident reporting (medium)	Fully complete	Not required	N/A
Policy (medium)	Fully complete	Not required	N/A

Appendix A: Management Action Plan

Previous Recommendation One – Medical Equipment and Device Register	Previous Priority Rating
Registers should be maintained for operational management of medical devices and equipment on 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 area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. 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.	**High**

Current Progress
The Medusa Database (the 'Database') has been introduced to record the location of assets, together with supporting management tools. We confirmed that the functionality of the Database is appropriate, but the updating of the records is yet to be fully completed, across all sites. Therefore, whilst progress has made to introduce a suitable system for the recording medical equipment and devices, the original recommendation remains outstanding.

Management response	Target Date	Responsible Officer
The EBME Manager has identified constraints in relation to the population of Medusa as a result of capacity and resource in the EBME team. The Medical Device committee will support a national benchmarking exercise to review EBME resource and to support management of risk and mitigation.	September 2022	EBME Manager

The population of location fields on Medusa remains underway and the system is being updated as repair and maintenance work is completed.

Previous Recommendation Two - Training	Previous Priority Rating
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.	**High**

Current Progress
The control framework for monitoring training remains as previously. Currently, the Medical Devices Workplan includes a timeframe as the end of June 2022, for a plan utilising ESR to be developed. This is expected to be a long term project. A delivery date has not yet been established to roll out a process for cascade training throughout the Health Board. Therefore, further progress is required to implement this recommendation.

Management response	Target Date	Responsible Officer
The recording of training on ESR needs to be mapped to training need analysis to support recording of training compliance rates. A short term action to upload all training to ESR will be explored in the immediate term.	September 2022	Risk Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Head of Internal Audit Opinion & Annual Report 2021/2022

June 2022

Aneurin Bevan University Health Board

Contents

Report status:	Final
Draft report issued:	6th May 2022
Final report issued:	7th June 2022
Author:	Head of Internal Audit
Executive Clearance:	Director of Corporate Governance
Audit, Risk and Assurance Committee:	17th May & 13th June 2022

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Aneurin Bevan University Health Board (the 'Health Board') is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

As a result of the continued impact of COVID-19 our audit programme has been subject to change during the year. In this report we set out how the programme has changed and the impact of those changes on the Head of Internal Audit opinion.

1.2 Head of Internal Audit Opinion 2021-22

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2021/22 is that:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

Due to the ongoing impact of COVID-19 on the organisation, the internal audit plan has needed to be agile and responsive to ensure that key developing risks are covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed

schedule. Changes required during the year have been approved by the Audit, Risk and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2021/22 year was initially presented to the Committee in March 2021.

There are, as in previous years, audits undertaken at NWSSP that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors (in 2018), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards for 2021/22. For this year, as in 2020/21, our QAIP has considered specifically the impact that COVID-19 has had on our audit approach and programmes. We are able to state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, and in part reflecting the impact of COVID-19, we also undertook a number of advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2021/22

Substantial Assurance	Reasonable Assurance
• Clinical Negligence Costs • Charitable Funds • Occupational Health • GUH: Financial Assurance (Follow-up) • GUH: Technical Assurance	• Financial Sustainability • Gifts, Hospitality and Declarations of Interest • Putting Things Right • Operational Plan for Resumption of Services • Pathology • Medicines Management • Falls Management • Facilities – Care after Death • Corporate Governance • Mental Capacity Act • Flu Immunisation • Flow Centre • Risk Management • IT System Controls • Tredegar Health and Wellbeing Centre • GUH: Follow-up • GUH: Quality • Waste Management • NIS Directive
Limited Assurance	**Advisory/Non-Opinion**
• Continuing Healthcare	• Datix (Support of Incident Management) • Follow-up of High Priority Recommendations • Medical Equipment and Devices
No Assurance	
• N/A	

Please note that our overall opinion has also taken into account information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit, Risk and Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit, Risk and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a

rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Digital Health and Care Wales which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2021/22 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit and Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised.

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2021/22 and reported to the Audit, Risk and Assurance Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).

- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the organisation.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, three were allocated Substantial Assurance, seven were allocated Reasonable Assurance. No reports were allocated a 'no assurance' opinion.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken **four** reviews in this area.

We completed a review of the Board Assurance Framework (BAF) within the **Corporate Governance audit** (reasonable assurance), noting that work is in progress to fully implement and embed the BAF processes.

We did not identify any significant matters for reporting in our review, but noted areas where improvements could be made, including the need for the individual Risk Owners to more effectively assess and address any weaknesses or gaps in the assurances being relied upon.

We also recommended that the engagement with sub-committees of the Board within the BAF process is more formally documented, and that the effectiveness of the BAF process in its entirety is periodically reviewed and reported to the Board.

We also completed an audit of **Risk Management** (reasonable assurance) and undertook a risk maturity assessment. We concluded the Health Board is progressing towards becoming a risk mature organisation and is currently 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.

We recommended that the objectives of the Risk Management Strategy should be monitored for implementation and a consistent approach across divisions towards the management of risk.

Finally, we recommended that risk management training should be considered throughout the Health Board.

The audit of **Gifts, Hospitality and Declarations of Interest** (reasonable assurance) found that the Health Board has a comprehensive Declarations of Interest Register (the 'Register'), with senior managers and Board members included. We examined the process to determine if it incorporated the Welsh Government's Citizen-Centered Governance Principles. We also examined what monitoring activities are in place at a corporate level to ensure safeguards have been implemented, where required, and in so far as possible that declarations have been made.

We reviewed a sample of declarations made for potential conflicts of interest and gifts / hospitality received to ensure the Standards of Business Conduct Policy (the 'Policy') was adhered to. Overall, we found good compliance.

However, we found that mitigation that has been implemented to prevent a conflict of interest arising is not documented, as there is no process for this. We also found that due diligence and completeness checks are not completed by the Central Team. This is not required under the Policy and is a recommendation to consider for strengthening the current process.

We undertook a review of **Putting Things Right** (reasonable assurance) and found good arrangements in place. We raised one recommendation over the monitoring of actions arising from complaints received.

Strategic Planning, Performance Management & Reporting

We have undertaken **one** review in this area.

The **Operational Plan for Resumption of Services** audit (reasonable assurance) reviewed the processes for resuming services and clearing the backlog of procedures. We found appropriate arrangements in place, with plans across Scheduled Care to maximise the resources available, prioritising more urgent care, but with further enhancements recommended.

Financial Governance and Management

We have undertaken **three** reviews in this area.

We completed an audit of **Financial Sustainability** (reasonable assurance) and found that budgetary procedures embedded in the Directorates and service areas have been flexed in response to the pressures place on management and staff during the Covid pandemic but have maintained control.

Whilst we did not identify any significant matters for reporting in our review, we have noted that improvements can be made in the development and approval of Transformation Projects, commenting on the need to develop measurement criteria that are SMART and accounting structures that capture the more complex multi services impact of these projects in support of the approval process.

We also recommended that consideration be given to how accounting for savings plans on a gross basis to improve trackability.

The audit of **Clinical Negligence Costs** (substantial assurance) reviewed the process for handling clinical negligence claims, to ensure the Health Board complied with the relevant standards, whilst seeking to minimise the financial impact.

We found good processes in place for the sample of claims tested, including governance arrangements and the approval of claims paid. However, we recommended that local policies should be reviewed and updated where applicable. In addition, we recommended improvements over the control for damage claims that require approval from the Litigation Group.

Within the **Charitable Funds** (substantial assurance) audit we assessed the charitable fund arrangements in place during the pandemic, including the receipt of donations and charitable expenditure.

We found good controls in place over charitable income and expenditure and the recording of donations in kind e.g. personal protective equipment provided by members of the public / local businesses.

Whilst the arrangements in place were robust, we recommended that the Health Board examines alternative methods of training ward staff in the processes for receiving donations and other related arrangements.

Quality & Safety

We have undertaken **four** reviews in this area.

The audit of **Continuing Healthcare** (limited assurance) 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.

However, we raised the following recommendations:

- ensuring sustainable improvements in terms of accountability and scrutiny for commissioned services is undertaken;
- wider Divisional attention and oversight of CHC / S117 commissioning activity is in place;
- assessing the quality of services delivered by providers on the All Wales Framework (AWF) is completed; and
- 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 is in place.

The audit of **Mental Capacity Act** (reasonable assurance) assessed the extent to which the Health Board complied with the principles of the Mental Capacity Act (the 'Act'), including in respect of the 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) process.

We found a comprehensive 'Assessment of Mental Capacity Procedure' in place to support the process, which includes decision making flowcharts and templates for assessors to document conclusions.

However, we found within our sample tested that documented capacity assessments were missing (eight from nine DNACPR forms completed where capacity was determined to be lacking). Whilst the Act permits informal day-to-day patient assessments, significant decisions require adherence to the documentation requirements. These assessments of the decision making capacity of a patient should be documented.

When capacity is deemed to be lacking a discussion with a relative is required. This should also be documented, but we found in two instances that the required documentation was not fully completed. However, in

general we found that details of these discussions are documented in multiple locations, including medical notes, Treatment Escalation Plans or Advanced and Future Care Plans.

We found a range of training courses available on ESR covering the scope of the Act (e.g. conducting compliant assessments, assessing patient best interests and addressing deprivation of liberty safeguarding matters). However, when we interviewed staff at the wards visited, we were told that they had not undertaken any training regarding the Act.

Throughout the audit, we were informed that discussions in accordance with the All-Wales guidance on the DNACPR process take place, but may be documented across a range of records. Whilst we found that a good control framework is in place within the Health Board, adherence to the documentation process requires strengthening.

The **Medicines Management** audit (reasonable assurance) found that the Policy for the Management of Controlled Drugs (the 'Policy') was generally complied with across each hospital site tested. Whilst we found isolated exceptions, we recommended that the Policy should be reviewed to ensure it remains suitable.

Within the audit of **Falls Management** (reasonable assurance) 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.

Information Governance & Security

We have undertaken **two** reviews in this area.

The **NIS Directive** audit (reasonable assurance) identified that work was completed on the Cyber Assessment Framework (CAF), but we provided recommendations over the retention of supporting information as part of the CAF assessment.

We also found that improvement actions have not been fully identified and a plan has not yet been developed nor is there regular reporting of cyber security to the Board or a sub-committee.

The **IT System Controls (WRIS)** audit (reasonable assurance) testing found that data held within the Welsh Radiology Information System (WRIS) is accurate, secure from unauthorised access and loss, and that the system is fully used and fits the needs of the service.

Whilst WRIS is provided by Digital Health and Care Wales (DHCW) we found governance arrangements in place, with representation from the Health Board. In addition, as the system is hosted within the Health Board, this has enabled changes to match any requirements. However, due to these arrangements the process for requesting changes is not efficient, with responsibilities and the flow of work requests not clear.

We also found WRIS is not currently meeting the needs of the Radiology service, with the manual inputting of requests and additional workarounds required. The Health Board has undertaken development to enable WRIS to better meet its needs, but there is still a lack of a full electronic request process.

We tested the database to ensure that it is securely hosted and found this to be the case, with access restricted appropriately. However, the current database version is SQL Server 2008, which is out of support and contains security vulnerabilities.

Furthermore, we confirmed that good controls over data entry are available in WRIS, with drop down lists to minimise the potential for user error and data quality reports to enable the retrospective identification of any errors. However, due to the level of manual inputting required we would expect to see a control to test the completeness of requests – i.e. that all patient requests have been inputted onto the system.

Finally, we found good continuity arrangements in place and work underway to ensure leavers from the Health Board no longer retain access to WRIS, with a couple of recommendations provided to enhance this further.

Operational Service and Functional Management

We have undertaken **five** reviews in this area.

The **Flu Immunisation** audit (reasonable assurance) 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.

We completed our review of **Medical Equipment and Devices** (not rated) to determine if a medical equipment / devices register was in place and is regularly updated. Whilst the review was not a follow-up audit, the recommendations raised within a previous audit from 2017/18 (rated 'limited' assurance) contributed to this year's audit objectives.

However, we found that progress had been significantly impacted by the pandemic and that work was still underway to fully embed the controls required for this area. Therefore, we have provided a Position Statement over what has been completed so far and whether the Audit Recommendation Tracking Tool (the 'Tracker') requires updating to reflect this.

Overall, we found the Tracker remains accurate in the objectives still to be delivered. We found two of the five previous recommendations have been implemented and work continues on the remaining three (which are now combined into two recommendations on the Tracker). Actions to address the remaining recommendations are being tracked within the Medical Equipment and Devices Group.

The **Flow Centre** audit (reasonable assurance) found good operational management and compliance with internal procedures within the Flow Centre service area. However, we recommended that the Health Board ensure business continuity arrangements are strengthened and the

completeness of information held on a patient's record is consistent across the team.

We also recommended that the Health Board undertakes an analysis of the overall benefits versus the risks of delivering the service.

Within the **Pathology** (reasonable assurance) directorate review we found appropriate arrangements in place across all audit objectives. However, we identified five areas of improvement.

We found that the process for co-ordinating and implementing recommendations from external assessors could utilise the existing QPulse software, by logging recommendations and examining trends emerging.

In addition, whilst we found appropriate business continuity arrangements in place, we recommended that these are tested on a regular basis.

There is considerable management reporting taking place. However, we suggested improvements over the data coverage currently included. For example, we found reporting is based on a sample of data and due to the automation of the process, we believe all data could be included. We also recommended a high level dashboard to be developed and used for reporting going forward, which should provide key highlights against the top risks identified.

Finally, we found that has been no exercise completed at a directorate level to determine if the benefits of Clinical Futures have been obtained or not. However, we did confirm that this exercise is to shortly take place at a Health Board level. Alongside this, we recommended that any workforce / facility requirements for the directorate are incorporated into future plans.

The **Facilities – Care after Death** (reasonable assurance) audit found that the arrangements for the storage of patients was good. We recommended an upgrade of the management software to assist with the end-to-end process.

Workforce Management

We have undertaken **one** review in this area.

The **Occupational Health** audit (substantial assurance) found good arrangements over pre-employment screening and the referral process to Occupational Health. This was supported by management information over the referral rates and average waiting time.

There was a significant increase of referrals during the pandemic, and we raised some suggestions over how this may be approached in the future.

Capital & Estates Management

We have undertaken **six** reviews in this area.

The **Tredegar Health and Wellbeing Centre** audit (reasonable assurance) reviewed the delivery and management arrangements in place to progress the Tredegar Health and Wellbeing Centre project and the performance to date against its key delivery objectives i.e. time, cost and quality.

Overall, we found that the Health Board is seeking to manage the current reported potential overspend of £364k incurred, as a result of the enabling and grouting works, within the approved project allocation. The associated reported delays, to date, will not adversely impact on service delivery recognising the nature of the facility (i.e. reprovision). These issues will need ongoing management scrutiny through to project completion.

To achieve this, we raised recommendations over:

- The inclusion of a summary financial position, on a cumulative basis.
- Improved scrutiny of the Key Performance Indicator returns.
- The maintenance of a costed project risk register.
- The improved management of contract documentation i.e. signing in advance of works and appropriate assessment of contract clauses.
- Compliance with the Enabling Works contract requirements of NHS Wales Investment Infrastructure Guidance.

The **Waste Management audit** (draft report - reasonable assurance) identified the following recommendations:

- Completion of the review of the out of date waste management policy guidance operational control procedures, and the associated intranet content;
- Development of a Waste Risk Register, and enhanced risk reporting processes;
- Enhanced waste management training awareness;
- The implementation of a consistent approach to the waste streams applied in public areas within the hospital sites;
- Compliance with waste management operational procedures across all sites.
- The reintroduction of waste recycling provisions and targets across the UHB;
- Enhanced monitoring and reporting arrangements, waste updates/assurance reporting to Board.

The **GUH: Financial Assurance (Follow-up)** audit (substantial assurance) sought to provide assurance in the area of Financial Assurance, focussing on the accuracy of the final account calculations and the adequacy of information supporting the sums claimed by the Supply Chain Partner. However, the final account was not available at the date of the audit, therefore the focus of work was on the assurance that additional costs arising from Covid 19 had been appropriately identified, reported and

managed. The audit of the final account will be deferred to the 2022/23 Internal Audit plan.

We found that the Covid-19 claim was found to be fully substantiated and that all of the previously agreed recommendations have been appropriately closed by management.

The **GUH: Technical Assurance** audit (substantial assurance) determined whether the project delivery and handover of the GUH was in accordance with the terms of the contract and other statutory requirements.

Overall, we found that the GUH has been delivered within the terms of the contract. The statutory requirements have been addressed and the Health Board has been provided with all technical documentation, specified within the contract, by the Supply Chain Partner.

For the **GUH: Follow-up audit** (reasonable assurance) we sought to determine the status of agreed audit recommendations contained within the previous GUH project audit reports.

Overall, we found that actions from the prior reviews have been largely implemented, with 18 recommendations closed and only two recommendations remaining to be addressed at this time.

We also closed a further six recommendations, noting the GUH project has now concluded and action with the project can no longer be taken. However, we recommended that the Health Board should ensure that these are implemented / considered for inclusion within future projects.

The **GUH: Quality** audit (reasonable assurance) 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.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give

only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on this year's (and to an extent last year's) programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2021/22 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit, Risk and Assurance Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2021/22.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at Health Board in conformance with the Public Sector Internal Audit Standards for 2021/22.

Our conformance statement for 2021/22 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2021/22 which will be reported formally in the Summer of 2022; and

- the results of the work completed by Audit Wales.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2021/22 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set out about below, with relevant comments and opinions attached, and relate to work at NHS Wales Shared Services Partnership.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion
Accounts Payable	Reasonable
Payroll	Reasonable
Primary Care Services	Substantial

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

The reports on Accounts Payable, Payroll and Primary Care Services are also included in the table in section 5.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion
Welsh Radiology Information System	Reasonable
Data Centre Transition	Substantial
Data Analytics	Reasonable
System Development	Reasonable
GP System Procurement Project	Substantial

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion
WHSSC – Risk management	Reasonable
WHSSC – Cancer and blood services	Substantial
WHSSC – All Wales Positron Emission Tomography (PET) Service	Reasonable
EASC – Governance arrangements	Reasonable

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2022/23 operational audit plan.

The audit plan approved by the Committee in April 2021 contained 30 planned reviews. Changes have been made to the plan with six audits (Quality Framework, Clinical Futures – Care Closer to Home, Monitoring Action Plans, Catering, Agile Working and Decarbonisation) deferred and Controlled Drugs and Medicines Management amalgamated. All these changes have been reported to and approved by the Audit, Risk and Assurance Committee. As a result of these agreed changes we have delivered 23 reviews, plus four capital audits completed as part of the integrated audit plan.

The assignment status summary is reported at Section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work,

undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed. These are reported quarterly.

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	April 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2020/21	G	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	86%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 28 audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings

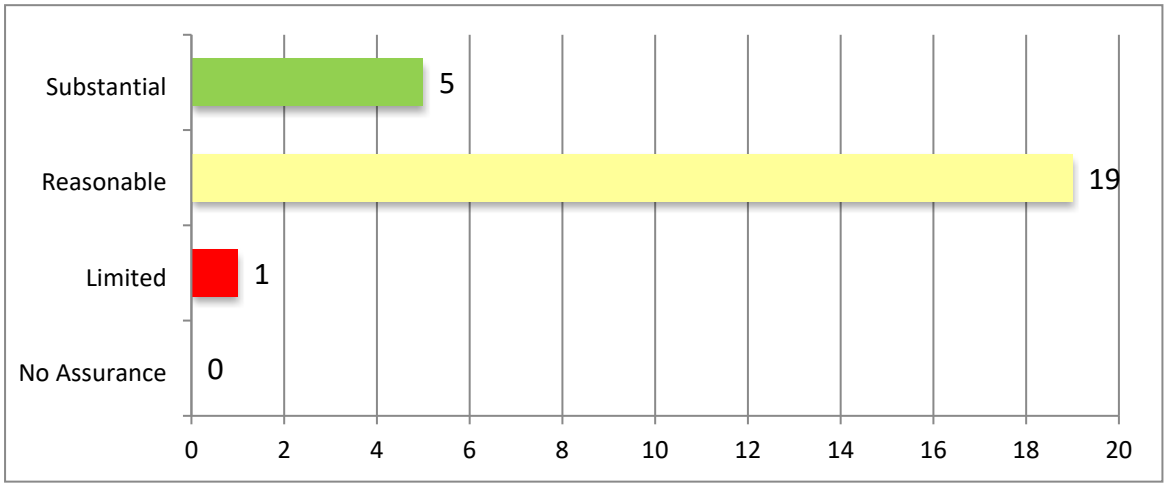


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Clinical Negligence Costs	The review sought to provide the Health Board with assurance that it complies with the relevant standards for the handling of clinical negligence claims, whilst seeking to minimise the financial impact to NHS Wales.
Charitable Funds	We evaluated the adequacy of the systems and controls in place for the management of charitable funds, including income and expenditure. We also reviewed progress made against implementing the recommendations

Review Title	Objective
	from the previous internal audit of charitable funds (November 2019).
Occupational Health	To provide assurance over the arrangements and controls in place for the management of the occupational health service.
GUH: Financial Assurance (Follow-up)	We sought to provide assurance in the area of Financial Assurance, focusing on the accuracy of the final account calculations and the adequacy of information supporting the sums claimed by the Supply Chain Partner. However, the final account was not available at the date of the audit (deferred to 2022/23), therefore the focus of work was on the assurance that additional costs arising from Covid 19 had been appropriately identified, reported and managed.
GUH: Technical Assurance	The audit sought to determine whether project delivery and handover of the Grange University Hospital has been in accordance with the terms of the contract and other statutory requirements.

5.3 Reasonable Assurance (Yellow)

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Financial Sustainability	To evaluate the monitoring and delivery of financial sustainability of the Aneurin Bevan University Health Board governance structure.
Gifts, Hospitality and Declarations of Interest	To provide assurance over the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests.

Review Title	Objective
Putting Things Right	We sought to provide the Health Board with assurance that it complies with the relevant standards for the handling of complaints, both in terms of quality and content and that improvements are made as a result of issues identified.
Operational Plan for the Resumption of Services	We evaluated the adequacy of the systems and controls in place for the operational resumption of services.
Pathology	This review aimed to provide assurance that the Health Board Pathology service is managing key risks and that the Clinical Futures model is delivering the benefits expected.
Medicines Management	To determine if the Policy for the Management of Controlled Drugs is adhered to across a sample of wards at different hospital sites and within theatres.
Falls Management	We sought to provide assurance that the Falls Policy for Hospital Adult Inpatients was being adhered to by staff and monitored appropriately.
Facilities – Care after Death	To provide assurance on the care after death service within the Facilities division, which commenced operations during January 2021.
Corporate Governance	To evaluate the Board Assurance Framework (BAF) process and supporting arrangements that are embedded within the Health Board's governance structure.
Flu Immunisation	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.
Mental Capacity Act	To assess the extent to which the Health Board complies with the Principles of the Mental Capacity Act, including in respect of the 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) process.
Flow Centre	This audit assessed the processes within the Flow Centre Team of the Health Board for: • ensuring patients are cared for in the right place, at the right time;

Review Title	Objective
	• ensuring local co-ordination with other partners; and • providing a single point of contact for transferring patients into and between hospital sites.
Risk Management	To provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board to ensure strategic objectives are achieved.
IT System Controls	To provide assurance that data held within the Welsh Radiology Information System is accurate, secure from unauthorised access and loss, and that the system is fully used and fits the needs of the service.
NIS Directive	To review arrangements in place for the implementation of the NIS (Network and Information Systems) Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.
Tredegar Health and Wellbeing Centre	The audit was undertaken to review the delivery and management arrangements in place to progress the Tredegar Health & Wellbeing Centre project; and the performance to date against its key delivery objectives i.e. time, cost and quality.
GUH: Follow-up	The audit sought to determine the status of agreed audit recommendations contained within previous Grange University Hospital project audit reports.
GUH: Quality	The agreed audit brief sought to provide assurance in the area of Quality Assurance, focusing on an assessment of the delivery Grange University Hospital building against the key business case objectives.
Waste Management	The audit was undertaken to assess the Health Board's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

5.4 Limited Assurance (Amber)

In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Continuing Healthcare	To provide assurance that there are robust commissioning arrangements in place within the Mental Health and Learning Disabilities Division, focusing on quality and safety.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Datix (Support of Incident Management)	The review sought to provide the Health Board with an overview of testing completed within other audits that a sample of incidents entered

Review Title	Objective
	onto Datix are being managed appropriately and in accordance with the Incident Reporting Policy.
Follow-up of High Priority Recommendations	The review sought to determine if a sample of high priority recommendations had been implemented or recognised as still outstanding on the Audit Recommendation Tracking Tool.
Medical Equipment and Devices	We sought to confirm that medical equipment and devices are being appropriately managed.

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for Deferral
Quality Framework	Deferred to the 22/23 plan due to Covid related pressures on the Health Board.
Clinical Future – Care Closer to Home	Deferred to the 22/23 plan due to Covid related pressures on the Health Board.
Monitoring Action Plans	Deferred to the 22/23 plan due to Covid related pressures on the Health Board.
Catering	Deferred due to an internal review scheduled by the Health Board.
Agile Working	Deferred to the 22/23 plan due to Covid related pressures on the Health Board.
Decarbonisation	The Health Board is not required to publish its Decarbonisation Action Plan until March 2022 and we will be unable to fully consider the expenditure and initial capital allocations until after that date.

Audits undertaken at NWSSP

We undertook the following reviews at NWSSP:

Review Title	Objective
Accounts Payable	The purpose of the audit review was to evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP Procure to Pay (P2P) service.
Payroll	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for payroll processing across NHS Wales.
Primary Care Services	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for primary care services across NHS Wales.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the organisation to support delivery of the Internal Audit assignments undertaken within the 2021/22 plan.

Simon Cookson
Pennaeth yr Archwiliad Mewnol/Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
June 2022

Appendix A

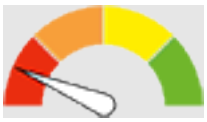
ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit, Risk and Assurance Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit, Risk and Assurance Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of

	specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit, Risk and Assurance Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit, Risk and Assurance Committee. An annual report and opinion is produced for the Audit, Risk and Assurance Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit, Risk and Assurance

	Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B - Audit Assurance Ratings

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

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

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 of Accounts Report – Aneurin Bevan University Health Board

Audit year: 2021-22

Date issued: 8 June 2022

Document reference: ABUHB2021-22ISA260F

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

We intend to issue unqualified audit opinions, except for the regularity opinion which we intend to qualify. There are some issues to report to you before you consider whether to approve the Performance Report, Accountability Report and Financial Statements.

Audit of Accounts Report

Introduction

1 We summarise the main findings from our audit of your 2021-22 annual report and accounts in this report.

2 We have already discussed these issues with the and the Interim Director of Finance Interim the Assistant Director of Finance (Financial Systems & Services) and their team.

3 Auditors can never give complete assurance that accounts are correctly stated. Instead, we work to a level of 'materiality'. This level of materiality is set to try to identify and correct misstatements that might otherwise cause a user of the accounts into being misled.

4 We set this level at £17 million for this year's audit.

5 There are some areas of the accounts that may be of more importance to the reader and we have set a lower materiality level for these, as follows:

- remuneration report/senior pay disclosure and exit packages;
- Related Parties; and
- the Ministerial Direction for clinicians' pay.

6 We have now substantially completed this year's audit and are in the final stages of review. We will provide an update to the Audit Committee on 13 June 2022.

7 In our professional view, we have complied with the ethical standards that apply to our work; remain independent of yourselves; and, our objectivity has not been compromised in any way. There are no relationships between ourselves and yourselves that we believe could undermine our objectivity and independence.

Impact of COVID-19 on this year's audit

8 The COVID-19 pandemic has had a continuing impact on how our audit has been conducted. We summarise in **Exhibit 1** the main impacts. Other than where we specifically make recommendations, the detail in **Exhibit 1** is provided for information purposes only to help you understand the impact of the COVID-19 pandemic on this year's audit process.

Exhibit 1 – impact of COVID-19 on this year's audit

Timetable	• The Welsh Government's deadlines for health bodies to submit their 2021-22 Performance Report, Accountability Report and Financial Statements are: – the draft Financial Statements by 29 April; and – the draft Performance Report and Accountability Report by 6 May. • The Health Board met the above deadlines. • The Welsh Government's deadline for audit completion and the submission of the audited documents is 15 June. • The Auditor General for Wales is scheduled to certify his audit report on 17 June. • Thereafter, we instruct the Senedd to lay the certified Performance Report, Accountability Report and Financial Statements. The laying tends to take place for all health bodies on the same day, with the preferred date being determined by the Welsh Government to coincide with its press notice.
Audit evidence	As in previous years, we received the majority of audit evidence in electronic format. We have used various techniques to ensure its validity. Where we have been unable to obtain access to paper documents because of COVID-19 restrictions, we have devised alternative audit methodologies to obtain sufficient audit evidence. Specifically: • the Finance Team provided audit evidence to the audit team via a secure file sharing portal; • the Finance Team were available on MS Teams for discussions, and also for the sharing of on-screen information/evidence; • Audit Wales also secured remote read-only access to the Health Board's Oracle ledger which enabled the audit team to query the ledger and hence reduce the burden on the finance team to provide this information; and • for testing of existence and ownership of assets we have used a combination access to our land registry tool and photographic evidence. Our Analytics Assisted Audit application was also used during the audit for risk assessing journals, carrying out financial statement tests and sampling populations. This application uses the Health Board's general ledger data provided independently by NWSSP which provides additional assurance over the transactions included within the financial statements.

Other	• Video conferencing has enabled the audit team to correspond effectively with the finance team throughout the audit. • Video conference-based Audit Committee meetings have enabled us to proficiently discharge our responsibility for reporting to those charged with governance.

Proposed audit opinion

9 We issue a 'qualified' audit opinion where we have material concerns about some aspects of your accounts; otherwise, we issue an unqualified opinion. We intend to issue an unqualified audit opinion on the 2021-22 financial statements, except for the regularity opinion which we intend to qualify.

10 We intend to qualify the regularity opinion because the financial statements include a provision (and corresponding expenditure) of £756,155, relating to the Health Board's estimated liability arising from a Ministerial Direction in 2019. The Direction instructed payments to be made to clinical staff, if claimed, to restore the value of their pension benefits packages.

11 For NHS clinicians who opted to claim the financial offer to settle their annual allowance tax charges arising from their 2019-20 NHS pension savings, their NHS employers would meet the impact of those personal tax-charges on their pension when they retire. Claims that were submitted by the deadline of 31 March 2022 are accounted for as expenditure within the 2021-22 financial statements. In my view, this expenditure is irregular and material by its nature.

12 Our proposed audit report is at **Appendix 2;** and our proposed narrative report is at **Appendix 3** which provides a more detailed explanation of the basis of the qualified regularity opinion.

13 We provide the intended opinions once you have provided us with a Letter of Representation based on that set out in **Appendix 1**. The Letter of Representation contains certain confirmations that we are required to obtain from you under auditing standards along with confirmation of other specific information you have provided to us during our audit.

Significant issues arising from the audit

Uncorrected misstatements

14 There is one misstatement in the accounts that is above our trivial level (£0.854 million) but lower than materiality (£17.081 million). This has been discussed with management, but in line with Welsh Government guidance remains uncorrected.

15 NHS land and buildings are subject to full revaluations every 5 years by the District Valuer Services (DVS). In the intervening years, the value of these assets is

indexed using indices advised by the DVS. In August 2021 the DVS provided the rates to be in 2021-22. The index quoted for buildings was 5%. In March 2022, due to increases in building costs, the DVS updated the buildings indexation rate to 7% for the last quarter of 2021-22.

16 In line with all other Welsh health bodies and in compliance with instructions from Welsh Government under Technical Update 7, the Health Board has not applied the latest rate in their calculation of indexation within the financial statements.

17 This has resulted in the following misstatements:

- an increase of £11.047 million in the value of land and buildings in respect of indexation, as at 31 March 2022;
- an increase in depreciation of £101,000 for 2021-22 to be charged to the Statement of Comprehensive Net Expenditure;
- a reversal of past impairments of £7.577 million for 2021-22 to be credited to the Statement of Comprehensive Net Expenditure; and.
- an increase in the revaluation reserve of £3.470 million, as at 31 March 2022.

18 Both individually and collectively, these unadjusted misstatements are not material to the financial statements. Therefore, the non-correction does not adversely affect our audit opinion.

Corrected misstatements

19 There were initially misstatements in the accounts that have now been corrected by management. However, we believe that these should be drawn to your attention, and they are set out with explanations in **Appendix 4.**

20 There are also a number of minor misstatements that have been corrected by management. However, we do not consider that they need to be drawn to your attention as part of your responsibilities over the financial reporting process. As well as a few additional disclosures, the financial corrections were minor and have not impacted on the reported surplus.

Other significant issues arising from the audit

21 In the course of the audit, we consider a number of matters relating to the accounts and report any significant issues arising to you. There were some issues arising in these areas this year as shown in **Exhibit 2**:

Exhibit 2 – significant issues arising from the audit

Significant issues arising from the audit	
Note 10 – Property, plant and equipment - additional work required by the HB to provide assurance over the Gross Book Value of plant and equipment whose Net Book Value was nil	Due to Covid, the Health Board decided not to undertake its annual asset impairment review and the process for verifying asset existence as at 31 March. As part of our review of asset lives, we sample tested assets recorded as having a Net Book Value (NBV) of 'nil'. Our review of these assets found that all of our sample tested, were no longer in use and therefore the Gross Book Value (GBV) of these assets was overstated. Further testing of an extended sample, identified further errors, resulting in a total error rate of 33% for the total population sample tested. The total GBV for those assets amounts to £49.9m, and therefore the potential overstatement of the GBV is £16.5m. Further work was undertaken by the Finance Team to provide assurance that the GBV was not materially miss-stated. The Finance Team received confirmation for assets totalling a GBV of £24.4 million, of which £5.1 million was confirmed as no longer in use and the financial statements were amended accordingly. In addition, responses from departments highlighted uncertainty over asset existence to a further value of £1.5 million, leading to a potential error of 25% (£6.6 million out of £25.9 million responses). Extrapolation of this error rate to the remaining £24 million assets, indicates a potential miss-statement of £6 million, which is below our materiality for the financial statements. For 2022-23 we recommend that asset verification reviews are undertaken annually, to ensure the verification of asset existence and values are correct/not materially miss-stated as at 31 March.

Significant issues arising from the audit	
Remuneration Report	Our work identified a number of amendments to the Remuneration Report which included: • Inclusion of annualised salaries for those individuals who were only in post for part of the year; and • Inclusion of correct post titles. The note was both further complicated by the number of staff changes at Senior Management level and Board members. For 2022-23 we recommend that the compilation of the Remuneration Report is reviewed to ensure compliance with the relevant guidance from Welsh Government.

Recommendations

22 We intend to discuss lessons learnt and recommendations arising from our audit of the financial statements at the joint post project learning session that we will hold jointly with the Finance Team. The agreed actions arising from this session and follow up of last year's recommendations will be presented to the Audit Committee scheduled for the Autumn 2022

Follow up of last year's significant issues arising from the audit

23 In our Audit of the Accounts Report 2020-21, we identified one significant issue arising from the audit:

- Contingent liability and emphasis of matter paragraph in audit report – this issue remains for 2021-22 as referred to in **Exhibit 2** above although this is now treated as a provision within the financial statements in accordance with guidance for 2021-22 and we have qualified our regularity opinion.

Appendix 1

Final Letter of Representation

[Audited body's letterhead]

Auditor General for Wales
Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

xx June 2022

Representations regarding the 2020-21 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Health Board for the year ended 31 March 2022 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- Preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Health Board will continue in operation.
- Ensuring the regularity of any expenditure and other transactions incurred.
- The design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Health Board and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole. A summary of these items is set out below:

- an increase of £11.047 million in the value of land and buildings in respect of indexation, as at 31 March 2022;
- an increase in depreciation of £101,000 for 2021-22 to be charged to the Statement of Comprehensive Net Expenditure;
- a reversal of past impairments of £7.577 million for 2021-22 to be credited to the Statement of Comprehensive Net Expenditure; and.
- an increase in the revaluation reserve of £3.470 million, as at 31 March 2022.

We have chosen not to amend these misstatements as the Health Board has applied the 2021-22 indexation rates issued by the District Valuation Office in August 2021. On 22nd March 2022, the District Valuation Office issued revised rates for the 2021-22 year. In line with all other Welsh health bodies and in compliance with instructions from Welsh Government under Technical Update 7, the Health Board has not applied the latest rate in their calculation of indexation within the financial statements.

Representations by Aneurin Bevan University Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Health Board on 13 June 2022.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
[Officer who signs on behalf of management]	[Officer or Member who signs on behalf of those charged with governance (director only for companies)]
Date:	Date:

Appendix 2

Proposed Audit Report

The Certificate and independent auditor's report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Aneurin Bevan University Health Board for the year ended 31 March 2022 under Section 61 of the Public Audit (Wales) Act 2004. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Aneurin Bevan University Health Board as at 31 March 2022 and of its net operating costs for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, except for the matter described in the *Basis for Qualified Opinion on Regularity* section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on Regularity

I have qualified my opinion on the regularity of the Aneurin Bevan University Health Board's financial statements because those statements include a provision of £756,155 relating to the Trust's estimated liability arising from the Ministerial Direction dated 18 December 2019 on senior clinicians' pensions. In my view, this expenditure is irregular and material by its nature.

Further detail is set out in my Report in **Appendix 3.**

Basis of opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial

statements section of my report. I am independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Report on other requirements

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and the Annual Governance Statement has been prepared in accordance with Welsh Ministers' guidance;
- the information given in the Performance Report and the other unaudited parts of the Accountability Report for the financial year for which the financial statements are

prepared is consistent with the financial statements and the Performance Report and the other unaudited parts of the Accountability Report have been prepared in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and the other unaudited parts of the Accountability Report or the Annual Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed; or
- I have not received all the information and explanations I require for my audit.

Responsibilities

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for the preparation of financial statements which give a true and fair view and for such internal control as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors and Chief Executive are responsible for assessing the board's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the [audited entity's head of internal audit] and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Health Board's policies and procedures concerned with:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, posting of unusual journals and (add as appropriate to the audit);
- Obtaining an understanding of Aneurin Bevan University Health Board's framework of authority as well as other legal and regulatory frameworks that the [LHB / SHA Name] operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Aneurin Bevan University Health Board;

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the [Audit Committee] and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Health Board controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Responsibilities for regularity

The Chief Executive is responsible for ensuring the regularity of financial transactions.

I am required to obtain sufficient evidence to give reasonable assurance that the expenditure and income have been applied to the purposes intended by the Senedd and the financial transactions conform to the authorities which govern them.

Report

Please see my Report in **Appendix 3**.

Adrian Crompton
Auditor General for Wales
17 June 2022

24 Cathedral Road
Cardiff
CF11 9LJ

Appendix 3

The proposed Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Aneurin Bevan University Health Board's (the HB's) financial statements. I am reporting on these financial statements for the year ended 31 March 2022 to draw attention to one key matter for my audit. This is the qualification of my 'regularity' opinion relating to expenditure recognised as a result of the ministerial direction on senior clinicians' pensions. I have not qualified my 'true and fair' opinion in respect of this matter.

Ministerial direction on senior clinicians' pensions

NHS Pension scheme and pension tax legislation is not devolved to Wales. HM Treasury's changes to the tax arrangements on pension contributions in recent years included the reduction in the Annual Allowance limit from over £200k in 2011-12 to £40k in 2018-19. As a result, in cases where an individual's pension contributions exceed certain annual and / or lifetime pension contribution allowance limits, then they are taxed at a higher rate on all their contributions, creating a sharp increase in tax liability.

In a Written Statement on 13 November 2019, the Minister for Health and Social Services had noted that NHS Wales bodies were: 'regularly reporting that senior clinical staff are unwilling to take on additional work and sessions due to the potentially punitive tax liability'. In certain circumstances this could lead to additional tax charges in excess of any additional income earned.

On 18 December 2019, the First Minister (mirroring earlier action by the Secretary of State for Health and Social Care for England) issued a Ministerial Direction to the Permanent Secretary to proceed with plans to commit to making payments to clinical staff to restore the value of their pension benefits packages. If NHS clinicians opted to use the 'Scheme Pays' facility to settle annual allowance tax charges arising from their 2019-20 NHS pension savings (i.e. settling the charge by way of reduced annual pension, rather than by making an immediate one-off payment), then their NHS employers would meet the impact of those tax charges on their pension when they retire.

The Ministerial Direction was required because this solution could be viewed by HMRC to constitute tax planning and potentially tax avoidance, hence making the expenditure irregular. Managing Welsh Public Money (which mirrors its English equivalent) specifically states that 'public sector organisations should not engage in…tax evasion, tax avoidance or tax planning'.

A Ministerial Direction does not make regular what would otherwise be irregular, but it does move the accountability for such decisions from the Accounting Officer to the Minister issuing the direction.

The solution applies only to annual allowance tax charges arising from an increase in the benefits accrued in the NHS Pension Scheme during the tax year ended 5 April 2020. For the tax year ended 5 April 2021, the Chancellor increased the thresholds for the tapered annual allowance and, as a result, it is anticipated that the risk to the supply of clinical staff has been mitigated.

The LHB has received sufficient information during the year to calculate and recognise an estimate of the potential costs of compensating senior clinical staff for pension benefits that they would otherwise have lost, by using the 'Scheme Pays' arrangement. As a

result, expenditure has been recognised as a provision as shown in Note 20 of the financial statements.

All NHS bodies will be held harmless for the impact of the Ministerial Direction, however in my opinion, the transactions included in the LHB's financial statements to recognise this liability are irregular and material by their nature. This is because the payments are contrary to paragraph 5.6.1 of Managing Public Money and constitute a form of tax planning which will leave the Exchequer as a whole worse off. The Minister's direction alone does not regularise the scheme. Furthermore, the arrangements are novel and contentious and potentially precedent setting. As a result, I have qualified my 'regularity' opinion for 2021-22.

Adrian Crompton

Auditor General for Wales

17 June 2022

Appendix 4

Summary of Corrections Made

During our audit we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process.

Exhibit 3: summary of corrections made

Value of correction	Nature of correction	Reason for correction
£119.854m £nil impact on the overall financial position	**Note 20 – Provisions** Reduce the year end balance for current provisions 'Clinical Negligence – Secondary Care' line by £119.022m and current provisions 'Defence legal fees and other administration' line by £0.833m with corresponding increases in the respective non-current provisions line.	To ensure that the provision is correctly classified based on when any payment is likely to be made within Note 20.
£19.603m £nil impact on the overall financial position	**Note 18 – Trade and other payables** Reduce the 'Non-NHS payables – Revenue' line, with a corresponding increase in the 'Non NHS Accruals' line.	To correct the classification of the annual leave accrual within Note 18.

Value of correction	Nature of correction	Reason for correction
£9.126m £nil impact on the overall financial position	**Note 21.1 – Contingent liabilities** Reduce the 'Legal claims for alleged medical or employer negligence – Secondary care' line with a corresponding reverse entry in the 'Amounts recovered in the event of claims being successful' line.	To ensure that the figures disclosed in Note 21.1 agree to the supporting accounting records.
£7.745m £nil impact on the overall financial position	**Note 20 – Provisions** Increase the 'Clinical Care – Secondary' line, 'Arising during year' column with a corresponding reverse entry in the same line under 'Structured settlement cases transferred to Risk Pool'.	To include the costs relating to Structured Settlement cases within Note 20.
£5.296m £nil impact on the overall financial position	**Note 3.3 – Expenditure on Hospital and Community Health Services** Reduce the 'Losses, special payments and irrecoverable debts' line with a corresponding increase in 'Other operating expenses' line.	To ensure that expenditure is correctly classified within Note 3.3.

Value of correction	Nature of correction	Reason for correction
£5.128m	**Note 11.1 – Property, plant and equipment** Increase the 'Disposals' under the 'Cost or valuation' section (£2.156m under 'Plant and machinery' and £2.972m under 'Information technology'), with a corresponding increase in 'Disposals' in the 'Depreciation' section.	To remove those assets with a nil net book value from the accounts that the Health Board no longer own
£0.756m	**Note 15 – Trade and other Receivables** Increase in the '2019-20 Scheme Pays – Welsh Government Reimbursement' line, with a corresponding decrease in the 'Other debtors' line.	To ensure that receivables are correctly classified within Note 15.
£0.215m	**Note 30.3 – Related Party Transactions** Inclusion of a related party for an Independent Member of the Board	To ensure all relevant related party transactions are disclosed in accordance with guidance
Various narrative	**Performance Report and Accountability Report** A number of amendments to the performance and Accountability Report, including the Annual Governance Statement.	To ensure full compliance with relevant guidance

Value of correction	Nature of correction	Reason for correction
Various amounts and narrative	**Remuneration Report** A high number of amendments to the remuneration report which included: • Inclusion of annualised salaries for those individuals who were only in post for part of the year; • Inclusion of correct post titles; • Pension benefits and bandings amended to reflect actual figures as per the 2021-22 P11Ds; • Correct disclosure of benefits in kind	To ensure senior managers' and directors' remuneration is correctly disclosed in accordance with relevant guidance.
Various amounts and narrative	**Other** A number of amendments to the disclosure Notes.	During the audit we identified a number of trivial amendments and errors in narrative which the Health Board has chosen to amend.

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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.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk and Assurance Committee Monday 13th June 2022 Agenda Item: 4.2

Aneurin Bevan University Health Board

Annual Report and Accounts 2021/22
Final Draft Performance Report & Final Draft Annual Accountability Report

Executive Summary

In respect of the Annual Report and Accounts 2021/22, this paper presents to the Audit, Risk and Assurance Committee the final draft audited versions of:

1) The Performance Report (Part 1)
2) The Accountability Report (Part 2), including:
   a) A Corporate Governance Report
   b) A Remuneration and Staff Report
   c) A Parliamentary Accountability and Audit Report.

for consideration and review prior to being submitted for formal approval at ABUHB's Board Meeting on 14th June 2022 and submitted to Welsh Government on 15th June 2022, in-line with HM Treasury Requirements.

Following presentation of the draft documents to the Audit, Risk and Assurance Committee on 17th May 2022, the final draft versions incorporate all comments and feedback received from Welsh Government; Audit Wales; and Board Members, including those comments made by the Audit, Risk and Assurance Committee when reviewing the drafts.

Part 3 of the Annual Report and Accounts 2021/22 are the Financial Statements 2021/22, and these are provided to the Audit, Risk and Assurance Committee under separate cover.

The Audit, Risk & Assurance Committee is asked to CONSIDER and REVIEW the Final Draft Versions presented prior to being submitted for formal approval by the Board on 14th June 2022.

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: Bryony Codd, Head of Corporate Governance

Report Received consideration and supported by:

Executive Team	✓	**Audit, Risk & Assurance Committee, 17th May 2022**	✓

Date of the Report: 6th June 2022

Supplementary Papers Attached:

a) Appendix A - Final Draft Performance Report 2021/22 (audited)
b) Appendix B - Final Draft Accountability Report 2021/22 (audited)

Context

NHS Bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by Welsh Ministers and the approval of the Treasury.

The Manual for Accounts, issued by Welsh Government, has been prepared to ensure that those determinations and directions are consistent with the 2021-22 Government Financial Reporting Manual (FReM) which sets out the accounting guidance applicable to bodies within the Resource Accounting Boundary. In setting the requirements of the FReM the government is advised by an independent body, the Financial Reporting Advisory Board (FRAB). NHS bodies are required to follow FReM guidance except where a divergence has been formally agreed with the Treasury.

The Manual provides principles–based guidance to NHS bodies on how to prepare and complete their annual report and accounts and financial returns. Application of the principles to the individual circumstances of a NHS body is a matter between the body and its external auditors.

The Annual Report and Accounts as a whole must be fair, balanced and understandable and the Accountable Officer takes personal responsibility for it and the judgments required for determining that it is fair, balanced and understandable.

Annual Report and Accounts - Requirements for 2021/22

As set out in the Manual for Accounts, NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes:

1) The Performance Report, which must include:
   - An overview.
2) The Accountability Report, which must include:
   - A Corporate Governance Report.
   - A Remuneration and Staff Report.
   - A Parliamentary Accountability and Audit Report.
3) The Financial Statements, including:
   - The Audited Annual Accounts 2021-22.

The detailed structure of the Annual Report and Accounts 2021/22, is set out at Annex A.

For 2021-22, there is no requirement to prepare a separate Annual Quality Statement, or to prepare a separate Annual Putting Things Right report. Information on dealing with concerns, that complies with the requirements in the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, should be contained in the Performance Report, unless a separate report has already been developed.

In recognition of the continuing challenges faced by NHS Wales during 2021-22 due to responding to COVID-19, the Manual for Accounts also seeks to streamline annual reporting in Wales and reduce duplication of content whilst ensuring all regulatory requirements are met.

For the 2021-22 reporting period the deadlines for submission are:

- Draft Performance Report Overview, Accountability Report and Remuneration Report to Welsh Government – Friday 6th May 2022
- Audit Committee meeting to Consider Draft Accounts and Draft Accountability Report – Tuesday 17th May 2022

- Audit Committee meeting to Consider Final Accounts, and Accountability Report - 13th June 2022
- Board meeting to approve Final Accounts and Accountability Report – 14th June 2022
- Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document – 15th June 2022
- Annual General Meeting – to receive the Annual Report and Accounts – 27th July 2022

Final Draft Performance Report 2021/22

The purpose of the performance section of the annual report is to provide information on the Health Board, its main objectives and strategies and the principal risks that it faces. The requirements of the performance report are based on the matters required to be dealt with in a Strategic Report as set out in Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013, No. 1970. The main features of the performance report should flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against that plan in the year of reporting.

The performance report must provide a fair, balanced and understandable analysis of the Health Board's performance, in line with the overarching requirement for the annual report and accounts to be fair, balanced and understandable.

The performance report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer).

The Draft Performance Report 2021/22 was considered by the Audit, Risk and Assurance Committee on 17th May 2022 where comments and feedback were provided to inform the Final Draft version, as attached. In addition, and subsequent to the Committee's meeting, Audit Wales (External Audit), has reviewed the draft performance report for consistency with other information in the financial statements (part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft and Audit Wales has consequently confirmed that these amends are deemed satisfactory. Welsh Government has also reviewed the draft performance report and, as with Audit Wales, updates to the document have been made to reflect feedback and comments received.

A summary of changes made since the first draft is provided in the below table to support Committee Members in undertaking final review:

	Section	Summary of Changes Made
1.	Overview	Immaterial change
2.	Reporting Requirements	Updated to include reference to Sustainability Reporting
3.	Aneurin Bevan University Health Board	Staff numbers amended to align with Staff and Remuneration Report
4.	Annual Plan 2021/22	Updated to included high-level achievements against the Annual Plan 2021/22 Priorities
5.	Impact of COVID-19 on delivery of services	Updated to include reference to some of the service changes during 2021/22 to respond to the impact of COVID
6.	Primary Care and Community Services	Immaterial change

7.	Testing and Immunisation for COVID	Immaterial change
8.	Infection Prevention and Control	Updated to include performance data and strengthened narrative
9.	Delivery of Essential Services	Referral to Treatment Section included
10.	Patient Experience: Listening and Learning from Feedback	Immaterial change
11.	Putting Things Right	Immaterial change
12.	Delivering in Partnership	New section
13.	Workforce Management and Wellbeing	Immaterial change
14.	Communications and Engagement	Updated to include a focus on engagement and feedback
15.	Well-Being of Future Generations Act	Updated to strengthen links with Public Service Board and Wellbeing Objectives
16.	Welsh Language	Immaterial change
17.	Value Based Healthcare	New Section
18.	Emergency and Business Continuity Planning	New Section
19.	Financial Management and Performance	New Section
20.	Conclusion and Forward Look	Updated by Accountable Officer

At its meeting on 17th May 2022, the Audit, Risk and Assurance Committee requested a Glossary of Terms be included for ease of reading. This has been developed and is included as Appendix 1 of the Annual Accountability Report, included at the conclusion of the Remuneration and Staff Report.

In support of sharing the Performance Report 2021/22 with the public, a summary document has been produced which will be finalised upon Board approval of the Performance Report 2021/22. This will be published in readiness for the Board's Annual General Meeting which will be held on 27th July 2022. A draft version is provided for Committee Members within a supporting appendices pack, issued with the meetings papers.

Final Draft Annual Accountability Report 2021/22

The purpose of the accountability section of the annual report is to meet key accountability requirements to the Welsh Government. The requirements of the accountability report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The Accountability Report is required to have three sections:

- Corporate Governance Report

The purpose of the Corporate Governance Report is to explain the composition and organisation of the Health Board's governance structures and how they support the achievement of the entity's objectives.

As a minimum, the corporate governance report must include:

  - The Directors' Report;
  - The Statement of Accounting Officer's responsibilities; and
  - A Governance Statement.

The Governance Statement is a key feature of the organisation's Annual Report and Accounts. It demonstrates publicly the management and control of resources and the extent to which the body complies with its own governance requirements, including how they have monitored and evaluated the effectiveness of their governance arrangements. It is intended to bring together in one place in the annual report all disclosures relating to governance, risk and control.

- Remuneration and Staff Report

The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

- Parliamentary Accountability and Audit Report

The Parliamentary Accountability Report contains disclosure on the following:

- Regularity of expenditure
- Fees and charges
- Public Sector Information Holders only - a statement is required if the entity has not complied with the cost allocation and charging requirements set out in HM Treasury guidance
- A brief description of the nature of each of the organisation's material remote contingent liabilities (that is, those that are disclosed under Parliamentary reporting requirements and not under IAS 37) and, where practical, an estimate of its financial effect. (This is included in the Annual Accounts [Part 3]).

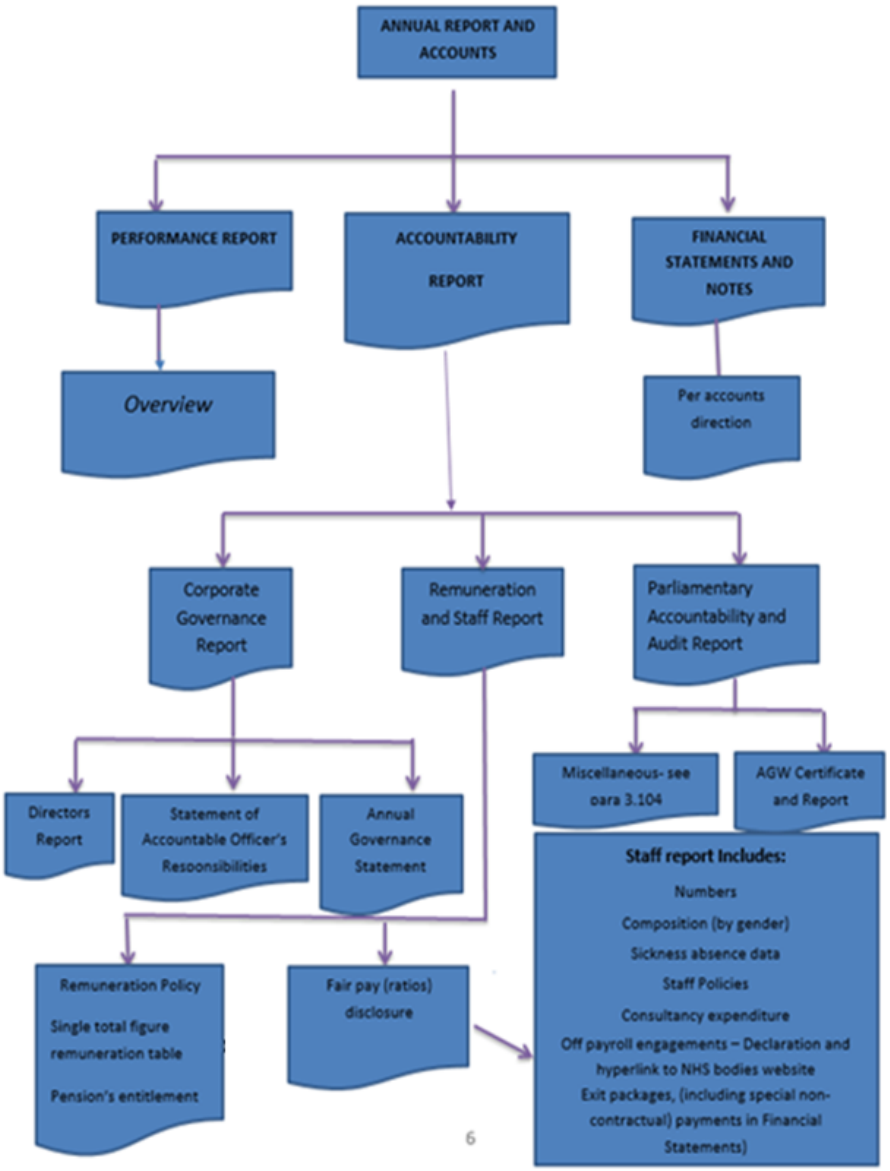
The performance report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer).

The Draft Accountability Report 2021/22 was considered by the Audit, Risk and Assurance Committee on 17th May 2022 where comments and feedback were provided to inform the Final Draft version, as attached. In addition, and subsequent to the Committee's meeting, Audit Wales (External Audit), has reviewed the draft accountability report for consistency with other information in the financial statements. Feedback and amendments received from Audit Wales have been factored into the Final Draft and Audit Wales has consequently confirmed that these amends are deemed satisfactory. Welsh Government has also reviewed the draft accountability report and, as with Audit Wales, updates to the document have been made to reflect feedback and comments received.

Material changes made since the first draft are highlighted in red within the attachment (appendix B) to support Committee Members in undertaking final review.

Recommendation	
The Audit, Risk & Assurance Committee is asked to CONSIDER and REVIEW the Final Draft Versions presented prior to being submitted for formal approval by the Board on 14th June 2022.	
Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Failure to agree the reports would mean that the Health Board would not comply with Welsh Government and HM Treasury requirements.
Financial Assessment, including Value for Money	No direct financial impact of this report.
Quality, Safety and Patient Experience Assessment	No direct quality, safety and patient experience elements of this report.
Equality and Diversity Impact Assessment (including child impact assessment)	No direct equality and diversity elements to this report.
Health and Care Standards	No direct health and care standards matters relating to this report. However, it will contribute to the good governance elements of the standards.
Link to Integrated Medium Term Plan/Corporate Objectives	No direct link with this report.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	No direct link with this report to the five ways of working.
Glossary of New Terms	No new terms have been identified in this report.
Public Interest	Open – this report is designed for reporting in the public domain.

ANNEX A


ANNUAL REPORT AND ACCOUNTS
PERFORMANCE REPORT
ACCOUNTABILITY REPORT
FINANCIAL STATEMENTS AND NOTES
Overview
Per accounts direction
Corporate Governance Report
Remuneration and Staff Report
Parliamentary Accountability and Audit Report
Directors Report
Statement of Accountable Officer's Resoonsibilities
Annual Governance Statement
Miscellaneous- see para 3.104
AGW Certificate and Report
Staff report Includes:
Numbers
Composition (by gender)
Sickness absence data
Staff Policies
Consultancy expenditure
Off payroll engagements – Declaration and hyperlink to NHS bodies website
Exit packages, (including special non-contractual) payments in Financial Statements)
Remuneration Policy
Single total figure remuneration table
Pension's entitlement
Fair pay (ratios) disclosure
6

Aneurin Bevan University Health Board Annual Report and Annual Accounts 2021/22

Our Annual Report is a suite of documents that tell you about our organisation, the services and care we provide and what we do to plan, deliver and improve healthcare for you. It provides information about how we performed in 2021/22, what we have achieved, how we plan to continue to improve next year and our plans for the future. This report also explains how important it is for us to work with you and listen to your views, to better deliver services that meet your needs, as close to your home as possible.

Our Annual Report for the period 1st April 2021 to 31st March 2022 includes:

- Our **Performance Report** which details how we have performed against our targets and the actions planned to maintain or improve our performance.

- Our **Accountability Report** which details our key accountability requirements and provides information about how we manage and control our resources, identify and respond to our risks, and comply with our own governance arrangements.

- Our **Financial Statements and Annual Accounts** which detail how we have spent our money and met our obligations.

Performance Report 2021/22

1. Overview

Across the last 12 months our organisation has faced multiple challenges with successive waves of Covid-19 itself but also dealing with the wider impacts on our population and services of the actions to deal with the pandemic. 2021/22 brought increasing demand across our urgent care and our planned care systems, increased pressure on primary care and community services, as well as mental health services. We have experienced high walk-in demand at our emergency departments, significant pressures in social care and high levels of absence across our workforce. This is in the context of restarting many routine services despite continued constraints on capacity.

Despite these operational challenges we are proud of the way in which our staff have responded, showing resilience, bravery, dynamism, resourcefulness and great skill over the last two years. Even with these challenges, our workforce enabled our system to introduce new ways of working to deliver the ambitions of the Annual Plan 2021/22, which was approved by our Board and submitted to Welsh Government on 31st March 2021, in line with the requirements of the NHS Wales Annual Planning Framework for 2021 to 2022.

The Health Board's Annual Plan for 2021/22 set out our core organisational priorities, which focussed on reducing the health inequalities experienced by our communities, through improving population health. In doing so, the Plan adopted a life course approach that optimised the health and wellbeing of our communities. We are confident that this approach will provide high returns for health and sustainable development, both by limited ill health and the accumulation of risk throughout life for our citizens. The Annual Plan 2021/22 was ambitious in seeking to support the organisation in delivering across its life course priorities and was designed to both meet the needs to respond but also support the organisation to look forward and focus on sustainability.

Our Clinical Futures Strategy has remained resilient and relevant for over a decade. The opening of the Grange University Hospital in November 2020, as part of a new hospital network, was a fundamental milestone in the delivery of the broader strategy. Clinical Futures seeks to improve population health, resilience and well-being, deliver the majority of care close to home, primarily thorough primary and community services, all supported by a hospital network.
One year on from the opening of the Grange University Hospital and moving to a new hospital model, six months early and in the middle of a pandemic, we are seeing benefits in terms of service sustainability, resilience, and capacity. In addition, recruitment has improved for specialist medical staff and registered nurses.

This Report provides an overview of our achievements in 2021/22, some of highlights include:

- Significant improvements achieved in Urgent Care performance, whilst recognising the challenging climate.
- Safe surgical zones were created to maintain urgent and essential services.
- By February 2022, 95% of over fifty-year-olds had received their first dose of the Covid vaccination, 94% their second dose and 86% had received their booster.
- Urgent Primary Care services were established in all Enhanced Local General Hospital (ELGH) sites.
- New ambulatory services were established.
- Nurse vacancies were reduced by 85% at the time of opening the Grange University Hospital.
- Implementation of the the Mental Wellbeing Foundation Tier programme, including Connect 5, SPACE (development of single point of access for children and young adults) and Melo.
- Achieved financial balance in-line with the Financial Plan 2021/22.

As we approach 2022/23, we will continue to embed the new models of care that could not be fully implemented as our system responded to the pandemic. Notwithstanding this, our main focus and key opportunities for achieving a sustainable system lie in delivering our broader strategy, strengthening the role of our enhanced Local General Hospital network.

We have therefore reshaped our Clinical Futures Programme to support the delivery of the organisations key priorities which, based on our understanding of our system, will deliver the biggest impact on improving the sustainability of our system.

Our Integrated Medium-Term Plan 2022-25 is a natural progression from the Annual Plan 2021/22, building on the life course approach, whilst recognising that the context within which the Health Board now operates is different from the one understood in 2020/21. This being a renewed focus on sustainable recovery, which is characterised by a fundamental shift that encompasses the wider role of Health and Social Care in reducing health inequalities, delivering the foundational economy, and protecting the environment for future generations with the Net Zero 2030 ambition.

2. Reporting Requirements

The purpose of the Performance section of this Annual Report 2021/22, as set out in the guidance provided in the NHS Wales 2021/22 Manual for Accounts, is to provide information on Aneurin Bevan University Health Board, its main objectives and strategies and the principal risks that it faces. The requirements are based on the matters required to be dealt with as set out in Chapter 4A of Part 15 of the Companies Act 2006, as adapted in the Financial Reporting Manual and NHS Wales Guidance Manual.

The main features of this report flow from the organisation's Planning, Delivery and Performance Frameworks and demonstrate how the Health Board has delivered against these.

It should be noted that the duty of quality comes into legal force in April 2023 in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The new reporting requirements will therefore be captured in processes in place for 2023/24. In the interim it is anticipated that there will be a non-statutory implementation of the duty of quality in autumn 2022. This will allow for testing the quality reporting indicators, measures and narrative framework concepts being developed during the duty of quality implementation phase as a hybrid reporting process for 2022/23. In the meantime, quality reporting requirements are embedded in this Performance Section of the Annual Report 2021/22.

There is no mandatory requirement for the Health Board to publish a Sustainability Report within the Annual Report and Accounts 2021/22. The Annual Accountability Report (Section 2), Page XX, includes a high-level overview of the Health Board's work in this area. The Board will receive its Annual Sustainability Report in September 2022, which will be published to the Health Board's website.

3. Aneurin Bevan University Health Board

Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our partners and stakeholders in the best interests of the population we serve.

As a Health Board, we serve the population of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The Demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the south Wales valleys.

Area	The total area of Gwent is 158,500 hectares – approximately 7.6% of the total area of Wales.
Population	The estimated population of Gwent is 594,164, approximately 19% of the total population for Wales[1]
Population density	The population density of Gwent is **3.75** persons per hectare. The population density is 1.52 people per hectare in Wales.
Dwellings	The dwelling count in Gwent is **275,882** approximately **18.2%** of the total number of dwellings in Wales[2].

Overall population	The overall population in Gwent is projected to **increase** by **6.2 %** between 2019 and 2043, roughly similar to the Welsh average (5.2%). For Gwent this would mean **36,987** extra people[3].
Aged 16-64	The number of people aged 16-64 living in Gwent is projected to slightly **rise** by **0.7%** by 2043, similar to the Welsh average (-0.5%). For Gwent this would mean **2,367** extra people in this age range[4].
Aged 65 and over	The number of people aged 65 and over living in Gwent is projected to **increase** by **31.2%** between 2019 and 2043, roughly similar to the Welsh average (29%). For Gwent this could mean an extra **37,263** people in this age range[5].
Aged 85 and over	The number of people aged 85 and over living in Gwent is projected to **increase** by **74%** between 2019 and 2043, slightly higher to the Welsh average (69.5%). For Gwent this could mean an extra **10,615** people in this age range[6].

Aneurin Bevan University Health Board population - key data

- In 2014, around 1 in 5 residents were aged over 65 years (19%), 6 in every 10 (62%) were of working age (16 to 64 years) and nearly 1 in 5 (19%) were aged under 16.
- The population aged under 16 has decreased by 2,700 (1%) between 2005 and 2014, from 114,100 to 108,300.
- There has been a significant decrease in the under 75 mortality rate of 17.1% and 17.4% for males and females respectively (a greater improvement than Wales). This demonstrates the positive impacts and significant improvements that a range of services, activities and targeted programmes have made to reduce mortality rates.
- The general fertility rate is broadly similar to that of Wales - but there are differences in the general fertility rates across ABUHB which will impact on the planning of maternity and child services - particularly for Newport and Monmouthshire.

The Health Board employs 12,276 whole time equivalents (WTE) which translates to 13,306 staff and is the largest employer in Gwent. Our workforce is ageing, as is the demographic profile of our population and the health inequalities of our population are also found within our workforce. 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans.

The Health Board has an annual budget from the Welsh Government of just under £1.6 billion per year from which we plan and deliver services for the population of Gwent. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015.

Detail on how the Health Board is governed is set out within the Accountability Report (Section 2 of the Annual Report and Accounts 2021/22).

4. Annual Plan 2021/22

The Annual Plan 2021/22, set out the Health Board's priorities based on adopting a life course approach. This approach optimises the functional ability of individuals throughout life, enables well-being, the realisation of rights, and recognises the critical interdependence of individual, intergenerational, social, environmental and temporal factors. The main outcome of the life-course approach to health is functional ability, which is the sum of the individual and environmental attributes that enable a person to be or do what they have reason to value. For a neonate or infant, functional ability could be manifested by feeding well and playing; for older adults, by the ability to function independently without dependence on care. This approach requires working with our citizens (as individuals, families and communities) to deliver the change our communities need.

This approach requires holistic, long-term, policy and investment strategies that promote better health outcomes for individuals and greater health equity in the population. We are confident this approach can provide high returns for health and sustainable development, both by limiting ill health and the accumulation of risk throughout life and by contributing to social and economic development.

Delivery of the Annual Plan Priorities for 2021/22

This Annual Report and Accounts 2021/22 provides an overview of the Health Board's performance during 2021/22, with key headlines provided below.

Priority 1 – Every Child has the best start in life

We believe that every child deserves the opportunity to have the very best start in life

In 2021/22:

- We have successfully implemented the ban on smoking across all premises.
- We launched a new online platform 'Healthier Together' to support families through the stages of pregnancy, birth, early childhood development, physical, emotional and mental health and well-being for children and young adults. This self-care resource is available to families, healthcare professionals and the general public.
- Smoking cessation advisors worked with pregnant women achieving cessation rates above the Welsh average. We have also strengthened the public health role of midwives through the expansion of the midwifery led weight management service in Ebbw Vale, supporting women to maintain a healthy weight during pregnancy.
- The consolidation of obstetric services at the Grange University Hospital has resulted in greater consultant presence/cover for labour ward supporting around 300 obstetric deliveries each month.
- Immunisation and vaccination programmes have been maintained with 92% uptake of 6–8-week baby checks. Monthly reconciliation of uptake rates incorporates childhood immunisation queues by practice with improvement plans and additional support offered to improve uptake.
- Our immunisation team delivered over 50,000 child vaccinations, the only Health Board in Wales to deliver this this level of activity.
- 6,574 children aged 2 to 3 years received the flu vaccine representing 50.3%, although lower than previous years our performance was higher than the All-Wales Average of 47.6%

Priority 2 – Getting it right for Children and Adults

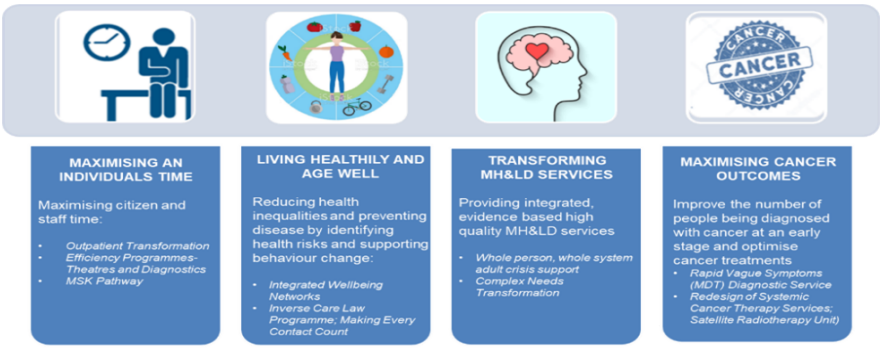
Young people are an important group, nurturing of future generations is crucial to our communities

In 2021/22:

- We have embraced the Welsh Government's 'Framework for Embedding a Whole School Approach to Emotional and Mental Wellbeing' with established and active mechanisms in place across the 195 State primary and 35 State secondary schools through our school nursing teams and school in-reach services.
- Students accessed and could book discrete sessions with school nurses, psychologists or councillors through QR codes within schools.
- We launched (April 2021) a single point of access for neurodevelopmental referrals (SPACE Wellbeing) facilitating a doubling in referral rates.
- The Human-papillomavirus vaccination programme continued to be implemented once schools reopened together with Meningococcal ACWY booster.
- A framework to support multi-factorial, multi-agency transition pathway for 15 -25-year-olds was developed. This will be progressed through our partnership mechanisms in 2022/23 in order to deliver transition pathways that meet the needs of young adults as they transition to adult services.

Priority 3 – Adults in Gwent live healthily and age well

We want our citizens to enjoy a high quality of life into old age we want them to be empowered to take more responsibility for their own health and care, so that they can retain independence



In 2021/22:

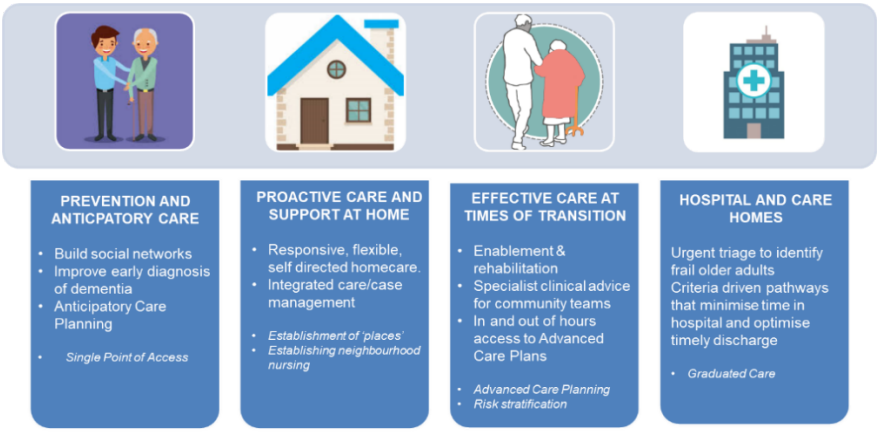
- Covid-19 was a trigger for more rapid adoption of change including digital solutions such as virtual outpatients and widespread adoption of electronic communications. During 2021/22 we continued to embed these approaches in addition to optimising See-on-Symptoms (SoS) and Patient Initiated Follow-Up (PIFU). Outpatient capacity remained constrained due to Covid-19 measures, notwithstanding this our system has made substantial progress towards pre-Covid levels of activity. The gap for new outpatients has been reduced from a 30% deficit to 11%, and the gap for follow-up from 31% to 14%.
- A key focus of attention has been on public protection in the context of the pandemic. Over one million PCR tests were undertaken on our residents during 2021/22, population scale contact tracing of over 175,000 positive cases has protected our

residents by breaking the changes of transmission. 1,312,335 vaccines were given by the Health Board, with high uptake rates. The accelerated booster programme delivering 100,285 vaccines in 14 days.

- We maintained a strong inequities arm to the programme successfully narrowing inequalities; vaccination in first mosque in Wales, community links to GDAS, supported by the Wallich utilising mobile bus and community halls for groups with low uptake.
- Psychological Wellbeing Practitioners based around Neighbourhood Care Networks were introduced as a new workforce to improve access to mental health support within the community and now provide 1,400 assessments each month.
- The Multi-disciplinary Rapid Diagnostic Clinic, designed for patients with vague or non-specific symptoms that may be a suspected cancer has reduced the diagnostic pathway to 12 days, 478 people benefited from this new service in 2021/22.
- Despite many significant challenges in delivering the single cancer pathway, we have treated more cancer patients in 2021/22 than any previous year, 4% higher than pre-pandemic activity.

Priority 4 – Older Adults are supported to live well and independently

We believe this to be a fundamental principle of social justice and is an important hallmark of a caring and compassionate community

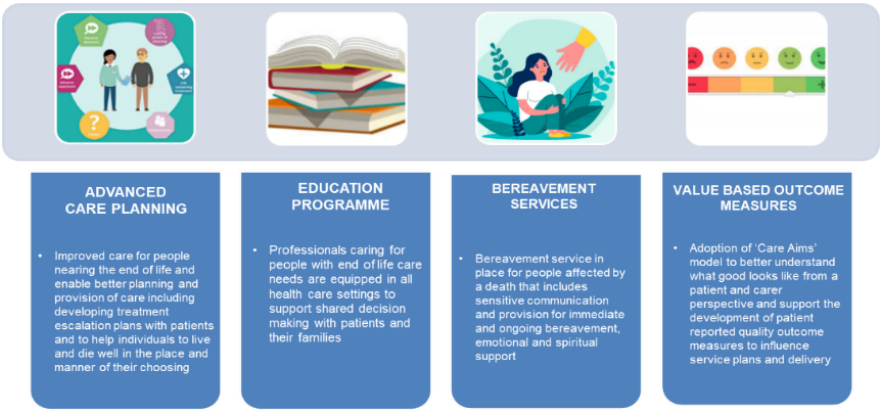


In 2021/22:

- Working with data partners, we identified cohorts of high-risk individuals who would benefit from focused, proactive intervention from community services to maintain their health and wellbeing in order to anticipate, support and manage crises that would normally result in an admission to hospital. This data has been actively used in two localities, with Monmouthshire about to adopt this approach for falls prevention in 2022/23.
- Direct admission pathways to avoid admissions to the acute system enabled 63 patients (over a 6-month period) to be admitted directly to a community hospital.

Priority 5 – Dying well as part of life

Death and dying are inevitable. The quality and accessibility of end-of-life care will affect all of us and it must be made consistently better. We have embraced the principles of the 'A Compassionate Country – A Charter For Wales' and are committed to continuously improving what we do to ensure that the needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities are addressed, taking into account their priorities, preferences and wishes



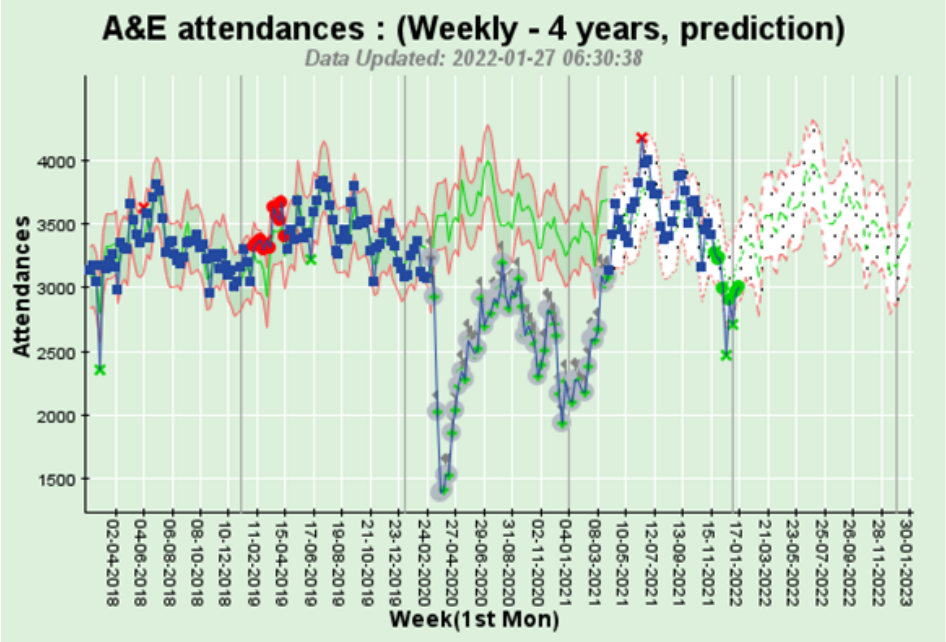
In 2021/22:

- 2,022 deaths were registered with Covid-19 on the death certificate over the course of the pandemic, around half of which were in acute hospital settings. During 2020 excess deaths rose by 12%, and in 2021/22 were 8% above the previous 5-year average (source ONS)
- Our hospital specialist palliative care teams supported clinical teams with symptom control guidance and management algorithms for Covid-19 and Palliative EOL in secondary care (August 21) and weekend and out of hours cover for all acute hospital sites.
- The Care After Death (CAD) team was established and expanded to provide a face-to-face service on all acute hospital sites. In addition to training over 100 Foundation Tier 1 doctors in care after death process, the team has secured 1,000 printing kits and 200 memory boxes and using these have supported over 50 bereaved families in the last 6 months.

5. Impact of COVID-19 on delivery of services

The first wave of COVID-19 saw significant reductions initially in urgent care demand across the NHS with an incremental increase throughout 2020 as the situation settled. Post the second wave urgent care demand rose sharply in the first half of 2021 as lockdown restrictions eased and the longer-term impact of restrictions presented new pressures for the NHS. Patterns of demand also changed for the numbers of Covid-positive, suspected and recovering patients that had to be and still need to be accommodated in the complex covid pathways that are required for Infection Prevention and Control.

The following graph and headlines summarise how demand has impacted on the system over the last 12 months.



Key Headlines include:

- Attendance levels across the system and particularly at The Grange University Hospital (GUH) sharply increased in the first six months of 2021 rising to above pre-pandemic levels with June 2021 seeing the highest Emergency Department (ED)/Minor Injury Unit (MIU) attendances on record for the Health Board.
- Increased demand of "walk-in" patients particularly at GUH beyond those planned have created significant pressure on the Emergency Department.
- Increased paediatric attendances and GP referrals are above pre-pandemic levels. Paediatric Services have also rolled out Healthier Together, a tailored website for the public and professionals to understand pathways and appropriate access.
- Increased demand post lockdown for a number of key specialties such as Cardiology and Emergency Surgery.
- All 3 Enhanced Local General Hospitals (eLGHs) have seen a step change increase in Medical Assessment Unit (MAU) activity since April 2021, with a corresponding decrease in GUH MAU activity. This indicates the system is moving closer in line with what was originally designed as a decentralised medical assessment and admissions service away from the main ED.
- Beds occupied by patients over 21 days across the Health Board have been steadily increasing since March 2021 and Average Length of Stay (AVLOS) is at its highest level since June 2016.

As seen across the UK, these highest ever rates of attendance, coupled with the ongoing Covid impact and mitigating measures, created a systemwide strain that requires ongoing active management to maintain safe services on each site.

During 2021/22, in response to these pressures, the Health Board was required to redesign services across the health and care system, taking a risk-based approach, to ensure delivery of Covid care and non-covid care wherever possible. Some of the measures introduced include:

- Temporarily reduced elective orthopaedic activity at the Royal Gwent Hospital and Ysbyty Ystrad Fawr. This allowed staff to be released to support other areas and for the Rhymney ward at Ysbyty Ystrad Fawr to be converted to an 'amber' pathway for non-Covid patients.
- Temporarily redeployed some registrants and non-registrants from the Primary Care Mental Health team to support the mental health inpatient areas and crisis teams that are facing significant staff shortages. A number of other actions have been put in place in Primary Care to mitigate some of the consequential risks.
- Temporarily centralised midwifery workforce at the Grange University Hospital and closed the Midwife-led Birthing Units at the Royal Gwent Hospital, Nevill Hall Hospital, Ysbyty Aneurin Bevan and Ysbyty Ystrad Fawr.
- Rapid adoption of clinical triage and remote consultation in primary care services.
- Establishment of Spirometry diagnostic hubs due to inability of General Medical Services to continue this activity due to Infection Prevention and Control restrictions.
- Dental services delayed routine dental checks for low-risk patients and prioritised care for urgent care and where treatment has been delayed following impact of restrictions associated with Aerosol Generating Procedure (AGP) in dentistry.
- Doubled the capacity within Urgent Dental Services to reflect the build-up of demand.
- Implemented 'Combined Community Teams' where District Nursing, Crisis Resolution Teams and Palliative Care services were pooled during times of heightened escalation / shift staffing and workload prioritised based on clinical urgency.
- Re-designed flows through community hospitals to best meet COVID pathways, including using single room environments where infection risks were greater.
- Adopted a nurse-led model of Specialist Palliative Care support to Royal Gwent Hospital and commissioned virtual medical cover through Supportive Care UK – partially driven by increased demands in COVID, irresolvable staffing deficits and the need to split care across 4 sites due to the Grange University Hospital.
- Re-prioritised care across the whole primary care sector with mass re-deployment of staff to Mass Vaccination Centres and to undertake housebound vaccinations – this meant reducing service provision for Living Well Living Longer, Primary Care Diabetes Nursing, Medicines Management Services, District Nursing and managerial support services.
- Self-help services within Mental Health Services were promoted to support patients, e.g. the Silver Cloud website.

6. Primary Care and Community Services

Approximately 90% of all Healthcare contacts take place in the primary care setting and we recognise the ongoing challenges regarding access in Primary Care throughout the pandemic and as services resume.

The Covid-19 pandemic has necessitated new ways of working, with Primary Care providers adapting the way they offer and provide clinical services with a greater degree of flexibility to meet patient and service needs, and now as services resume, many of these changes are being taken forward where they are still appropriate. The need to maintain a safe environment for staff and patients remains paramount.

Although Wales has reverted to level 0, several measures remain in place within Health Care settings in order to protect staff and patients and it is important to recognise that this does still have an impact on patient throughput.

There continues to be ongoing workforce challenges with teams being exhausted from their continued efforts during the pandemic and also a high number of staff absence due to testing positive as COVID-19 continues to circulate in the community and restrictions ease.

General Medical Services

As a Health Board we are responsible for ensuring the provision of General Medical Services (GMS) to our residents. We commission services from independent contractors and we also directly manage the provision of services in four practices where we have been unable to secure an independent contractor.

Outside of "core hours", access to medical care is provided by our Out of Hours Service, which operates between 6.30pm and 8.00am each weekday evening and throughout weekends and Bank Holidays.

It is well rehearsed that General Practice adapted very quickly to new ways of working in response to the pandemic. With national guidance continuing to advocate *telephone first*, practices have now adopted a blended approach to patient consultations, offering both face to face and remote consultations, as appropriate. The number of face-to-face appointments is increasing, however there are challenges with this, especially in relation to managing social distancing and throughput of patients and, whilst the pandemic continues, a level of remote consultations will remain in place for those patients who would benefit from such a service. Additionally, a blended approach to consultations in the future will ensure that all patients have access to their local GP services in a way that is right for them.

The Health Care system as a whole remains under unprecedented pressure, and it remains vital that we are able to clearly gauge, articulate, understand, and

influence the delivery of GP services and the impact on the wider system and vice versa.

In June 2021, we worked closely with practices and other partners including Gwent Local Medical Committee (LMC) and Aneurin Bevan Community Health Council (ABCHC) to undertake a comprehensive review of access arrangements in General Practice. This review looked at the number of clinical sessions, number of telephone lines and percentage of face-to-face consultations, per registered patient.

An in-depth review and analysis of all data captured was undertaken at practice level, alongside the access standards and other data available including A&E attendance, Urgent Primary Care, Minor Injuries and Out of Hours activity, with individual reports prepared for each practice and also at a Neighbourhood Care Network (NCN) level, to inform directed conversations with practices and provide benchmarking information for NCN based discussions.

Following the Access Review there were immediate changes, such as doors being unlocked, changes to appointment systems and staffing rotas and the development of schemes both nationally and locally to support practices to try to meet the demand and ensure access to services for patients, in a safe and timely manner. It is clear that face-to-face consultations are increasing and practices and patients are adapting to the new blended approach to consultations.

The review has demonstrated that in many cases, practices are meeting the 1:200 benchmark for clinical sessions and yet are still unable to meet demand for a number of reasons. As part of the Restart and Recovery Programme several schemes have been developed and designed to support practices with additional capacity/resource to meet some of these pressures and to support with addressing the back log of care. These include:

- **Additional Clinical Sessions Scheme** to provide support for GP practices by funding additional Clinical sessions from December 2021 to March 2022. This is available to those practices meeting the minimum requirement of one clinical session per 200 registered patients. 61 practices are currently participating in this scheme.

- **Additional Reception Hours Scheme** to provide support for GP practices by funding additional reception hours from December 2021 to March 2022. Practices must have a minimum of 1 telephone line per 1000 patients to apply to participate in this scheme. 25 practices participated, providing an additional 917.50 hours per week (24wte).

- We commissioned **additional weekend cervical screening clinics** through the Sexual Health team, in order to support the backlog in Primary Care. Dedicated booking line for patients to ring and book appointment. 611 additional appointments have been provided to date.

- As part of the Covid-19 strategy Welsh Government issued a **National Enhanced Service for the provision of essential General Medical Services, outside of core hours**. The purpose of this Enhanced Service is to cover the provision of essential GMS to patients requesting advice, a consultation or other essential service, outside of GMS core hours. 9 practices participated during December and January, with 8 in February 2022. This has provided 113 GP equivalent sessions (approx. 1,600 appointments).

- Development of a **Care Home Ward Rounds Scheme** to fund practices to deliver weekends and/or Bank Holiday Ward rounds over the winter months. This will ensure continuity of care and has the potential to reduce demand on both the GP Out of Hours Service and a reduction in onward referral outside of core hours. 3 practices participated with 46 ward rounds provided to date.

- £2m has been made available during this year to support **additional capacity within GMS**, with particular emphasis on winter pressures. The scheme offers reimbursement of 100% of the total cost of either additional posts upon appointment or additional hours worked by existing post holders. 26 practices participated with an additional 80 weekly GP equivalent sessions provided as a result (approx. 1,200 appointments per week)

- Commissioned a **new Local Enhanced Service (LES) to fund additional clinical sessions.** This supports an additional clinical session per week, per practice and is available to Practices meeting the minimum requirement of one clinical session per 200 registered patients. 19 practices participated with an additional 27 weekly GP equivalent sessions being provided (approx. 405 appointments per week).

Resumption of core services

We reinstated National and Local Enhanced services from 1st April 2021 and all services resumed from the 1st October 2021. A reconciliation exercise was undertaken with all practices to ensure continuation of services previously provided.

General Dental Services

NHS dental practices across the Health Board continue to provide dental care in accordance with Welsh Government Dental specific guidance. Dental practices are currently operating in the "Amber Phase" of the dental recovery plan and practices have been asked to implement a phased, risk-based re-establishment of dental services to meet population needs and to prioritise dental care for at-risk groups and people with urgent/essential dental needs.

Dental practices have been asked to delay routine dental checks for low-risk patients, so that they have appointment slots available for those who need urgent treatment or treatment that has been delayed. Practices will start to provide

dental recalls once all urgent and essential patient needs are addressed. This will vary depending on practice capacity and patient needs.

Some types of dental treatment require the use of dental equipment that produces a fine water mist, and these procedures are called Aerosol Generating Procedures (AGPs). For practices to provide AGPs, there are robust procedures that dental practices must follow, and they are required to have the appropriate ventilation units fitted in the surgery to improve the air quality following an AGP.

A deep clean of the surgery is undertaken following an AGP and the surgery space is left dormant in order for the air particles to settle, this is known as 'fallow time'. The length of time the surgery cannot be used for is determined by the ventilation unit. This is to ensure dental team members and patients remain safe when accessing dental care.

With these measures in place, patient throughput has been significantly reduced.

Recognising the challenges posed by Covid-19, we have continued to work collaboratively with Welsh Government, Gwent Local Dental Committee and other relevant stakeholders to develop, manage and support practices with the implementation of updated guidance and whilst patient access is a priority for the Health Board, the safety of our patients and dental teams also remains paramount.

The usual measure for dental activity is Units of Dental Activity (UDAs), however this measure has been suspended and practices have been asked to deliver their NHS GDS Contract against revised criteria.

In accordance with Welsh Government guidance, access to service provision over the last 12-18 months has increased. Practices are expected to accept and treat a number of new patients (a new patient is defined as an adult patient that has not received a banded course of treatment in the previous 24 months and a child patient that has not received a banded course of treatment in the previous 12 months) based on their annual contract value (ACV).

General Dental Services activity 2021/22 (at end February 2022) is provided in the table below:

Total number of adults seen	99,214
Total number of children seen	37,960
Total number of urgent patients seen (combined adult and children)	35,954
Total number of orthodontic claims processed	1,445 cases started

Restart and Recovery

As part of the Restart and Recovery Programme, we have secured additional investment to address the backlog of dental care. The table below highlights the areas that investment has been made since June 2021.

Investment	Service Description	Planned Activity
£46k	Sedation: Additional weekly sessions commissioned	Up to 120 patients
£27k	OOH: Additional weekly session commissioned	Approximately 7 additional patients to be seen/week
£198k	Oral Surgery: Additional sessions commissioned	Approximately 850 additional patients to be assessed/treated
£17k	Prison Dental: Additional sessions commissioned	Approximately 169 additional patients to be seen
£163k	Access: Additional sessions commissioned to increase in-hours access and OOH access over Bank Holiday periods	Approximately 1188 additional patients to be assessed/treated
£403k	Orthodontics: Additional sessions commissioned to increase the number of patient assessments and case starts	Approximately 850 additional patients to be assessed and 247 to commence treatment
£10k	Asylum Seekers: Additional fortnightly session commissioned	Approximately 5 additional patients to be seen/week
£864k		

Dental Care Workforce

It is widely acknowledged that recruitment and retention within dental services, along with other service provision, has been challenging over the past 2 years. Whilst we do not directly employ General Dental Practitioners (GDP) or their team members, Welsh Government and Health Education and Improvement Wales (HEIW*)* are working collaboratively to scope and develop various training schemes to support trainee dentists and dental nurses.

In addition, there are 11 dental practices within our area that are accredited as part of the Dental Foundation Trainee Scheme. These practices provide placements for trainee dentists, offering them guidance, support, mentorship and hands on clinical experience in order for the trainees to complete their oral health portfolio and become accredited dentists.

Urgent Access

Prior to Covid-19 we commissioned 157 urgent dental appointments per week, this has now increased to 300.

On average, the Dental Helpline answers approximately 400 calls per week from patients residing in our area. Patients contact the Dental Helpline to seek urgent dental care and to request contact details of dental practices. This was the same pre-Covid.

Whilst the Dental Helpline always attempts to signpost patients to practices close to where they reside, this is not always possible and as there are no boundary restrictions within dental, on occasions patients may be asked to travel to a dental practice outside of the borough they live.

It should be noted that the dedicated urgent dental service commissioned is in addition to practices providing their own urgent service. As part of current working arrangements, practices must provide urgent dental care to existing patients.

General Ophthalmic Services

Optometry practices have continued to be open for urgent and essential appointments and can also provide routine sight tests to patients.

Optometry practices will prioritise and schedule patient appointments based on clinical need and presenting symptoms relative to the risk of sight loss and harm.

If patients require an urgent eye appointment or are at a higher risk of eye disease, they can access the Eye Health Examination Wales (EHEW) Scheme free of charge. Additionally, a GP or Pharmacist can also refer them to an optician that is EHEW accredited.

Restart and Recovery

As part of the restart and recovery programme there has been an additional investment of approximately £67k.

We have developed a number of pathways to address the significant waiting lists in Secondary Care. Suitable patients, as determined by Ophthalmology, were referred under the following pathways up until the 31st March 2022:

- Glaucoma Open Angles – Patients with open angle glaucoma who are high risk and have been waiting a considerable time will be assessed in Primary Care
- Narrow Angle Glaucoma- Patients with a suspected narrow anterior chamber will be assessed in Primary Care
- Medical Retina – Patients with a medical retina issue will undergo a medical retina review in Primary Care
- Paediatrics – Patients who require cyclopentolate refraction (and the prescription of spectacles as necessary) will undergo this interim refraction in Primary Care.

Community Pharmacy Services

During 2021-22, Community Pharmacy experienced critical challenges associated with the Covid-19 pandemic including staff sickness/well-being, shortage of

professional staff, isolation of staff and social distancing. Essential services were however largely maintained, with evidence of increased activity in some cases:

- Dispensing rates increased by 1.8% with over 12.3m items being dispensed up until December 2021.

- The Emergency Medicines Service, designed to improve patient access to regularly prescribed medicines has increased by 131% with over 15,000 supplies (Apr20-Jan21)

- Influenza vaccine delivery increased by 77% with over 29,000 vaccines being delivered in community pharmacies during the 2020/21 Flu season.

- The Common Ailments Service has operated right through the pandemic utilising phone and video consultations, although rates were lower at the start of the pandemic, an increase has been seen and currently there is an increase of 43% in activity with 15,874 consultations (April 20-Jan 2021)

- Provision of Emergency Hormonal Contraception activity has increased by 11% with 3612 consultations (April 20-Jan 2021)

Other services, such as smoking cessation, supervised consumption, needle exchange, among others, are recovering well and are now approaching pre-pandemic levels. Four community pharmacies were involved in the provision of Covid-19 vaccinations to improve access for patients and support practices.

In response to the Welsh Government strategy for Community Pharmacy developed in 2021, our pharmacy team has successfully introduced 15 pharmacists delivering an extended prescriber led Common Ailments service including treatments for lower Urinary Tract infection, Impetigo and Otitis Media. Between April 2020 and December 2021, 2597 consultations have been delivered negating the need for a GP appointment. Although this is a new service, patient testimonies have been positive:

"This is an excellent service, as well as being innovative, thorough and timely; F.... was offered an appointment within the hour and J..... prescribed the medication that F……. required. I just wanted to share with you my brief reflections as well as my thanks to J.....– I feel that this is definitely a service that warrants expansion across our boroughs."

Access to pharmacies was maintained despite social distancing, with operating models adjusted at individual pharmacies. 27 pharmacies have taken up the Welsh Government initiative to relax pharmacy opening hours to catch up on work being undertaken and improve staff wellbeing.

In 2020/21, we published our first Pharmaceutical Needs Assessment, which is a legally required document used in the planning and delivery of pharmacy services

across the Health Board. This was a major piece of work including consultation with all identified stakeholders.

Urgent Primary Care

Our Urgent Primary Care (UPC) Service continues to manage all Urgent Primary Care activity when General Medical Practices are closed, between 6.30pm to 8am Monday to Thursday and 24/7 at weekends and Bank Holidays. The UPC Service is staffed by a multidisciplinary team of GPs, Nurse Practitioners and non-clinical staff. Working closely with the 111 South East Hub, expanding the Multidisciplinary Team to include pharmacists and mental health practitioners.

There has been an increase in salaried GPs within the service and recruitment is ongoing, in order to improve this position and provide further stability for the service.

In addition to core services, the UPC team have also rolled out a 24/7 UPC centre at RGH and NHH eLGHs. These centres provide face to face assessment to patients who have attended ED or MIU incorrectly, or have accessed the service via 111 and the Think 111 First pathway, Monday to Friday during daytime hours.

The core UPC service has managed **86,746** patients during out of hours periods, with an additional **7,944** patients managed via UPC re-directions and **6,497** patients via the Think 111 First pathway.

The team were heavily involved in the first National Learning event for the six goals for Urgent and Emergency Care, demonstrating the work undertaken in the development of the Urgent Primary Care Centres.

Community Services

Recognising the national issues associated with delays for patients waiting to leave hospital with domiciliary care support, it was agreed to appoint 25 WTE **Reablement Support Workers** to increase community capacity. This was the equivalent of increasing care capacity by circa 800 hours per week. This would seek to introduce a greater onus on discharge to recover and assess, accessing Reablement in the first instance and assessing citizen's independence in their own home after a period of recovery before determining long term needs. Given the region's commitment to this approach, we committed to fund these posts on a permanent basis rather than via short term grant funding.

To date, 17 of the 25 permanent roles have been appointed to and work is ongoing to promote the remaining vacancies through recruitment events and communication with the public to encourage enthusiasm for roles in home care.

From August 2021 a **direct-admission pathway** from the community setting into community hospitals was established to support patients not requiring an acute intervention to bypass the acute system. To date, 72 patients have accessed services via this route, therefore reducing unnecessary demand on acute sites

and, it is forecast, reducing the number of bed days incurred by this cohort of the population.

A **Step Closer to Home Unit** (SC2HU) has been established in St Woolos Hospital to support the discharge of patients who require an extended stay in hospital for reablement in order to achieve a safe discharge with less reliance on a package of care. The unit is Therapy/Nurse led with Clinical Governance being held by Urgent Primary Care GPs. Referrals for patients who are medically fit for discharge home are received from Hospital sites, Hospital Discharge Team and all Community Resource Teams across the Health Board area. The unit is open to all current ABUHB hospital inpatients who meet the unit criteria regardless of the Borough they reside in.

The Unit opened on 24th January 2022 and has received 53 admissions to the end of March 2022. In that time the service assess that they have reduced demand for packages of care in 86% of cases, with 21 people admitted already in receipt of community care but with their ongoing needs reduced in 18 instances following therapy input.

Flow Centre Pathway

Pathways for access to Rapid Response Services have been reviewed and a pilot allowing the Health Board's Flow Centre to re-direct appropriate GP referrals to medical teams in Caerphilly have been implemented. In the first two months, 33 patients were referred to the Caerphilly team, indicating potential to re-route unmet need. The pilot has been extended to Blaenau Gwent and will be reviewed during 2022/23 to determine wider roll out and resourcing implications.

COVID-19 Vaccinations for Housebound

In addition to sustaining core services within the community, community nursing teams combined resources to undertake a significant domiciliary vaccination programme for housebound patients within Gwent. In total, it is estimated that 11,773 COVID-19 vaccinations have been administered to date within a domiciliary setting, contributing to the overall success of the programme and with a particular focus on some of the more vulnerable members of the population.

Therapy Services

Therapy services operated flexibly; mobilised services to maintain people within their own homes, prevent hospital admission via community, domiciliary and community clinics (face to face and virtual interaction) and to maximise the in-hospital response to manage the increase in demand for both Covid related and non-covid related admissions.

Some highlights of the Therapies response and work during the past year is captured below and shows great flexibility, diversity, and innovation in service delivery and in our staff.

- Development of 6-month scoping posts commenced to **support *Occupational Therapy in Occupational Health* response to Long COVID** for our staff. Early information indicates that occupational therapy intervention clearly increased engagement in staff members' activity and demonstrated an increase in staff members' confidence in returning to work, demonstrating that OT intervention is cost effective and essential within Occupational Health.

- Scoping project undertaken to establish the need for **Occupational Therapy posts in Primary Care**, with two 2year fixed term posts established as a result.

- Niwrostwt Neuro Recovery College modules transferred to virtual delivery options. The Niwrostiwt is a patient supported self-management approach which supports wider learning by utilising the shared experiences to support the wider community. The Niwrostiwt forms part of the highly successful Recovery College model within **Community Neuro Rehabilitation Services**. This Virtual offer (run alongside essential face to face services) has proven successful with people who have experienced brain injury and stroke showing improved attendance and reduced DNA rates. 217 attendances during Quarter 1.

- Further development of the **MSK (Musculoskeletal) Therapies ultrasound service** with qualified Podiatrists and Physiotherapists independently scanning and providing US guided interventions. This therapies wide approach has podiatrists and physiotherapists contributing to the clinical workforce. 607 scans were undertaken in 2021-22. Key benefits include reduced referral to diagnosis and referral to treatment times, more accurate diagnosis and managing patients in the community.

- Transformational services across **Child Psychology** leading the National direction of travel towards implementing the NEST Framework across Regional Partnership Boards (RPBs). Now established as a Programme for Government for the next five years, with clear expectations for delivery sitting with Regional Partnership Boards, this is an evolution of the ICEBERG CAMHS Transformation. The key benefits include the alignment of services developed as part of the Iceberg Transformation with NEST:
    - Gwent Attachment Service
    - Helping Hands
    - C & F Community Psychology
    - Family Intervention Team
    - Intensive Positive Behavioural Support (IPBS)
    - MYST (My Support Team)

- Commenced independent prescribing within **Community Podiatry Limb at Risk Service**, pilot with primary care support for prescribing across 12 NCN practices. The benefits include timely intervention, improved patient experience and patient care and improved access to healthcare.

- ***Lower Limb Wound Portal single point of referral hosted by Podiatry*:** This is a single point of referral process which aims to:
    - stream line and simplify the referral pathways to remove variations to ensure timely access to the appropriate healthcare professional and speciality for patients with lower limb wounds and foot ulcers.
    - reduce duplication
    - work across the system, primary care & Community, Scheduled and Unscheduled Care and Family & Therapies
    - work across Specialities i.e. Diabetes, Vascular, Orthopaedics.
    - Develop a Single Portal for GPs, community and primary & secondary care professionals for referral and discharge

- Development of a **CHAT Bot for procedural anxiety**. All children and young people (CYP) receive multiple vaccinations as part of the Public Health Wales programme. The impact of Covid has resulted in more vaccinations being given to CYP. Procedural anxiety, specifically, around blood tests and injections, impacts on wellbeing and can lead to treatment ruptures and a withdrawal from vaccination programmes. The CHAT Bot enables CYP and their families to engage with information and coping strategies tailored to their needs to support them when having blood tests and vaccinations. The CHAT Bot has also been utilised by Adult with Procedural anxiety.

- Development of a **multi-disciplinary recovering from illness (post Covid) pathway for children.** Clinical pathway and integrated specialist MDT Service developed to meet the complex needs of children and young people coping with the impact of Long COVID. The pathway delivers universal, targeted and specialist services in collaboration with health, education, social services and the third sector. There is scope for pathway to meet longstanding service gaps for children and young people with ME/Chronic Fatigue Syndrome, Fibromyalgia and Chronic Pain. The Health Board's pathway has been adopted as the All-Wales Approach.

- Adaptation and development of **Physiotherapy webpages** across all specialties to offer public health advice and self-management principle, providing improved access to information to enable the public to access tools and resources to manage their own condition and be aware of health promotion and prevention activities.

- Pilot of a ward-based **nutrition support worker** for orthogeriatric ward at the Royal Gwent Hospital. This provides improvements in all key metrics associated with nutrition screening and care plans, fundamentals of care and clinical outcomes, together with improved patient and staff experience.

- Replacing group education delivered to parents for a child diagnosed with a Cow's milk protein allergy with a recorded session available via closed YouTube

link and comprehensive written guidance, in order to allow immediate access to an evidence based resource.

- Speech and Language Therapies utilising Virtual clinics (as part of Hybrid offer – Face to Face and virtual) to offer evidence-based interventions across clinical pathways.

7. Testing and Immunisation for COVID

We have continued to work in partnership with the five Local Authorities in Gwent at a scale and pace and to a new level of public service integration in meeting the regional challenges of the global COVID-19 pandemic.

As part of the Gwent Test, Trace, Protect Service we have protected our residents by breaking chains of transmission in our communities and workplaces and we have achieved new successes, as we were confronted by Delta and Omicron Waves during 2021-22 in:

- *Population Scale Contact Tracing:* we have traced over 175,000 positive cases since the service began. And we have reached out to more than 50% of our 600,000 residents whilst making contact and providing support to quarter of a million of them.

- *Digital Innovation:* our approaches have become the basis of national policy in Wales. We used approximately 37,500 electronic tracing forms with a 62% response rate during the Omicron wave in the winter period. Continuing to protect the most vulnerable when, operationally, we were most under pressure.

- *Integration of a Specialist Workforce:* collaborating across Health Board Infection Prevention & Control, Clinicians, Public Health Specialists, Environmental Health Officers, Health Protection Specialists and Enforcement Officers we have been able to rapidly share intelligence and expertise in support of health protection.

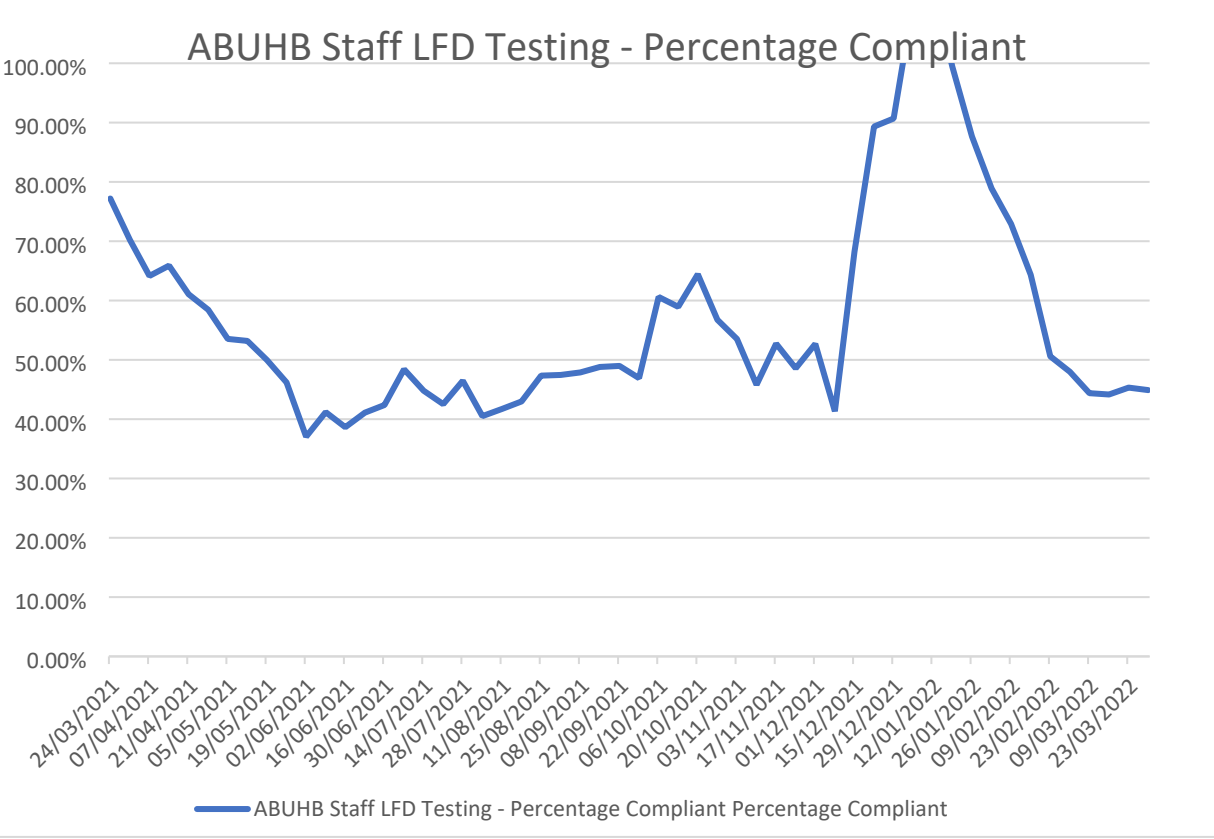
We are maintaining a workforce for the future which will enable us to continue to protect the most vulnerable with a focus on Health and Social Care settings. We will also be ready to scale up our workforce and the level of our response as required, should there be a deterioration from a 'stable' to an 'urgent' scenario.

Testing is an integral component of Gwent region's ability to discharge its responsibilities set out in the Coronavirus Control Plan for Wales. The table below provides a summary of the COVID-19 PCR Tests undertaken on our residents in 2021/22.

Total Tests	1,090,006
Tests performed by PHW	263,267
Total care home tests	247,820
Care home tests performed by PHW	52,761
Total pre-operative requests	30,542
Pre-operative requests (performed by the community COVID-19 Testing Service)	22,307
In-patient tests	18,403
COVID-19 tests undertaken in the patient's own home by ABUHB testing team	11,796
Total staff LFD tests recorded through ABUHB	381,402

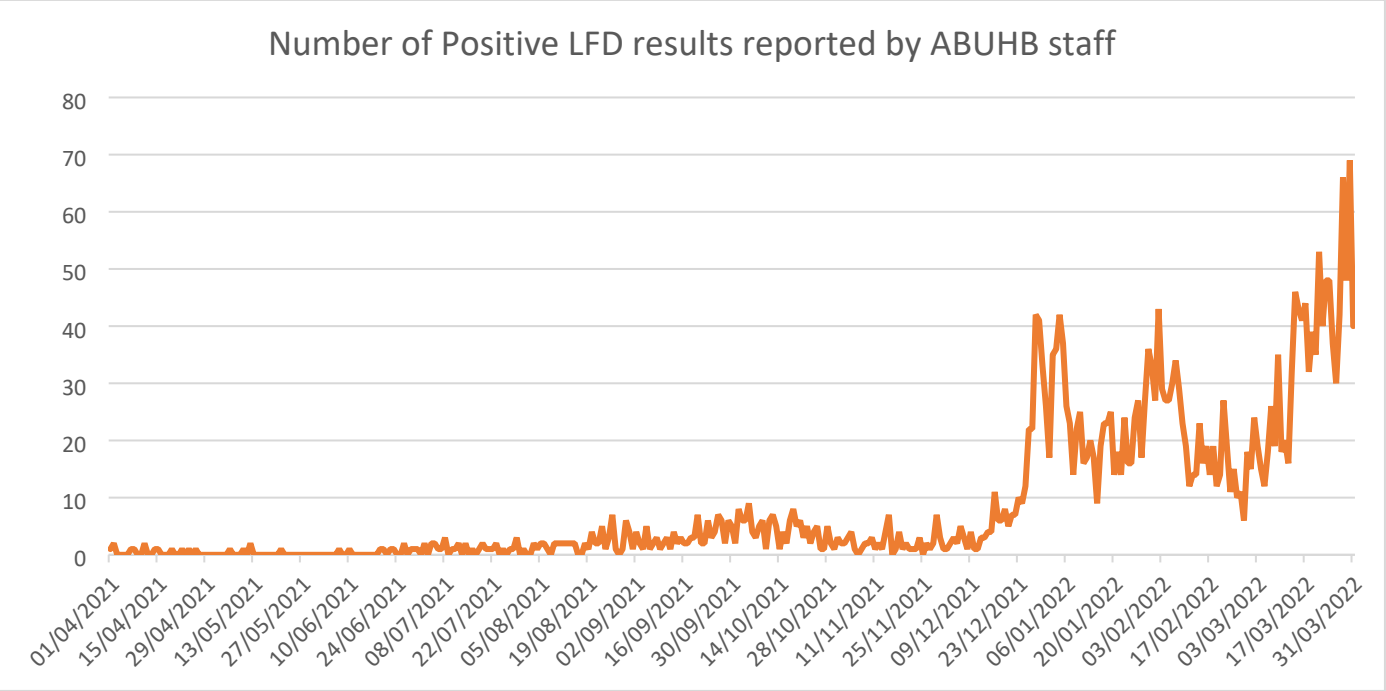
LFD staff testing

Routine asymptomatic testing for staff using Lateral Flow Devices (LFD) has played a crucial part in the last year to reduce the risk of transmission amongst staff. In light of the Omicron variant, we took the decision to increase testing, so all staff were advised to test prior to each shift. The graph below highlights the change in protocol which resulted in compliance remaining over 80 percent during the peak of Omicron in January 2022.



The total number of LFDs reported by staff from 1st April 2021 – 31st March 2022 is 381,402 with 3,063 positive results recorded.

Note the increase in positivity on the graph below, this reflects the change in national guidance where restrictions were lifted and prevalence of Covid remained high.



Point of Care Testing (POCT) plays an integral role in aiding patient flow whilst being admitted to hospital.

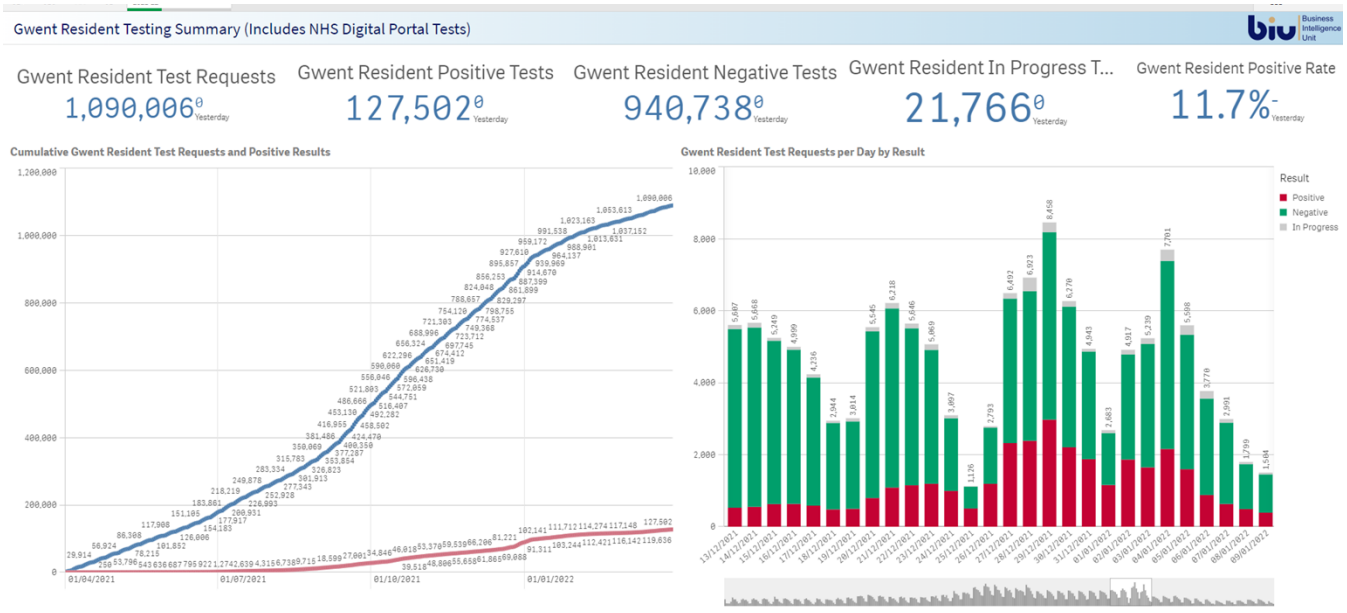
Understanding the COVID-19 status of our patients as they are admitted into hospital is vital. It allows us to protect staff, patients and services. Rapid POCT Covid testing allows the rapid assessment and safe movement of patients through the Health Board. We have 7 Roche Liat devices and 14 Abbott ID Now machines to process these tests. These devices are heavily used within the emergency department and other areas across all eLGH sites. The table below illustrates the total number of Covid tests carried out using these two point of care testing platforms.

	Number of tests performed	Total number of positives
Abbott ID now	10,752	531
Roche Liat	11,851	488

Gwent resident testing summary from April 1st 2021 – 31st March 2022

The graph below shows the quantity of COVID-19 tests undertaken on Gwent residents over the past year, alongside the percentage positivity. When COVID-19 testing first began there was limited laboratory capacity and testing was targeted to ensure health board and partner organisation staff could safely return to work.

As laboratory capacity increased, we were able to deploy a number of mobile testing units across the Gwent area to provide accessible access to testing. Testing peaked for Gwent residents on 29th December 2021 during the peak of Omicron. The positively rate at that time was 35.2% with 2,977 testing positive out of 8,458.



Turnaround times for ABUHB samples

The table below shows the time taken for COVID-19 samples to be processed, from arriving at the laboratory to having a result. A large proportion of people tested in Gwent will now routinely have the result within 24 hours of their test. This underpins our ability to rapidly react to outbreak clusters and safely manage community transmission especially in reference to variants of concern. Utilising our own reactive transport service in house we can ensure samples are processed faster now than at any point during the pandemic.

ABUHB COVID-19 Samples processed within PHW laboratories			
From received to authorised	**30/03/2020**	**30/03/2021**	**30/03/2022**
Tested within 12 hours	16%	57%	57%
Tested within 24 hours	39%	92%	98%
Tested within 48 hours	81%	100%	100%

COVID-19 Samples processed within ABUHB laboratories			
From received to authorised	**23/11/2020**	**29/03/2021**	**31/03/2022**
Tested within 12 hours	20%	51%	28 %
Tested within 24 hours	32%	95%	74%
Tested within 48 hours	92%	100%	100 %

The turnaround times within the Health Board has declined over recent months due to significant downtime on one of the testing platforms. Microbiology has recently validated a new platform which will provide additional testing capacity in house and improve turnaround times.

Microbiology in the Health Board and Public Health Wales continue to work in partnership to support Covid testing for Gwent residents.

Inpatient twice weekly asymptomatic testing

Over the last year the Testing Team has delivered two services within our hospitals - routine swabbing and reactive support. We provided a complete twice weekly COVID-19 inpatient testing service on four hospital sites. This system removed pressure on frontline staff, reduced nosocomial transmission and supported patient flow/discharge of patients. This enhanced phlebotomy style service ensured everyone was offered a test.

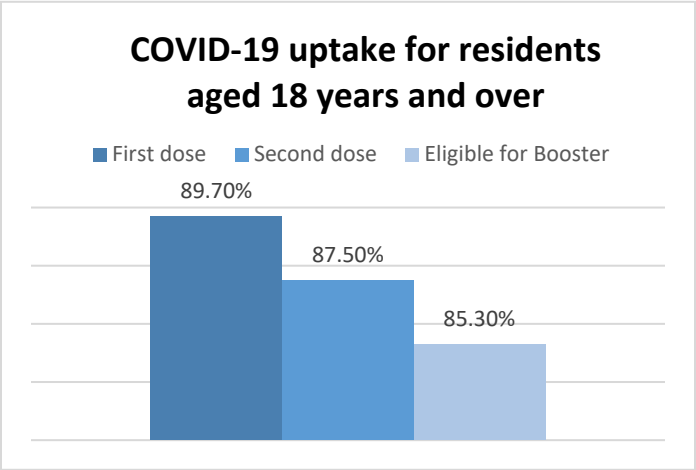
In response to demand decrease Ysbyty Ystrad Fawr Hospital (YYF) moved to once weekly testing at the end of February as a pilot to monitor outbreak transmission before implementing changes across all sites.

Changes in national guidance in March 2022 has now removed routine asymptomatic testing for all inpatients unless they become symptomatic or become part of outbreak incident management.

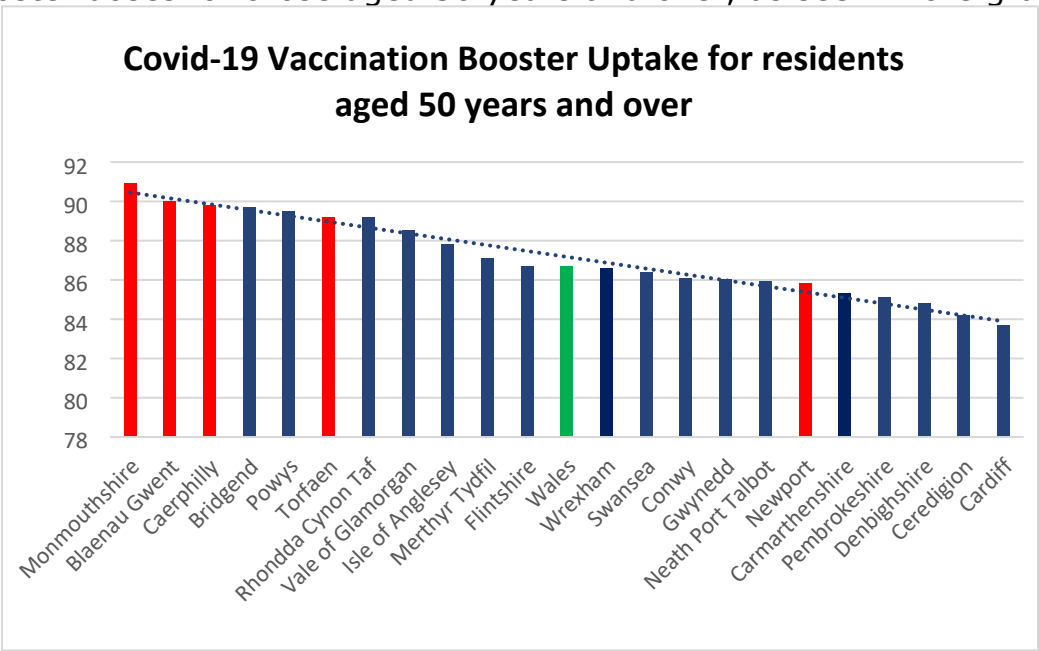
Progress against Mass Vaccination Programme

The Mass Vaccination Programme has delivered vaccination to the population in line with JCVI and WG guidance, commencing with phase 1 of the programme on 8th December 2020, offering vaccinations to initially the most vulnerable of the population. This has been followed with the offering of first, second and booster dose for residents aged 12 years and over living our area. The programme also offers vaccination to 5-11 year olds in line with WG advice.

As of 6th March, the phenomenally successful programme has delivered 1,312,335 vaccines, with 100,285 of these being delivered in 14 days during the accelerated booster programme during mid/end December.



Our programme has a strong leaving nobody behind strategy to narrow inequalities in uptake and continues to achieve high coverage rates with four of the five local authority areas in our area having the six highest uptake rates for booster doses for those aged 50 years and over, as seen in the graph below.



Staff Flu Vaccination Programme

Welsh Health Circular 2021-019 sets out an ambition to achieve a minimum of 80% staff flu vaccine uptake and a vaccination offer of 100% for 2021-22.

In 2020-21, the staff flu immunisation target was 75%. In our Health Board, the number of staff vaccinated at the end of the season was 9190, which was 66.4% of all staff and an increase by 5.4% in comparison to the 2019-20 season uptake (61%).

To achieve the ambitious target of 80% uptake, our staff flu vaccination plan 2021-22 was developed with a great deal of focus on engagement and communication with the staff to motivate and encourage them to take up flu vaccine. As in previous years, the delivery model was through peer immunisers, with the addition of the offer of a flu vaccine to staff when they attend a mass vaccination centre for their COVID booster vaccine.

In the 2021-22 season, we had about 500 flu champions. They are voluntary peer vaccinators, who engage with their colleagues to offer flu vaccine in both clinical and non-clinical areas. We had an incentive scheme for 'Flu Champions' in recognition of their efforts to promote and administer the vaccination. All divisions nominated a Flu Champion from their division to receive a Flu Voucher.

We have eight Divisional Flu Leads (DFL), one for each division. They take ownership for the planning, co-ordination and monitoring of how the division will meet its flu target.

As in previous seasons, Occupational Health planned to offer flu vaccination appointments for staff throughout the season and arrange clinics in areas that were not supported by flu champions.

However, this year due to pressures on staff, especially during the emergence of the Omicron variant, staff found it difficult to find the time to vaccinate. This was compounded with redeployment, high sickness levels and restricted movement around sites. Post-Christmas the programme was effectively relaunched to try to make up lost ground. Despite best efforts employees were generally unresponsive to all attempts to try to administer the vaccine. The general feeling was that employees didn't want "another" vaccine and the timing was perceived as late and wasn't worth having.

Despite these debilitating factors the Staff Flu Programme has achieved a 58% (8216 employees) vaccination rate. This places the Health Board 4th overall when compared to other health boards in Wales.

Community Flu Programme

Seasonal flu action plans were implemented in primary care (including care homes), primary and secondary schools and for Health Board staff. The Primary Care and Community Service Division provided oversight and support through a Community Flu Group. A campaign to increase staff uptake was launched mid-September involving Flu champions. The Neighbourhood Care Networks delivered a number of cluster based initiative to increase uptake. After the December booster programme a targeting health visiting interventions was undertaken to increase uptake among 2 and 3 years olds following the CMO letter highlighting concerns about co-circulation of influenza and Covid-19. As at 29th March 2022 the flu vaccination uptake in the health board area among those 65 years and older and in clinical risk groups aged 6 months to 64 years was the highest in

Wales at 80% and 53.6% respectively. Uptake among 2 and 3 year olds was 50.3% which is higher than the All Wales average of 47.6% (see table below).

Summary by Health Board and Local Authority (29mar2022)

		Children 2 to 3 years			Clinical risk 6m to 64y			65y and older		
		Denominator	Immunised	Uptake (%)	Denominator	Immunised	Uptake (%)	Denominator	Immunised	Uptake (%)
Aneurin Bevan UHB	Blaenau Gwent	1,528	833	54.5%	11,515	6,044	52.5%	14,432	11,041	76.5%
	Caerphilly	3,824	1,894	49.5%	27,300	13,938	51.1%	37,334	29,232	78.3%
	Monmouthshire	1,760	1,191	67.7%	13,171	8,314	63.1%	25,864	22,111	85.5%
	Newport	3,909	1,810	46.3%	22,138	11,597	52.4%	27,295	21,536	78.9%
	Torfaen	2,036	846	41.6%	14,769	7,767	52.6%	19,924	15,926	79.9%
	AB Total	13,057	6,574	50.3%	88,893	47,660	53.6%	124,849	99,846	80.0%
Wales	Wales	64,714	30,847	47.7%	444,742	214,271	48.2%	687,337	536,106	78.0%

8. Infection Prevention and Control

There are several policy and strategic drivers influencing the prevention and control of infection agenda across NHS Wales, but a notable framework is 'The Code of Practice'. The Code sets out the minimum necessary infection prevention and control (IPC) arrangements for NHS healthcare providers in Wales. There are nine elements that organisations are expected to meet in full across the range of healthcare services. The Code refers to both antimicrobial stewardship and the decontamination of medical devices, both of which are included in this Annual Report, which is underpinned by Health and Care Standard 2.4 Safe Care: effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare infections.

Nationally, the acquisition of a healthcare associated infection (HCAI) remains a major cause of avoidable patient harm and has been shown to pose a serious risk to patients, staff and the public. HCAI impacts negatively on patients in several ways for example severe or chronic illness, pain, anxiety, depression, reduced quality of life and loss of earnings or more seriously death. They also impact on the health service in terms of extended lengths of patient stay in hospital and time away from home, the costs of diagnosis and treatment of the infections and their complications, and the costs of specific infection control measures, hence infection prevention and control is a national and organisational priority.

The emergence of an increasing trend of antimicrobial resistance is seen as a global priority and one where the prevention of infection is paramount to support reducing the demand for antibiotics. It is therefore imperative that clinically effective measures are adopted within all health care settings to minimise the risk of transmission of any organism which has the potential to cause harm.

The Health Board recognises that the prevention of infection is fundamental to the quality of care delivered and is committed to ensuring that a consistently high

standard of infection prevention and control practice is seen as an essential requirement of assuring high quality, safe and effective care. The Health Board is committed to the minimisation of preventable healthcare associated infections (HCAIs) and has made significant improvements in reducing HCAIs in recent years, including Methicillin Resistant Staphylococcus Aureus (MRSA) bloodstream infections and infections caused by Clostridium difficile (Cdiff). Progress against the antimicrobial agenda has been somewhat stifled by Covid-19 with Welsh Government targets suspended during the Pandemic but work has continued, as far as reasonably possible, to address the implementation of the national antimicrobial resistance reduction programme. In terms of Decontamination the Health Board received a 'Reasonable Assurance' rating from the Authorising Engineer and the Health Board is cognisant of the All-Wales Decontamination Strategy, making good progress in this area with the opening of a brand new, state of the art sterilisation and decontamination unit on the site of the Grange University Hospital.

Welsh Government issue annual HCAI targets but in response to the pandemic no numeric targets have been set. Nevertheless, there was an expectation that Health Boards would continue to reduce the number of HCAI's based on previous year figures. It is pleasing to note the Health Boards performance is positive for 2021/22, which is noteworthy when considering the impact of the Covid-19 Pandemic.

Notwithstanding the continued domination of Covid-19 during the 2021/22 reporting period, there is an important story to tell in terms of the prevention and control of infection agenda and performance across the Health Board. The IPC work programme for 2021/22, is outlined in the following table, with a RAG rating in terms of performance.

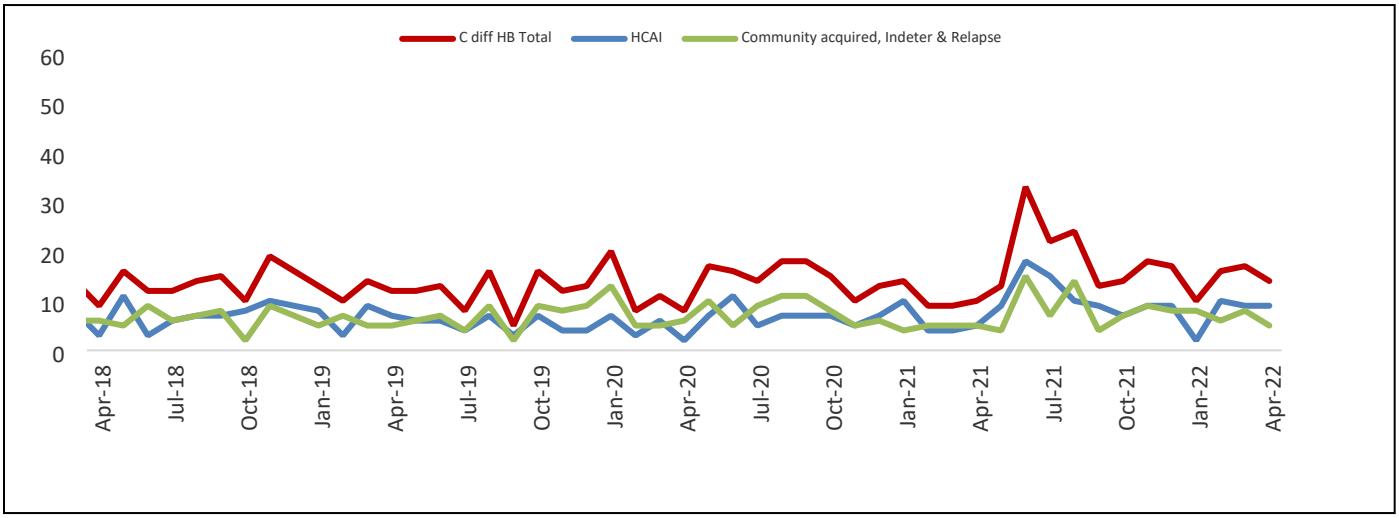
Priority 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks the environment and other users may pose, maximising the use of ICNet.	
Priority 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates robust compliance to the prevention and control of infections, to include systematic HPV.	
Priority 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	
Priority 4	Provide suitable and accurate information on infections for service users.	
Priority 5	Ensure prompt identification of people who have or are at risk of developing an infection so they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people.	
Priority 6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and	

	controlling infection. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities through education and training.	
Priority 7	Ensure all IPC policies are up-to-date and evidence-based.	
Priority 8	Undertake outbreak reviews from Covid surge 1 and 2, together with individual death reviews associated with each outbreak and ensure organisational learning and preparedness for future surges.	
Priority 9	Actively contribute to the Covid-claims agenda.	
Priority 10	Implement a staph aureus reduction plan.	
Priority 11	Prepare a business case for strengthening of, and investment, in the IPC team and infrastructure.	

Healthcare associated infections are robustly monitored to quickly recognise an emerging period of increase incidence (2 or more new cases in a 28-day period). In these circumstances, a Serious Incident (SI) meeting is convened to explore a standard set of actions dependent on the organism. The investigative approach follows a prescribed format to determine the root cause.

A number of wards have been affected by an increase incidence of C *difficile* infection during 2021/'22.

There have been 205 cases of C *difficile* reported from April 2021 - March 2022. This is 40% more than the equivalent period 2020/21 equating to a rate of 34.27 per 100,000 population. C *difficile* continues to be above trajectory and remains a concern albeit an improvement is being seen and is a picture seen nationally.



Serious Incident meetings have been convened, ward action plans developed and monitored. Lessons and learning has been discussed at Directorate/Divisional Governance and Patient Safety meetings. Common actions include environmental decontamination using Hydrogen Peroxide Vapour (HPV), audits of the environment and practices on the ward and hand hygiene assessments.

Learning identified from C *difficile* Serious Incident meetings include:

- Antimicrobial compliance
- The number of individual patient inter-hospital and ward transfers
- Compliance with hand hygiene audits (WHO 5 moments)
- Cleaning standards
- Prompt recognition and cubicalisation

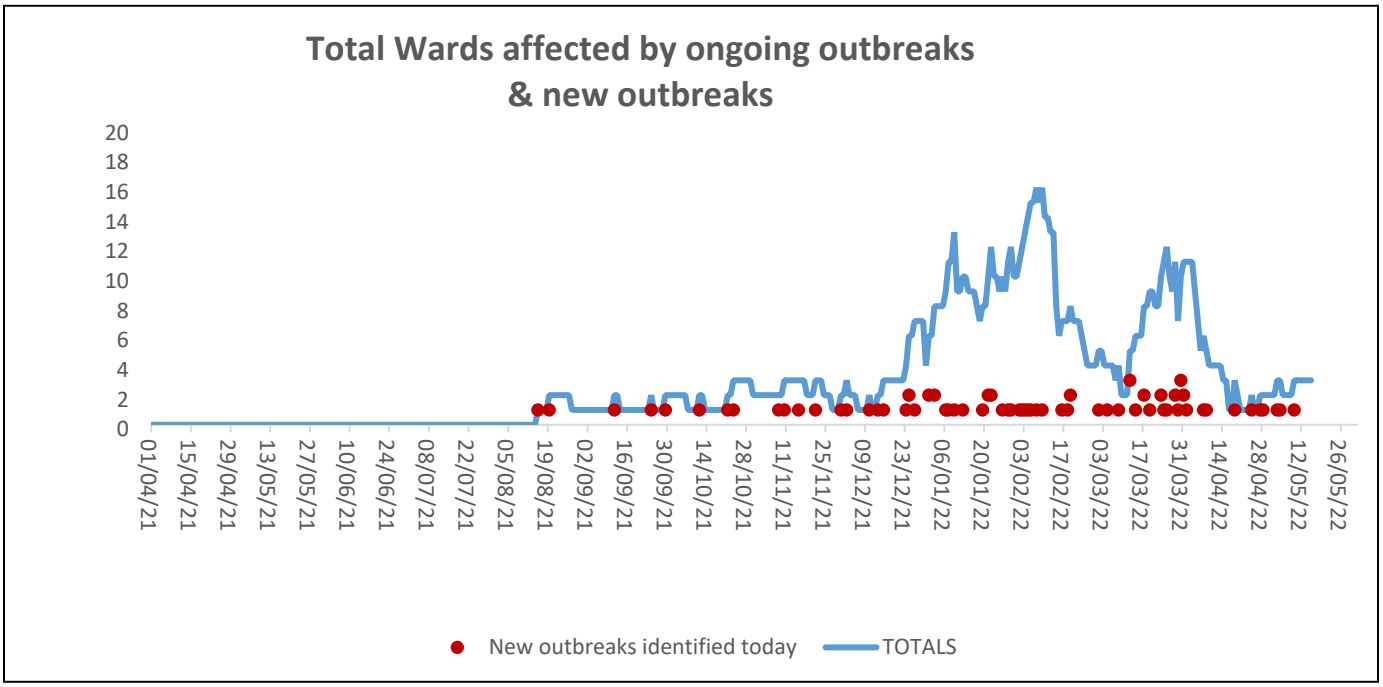
Covid-19 Outbreaks

An outbreak, as defined by Public Health Wales is 2 or more cases occurring in the same ward environment, within a specific time period and is a notifiable incident. The ongoing community transmission is inextricably linked to hospital acquired cases.

At its highest point in February 2022, 16 wards across the Health Board were affected and closed due to outbreaks of Covid-19 placing significant pressure on bed capacity, workforce, and staff wellbeing as well as, of course, impacting on patients and their families.

The number of wards impacted undoubtedly affected patient flow with varying numbers of beds lost due to ward closures. The IPC team, together with microbiology, provide advice and guidance on management, considering whole system risk. In some instances, patient experience was impacted by multiple inter-ward and hospital transfers to ensure they are cared for on the appropriate Covid pathway which resulted in patients being cared for in a different speciality to their initial clinical presentation.

The number of outbreaks has reduced significantly, as shown in the following graph, undoubtedly impacted by the changes to testing.



Pragmatic decision making has been implemented for Mental Health wards and acute services to mitigate risks to patient experience and inpatient capacity. These have included reducing the ward closure time from the date of the last identified case from 14 to 10 days, for example.

Outbreak investigations have identified that in the majority the index case has been an asymptomatic individual. In order to mitigate this risk, all inpatients were PCR tested every 5 days and all staff requested to undertake a pre-shift LFD test every day. This strategy meant increased identification of asymptomatic patients and staff and has therefore led to increased outbreak reporting. However, the early identification of these outbreaks meant outbreak measures, including daily LFD tests, started earlier reducing further transmission and allowing earlier re-opening of wards.

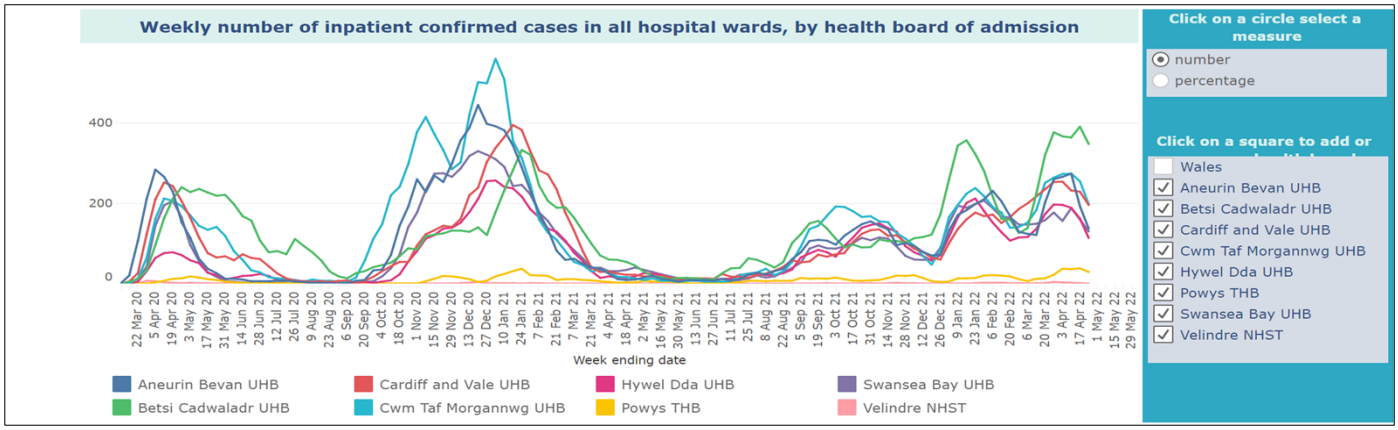
Continual use of PPE, sickness and absence coupled with ever changing guidance around isolation and testing requirements has impacted on establishment and staff wellbeing. To maintain patient flow, wards have rapidly switched pathways or moved to create additional capacity and manage whole system risks. Staff embraced the challenge against the backdrop of managing extremis sickness absence and staffing deficits.

From May 2021, the number of patients with Covid in hospital started to reduce until September 2021, when cases began to rise again peaking in January 2022. At the end of January 2022, there was a requirement for additional red (Covid) capacity to be established on the Royal Gwent Hospital site to cope with inpatient demand. In March 2022, the Health Board was in a much better position and red pathways returned to single room hospital sites only (Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan).

The number of patients requiring critical care and high-level respiratory care has been significantly lower during the Omicron surge than in the previous surges.

A decline has been experienced in the number of positive inpatients up to the 24th April 2022. At this point, Aneurin Bevan University Health Board demonstrated an admission rate of 9% for positive Covid-19 patients, which is slightly below the Welsh average of 11%.

The following graph shows the number of inpatients with Covid-19 compared to other Health boards in Wales.



Eliminating avoidable healthcare associated infection remains a top priority for NHS Wales and ABUHB. It has been another challenging year for the IPC team with the majority of their work focused on responding to the Covid pandemic, with IPC playing a central and fundamental role. The Divisions, alongside other teams and in particular Health and Safety and Facilities, have supported delivery of the IPC agenda.

The achievement of the majority of the Welsh Government reduction targets during 2021/'22 has been positive, not least against the backdrop of Covid-19 and the pressure this presented across ABUHB.

With the exception of C *difficile*, ABUHB has the lowest rates for all other measures across Wales, as can be seen in the following table.

Higher than same period of previous FY | Lower than same period of previous FY | Same as same period of previous FY

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	205	34.27	4	0.67	130	21.73	134	22.40	344	57.51	93	15.55	31	5.18	468	78.24
Betsi Cadwaladr UHB	215	30.57	10	1.42	169	24.03	179	25.45	436	61.99	138	19.62	37	5.26	611	86.87
Cardiff and Vale UHB	156	30.92	11	2.18	131	25.97	142	28.15	311	61.65	120	23.79	35	6.94	466	92.37
Cwm Taf Morgannwg UHB	155	34.46	2	0.44	118	26.23	120	26.68	390	86.70	81	18.01	29	6.45	500	111.15
Hywel Dda UHB	152	39.00	16	4.11	105	26.94	120	30.79	356	91.35	87	22.32	31	7.95	474	121.63
Powys THB	11	8.27	0	0.00	0	0.00	0	0.00	3	2.26	0	0.00	0	0.00	3	2.26
Swansea Bay UHB	196	50.13	10	2.56	129	33.00	139	35.55	288	73.67	94	24.04	24	6.14	406	103.85
Velindre NHST	5		0	0.00	3		3		5		4		1		10	
Wales	1,095	34.55	53	1.67	785	24.77	837	26.41	2,133	67.30	617	19.47	188	5.93	2,938	92.69

As the organisation stabilises, following the second Covid surge, it is important to refocus on the fundamental principles of IPC, strengthen cleaning and the HPV programme and to re-embed the IPC agenda as being owned by everyone.

Redesign of local estate to deliver safe services during COVID

All outpatient facilities were assessed by Health and Safety, infection control, and nursing teams, to establish the correct pathways for patients attending face to face clinics (as can be appreciated initially a lot of face-to-face clinics ceased, and increased non face to face processes were put in place).

This assessment ensured that the clinic areas adhered to the two metre social distancing rules, and waiting areas were marked out accordingly, and chairs removed and/or marked up that they could not be used and gave the Health Board the ability to manage the activity through the waiting rooms and onto the clinic rooms. In addition, depending on the layout and size of waiting areas in clinics, additional cover ways were placed outside a couple of the clinic locations, to help with keeping people safe while waiting.

After the initial wave of Covid 19, the two-metre ruling was decreased to one metre in a number of clinic areas – commencing in Royal Gwent Hospital in June 2021. Screens were erected in waiting rooms to give added protection with cleaning down rules applied. This would have doubled the activity to those clinic areas. Not all areas would have been suitable due to layout of clinics and overall space.

9. Delivery of Essential Services

We continue to monitor closely the implementation of the prioritisation framework. Elective activity undertaken is defined by the clinical prioritisation of the patient, rather than a time-based approach, this enables timely care for the most urgent patients and clinically led decision making. This will have an impact on Referral to Treatment Time (RTT) waits in some services.

Outpatient Services

Services have embraced new ways of working due to COVID-19, especially within outpatient services, where the focus has been on virtual clinics and reviews and office-based decisions. The key aim of our Outpatient Transformation Programme is to improve the patient experience and ensure the patient is central to the transformational work.

"My Medical Record"
The Urology Service is leading a project to utilise a patient platform 'for use with patients who are in a stable condition, where their prostate specific antigen (PSA) results can be reviewed by both the patient and the clinical team. This means that patients do not need to attend clinic unless required. This type of process will also be considered for other patient conditions in the future.

An "advice only" process introduced into the Health Board in 2020-21 has meant that, following a referral where appropriate written advice has been provided swiftly to the GP, the patient isn't required to be seen in clinic or in a non-face-to-face consultation. Figures are below:

Mid 2020 to 2021	4,882 patients
2021 to 2022	8,767 patients
2022/23 to date	336 patients
TOTAL	13,985 patients

Other areas of focus have been around identifying other ways to manage patients appropriately, e.g. SoS (See on Symptom) and PIFU (Patient Initiated Follow-ups), non-face to face consultations. The current status is as follows:

Area of Focus and Target	Family and Therapies	Medicine	Scheduled Care	Mental Health	TOTAL
Virtual Activity (35%)	27.39% New 20.22 % FU	44.86% New 50.50% FU	17.91% New 26.80% FU	65.41% New 33.76% FU	**25.45% New** **32.08% FU**
SoS and PIFU (20% target)	22.8%	9.6%	5.5%	0	**9.2%**

Specialities' Outpatient Delivery Plans have concentrated on modernising and transforming pathways within their services, as well as ensuring that outpatient capacity is utilised for those patients most at risk. Further detailed work is underway working with clinical teams to link the demand and capacity plans for 2022/23 to those patient conditions most at risk, thus helping to reduce harm to patients. We are currently prioritising patients 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 .

We are also risk stratifying patients in a number of specialties, for example:

- PROMS in Neurology, COTE, Respiratory
- Gastroenterology – PROMS for Hepatology and Alcohol Liaison.
- Triage of patients within Paediatrics (patients reclassified where appropriate), Dietetics, Physiotherapy and some orthopaedics.
- Reviewing paediatric orthopaedic patients.

In addition, we have contacted patients who are waiting over 52 weeks for a new outpatient appointment to establish whether they still require the appointment, for example their condition may have 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). The process has also been undertaken for patients who are waiting 36-52 weeks and a process has also commenced with selected follow-up outpatient waiting lists, with the aim of determining if the appointment is still required. These processes enable us to cleanse our waiting lists and use our capacity for patients who need the appointment.

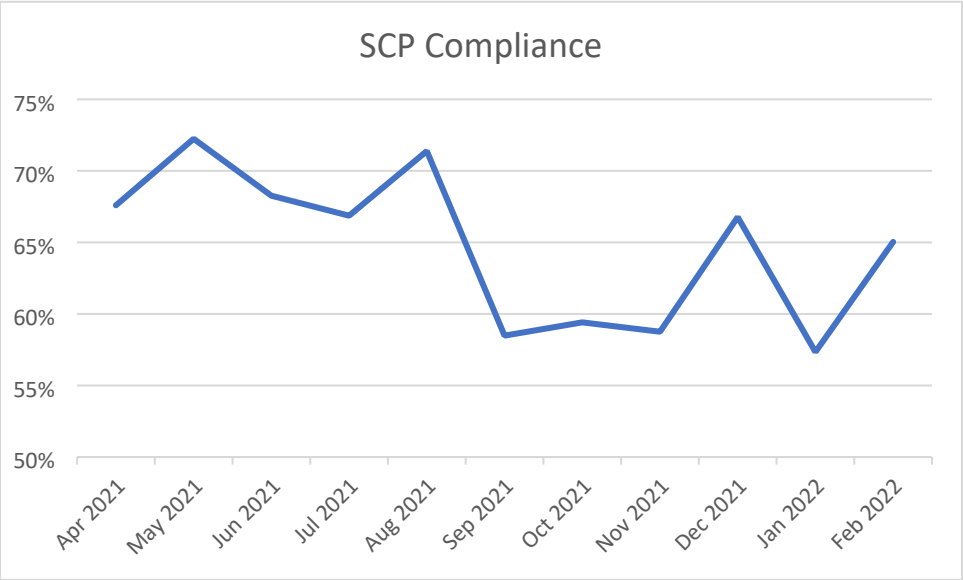
Cancer Services

Cancer services continued to experience considerable challenges in 2021/22 as the result of fluctuations in operational capacity resulting from the changing COVID-19 pandemic. Despite these challenges, the diagnostic and treatment pathways continued to be delivered with innovation and development in many specialties to help improve access and experience for cancer patients.

The implementation of the Single Cancer Pathway in 2020 continues to ensure that patients are receiving equitable access to services and is a prompt for continuous improvement for experience and the accessing of diagnostic services and treatment.

Following a year of supressed demand, March 2021 saw a rapid increase in referrals, returning the referral rates to expected ranges and beyond. This demand was sustained throughout the year, irrespective of changes in the COVID environment which is very encouraging. For most specialties, 2021 set new records for the numbers of referrals received. Managing this level of demand within the ongoing pandemic has been a challenge and innovation has been required to ensure patients are receiving diagnostic tests in the fastest possible manner.

Achieving the 62 day suspicion to treatment cancer target remains the primary focus for cancer services. In the past financial year we did not achieve the 75% pass threshold, despite promising signs in May and August. Performance in the latter part of the year was particularly impacted by spikes in demand, combined with periods of high staff absenteeism as a result of COVID-19. Services are working to address the capacity mismatch whilst also balancing recovery or routine services.



The recovery of the cancer waiting lists is a key priority for 2022/23. This will be achieved with a focus on improving access times to first appointments and wait times for diagnostic services. This in turn will play a vital role in improving the compliance rates to the 75% pass threshold. This improvement work is being supported by newly developed innovations in referral software and Artificial Intelligence planning tools, which will support services in sustaining sufficient capacity.

Cancer Services are working closely with the Delivery Unit and the Cancer Board to provide the operational infrastructure necessary to support in the sustainability of diagnostic capacity. The opening of the new Breast Cancer Unit in Ybyty Ystrad Fawr will play an important role in improving access and patient experience for all breast cancer referrals, with innovative recruitment plans being considered to address the current staffing challenges.

Development plans for the Nevill Hall Cancer Centre are progressing at pace with a collective emphasis on improving patient experience and access for our community. Following the approval in October for substantive funding for the Rapid Diagnostic Cancer Service, expansion plans are underway which will see the service running from both Nevill Hall and the Royal Gwent Hospitals.

General Surgery

The General Surgery Directorate has continued to prioritise care and treatment for those suspected of or experiencing cancer. Delivering a robust service remains challenging with every effort made to ensure patients are diagnosed and treated in a timely manner.

The Upper GI Suspected Cancer pathway treatment target of 62 days averaged 58% over the previous year with confirmed cancers treated by our partner Health Board Cardiff and Vale. Our patients on average currently wait just 14 days from referral to the service to consultant outpatient appointment.

Colorectal compliance averaged 42.4% for the previous year as a result of a significant increase in referrals. July 2021 saw the highest number of recorded referrals with a 46% increase on pre pandemic averages.

This sustained demand has challenged the service to introduce new ways of working, from increasing virtual appointments, the expansion of the Straight to Test Service and the restructuring of the Multi Disciplinary Team. Diagnostics and treatment remains a constraint to improvement, however the outsourcing of endoscopy and the Directorate's ongoing work to maximise theatre capacity should translate into quicker access to services for patients in the coming year.

The Breast Service averaged 60% compliance in 2021/22, again referral rates reached an unsurpassed level with referrals 47% higher in September 2021 than pre pandemic. In conjunction with high demand the service was also affected by a reduction in activity due to staff absence and the challenges in recruiting suitably qualified and experienced radiologists.

However, in January 2022, two new Consultant Breast Surgeons were appointed to the team, adding much needed capacity to the service. Recent adjustments have also been made to the Breast Radiologists job plans that should aid in the timely care of patients with further Radiologist recruitment underway. The planned opening of the Unified Breast Unit at Ysbyty Ystrad Fawr in early Summer 2023 will offer a breast cancer centre of excellence which will further improve patient care, experience and outcomes.

Urology

All referrals are clinically triaged against nationally agreed criteria. Plans are in place to increase access to 1 stop Haematuria appointments from 30 per week to 50, due to increase in demand, from w/c 6 June 2022. Waits were in excess of 25 days. It is anticipated this will reduce length of wait to below 1 week.

As per the optimal pathways, the straight to MpMRI service for suspected prostate cancer will be implemented following recruitment of additional Clinical Nurse Specialist. This will significantly reduce the time to diagnosis for prostate patients which is currently the biggest contributor to breaches. This work is planned for implementation in July 2022.

By streamlining the front end of these pathways and with these improvements it is likely that performance compliance will increase to 70%-75%.

Head and Neck

Following a period of suppressed demand throughout 2020, referrals increased considerably in March 2021 and this increase was sustained throughout the year. Despite this increase, referral rates remains around 10% below that of pre pandemic rates which is a cause for concern. The service did not achieve the 75% pass threshold in the year, however considerable improvements were observed in November and December. Pressures seen on urgent care services have had a

considerable impact on the Head and Neck Cancer Service due to the requirement for bed space at the Grange University Hospital. The coming year includes plans to relocate diagnostic services from GUH which will improve bed capacity and access for suspected cancer patients. Further outpatient capacity is also being released for suspected cancers which will improve the early access for patients.

Eye Care

Eye care measures were developed to ensure that follow up patients are given appropriate priority alongside new patients. The measures require every ophthalmic patient to be allocated a clinically determined target date for next clinical event and a category of clinical priority based on the risk of irreversible adverse outcome associated with their clinical condition(s). These risk/priority categories are:

- R1: Risk of irreversible harm / significant patient adverse outcome if patient target date is missed.
- R2: Risk of reversible harm / adverse outcome if patient target date is missed.
- R3: No risk of significant harm.

During the Pandemic only R1 patients were seen face to face in clinic. Numbers in clinic were reduced due to social distancing requirements and the absence of several consultant staff due to shielding. Subsequently approved funding to address this problem in the Wet AMD service i.e. delayed follow up appointments leading to serious incidents due to patients being left with permanent sight loss which has enabled the Health Board to implement new ways of working though the recruitment and training of nurse injectors and increase capacity though additional clinics on peripheral hospitals. The directorate also has plans to increase the number of injectors through the training of optometrists.

Implementing Royal College of Surgeons Risk Stratification

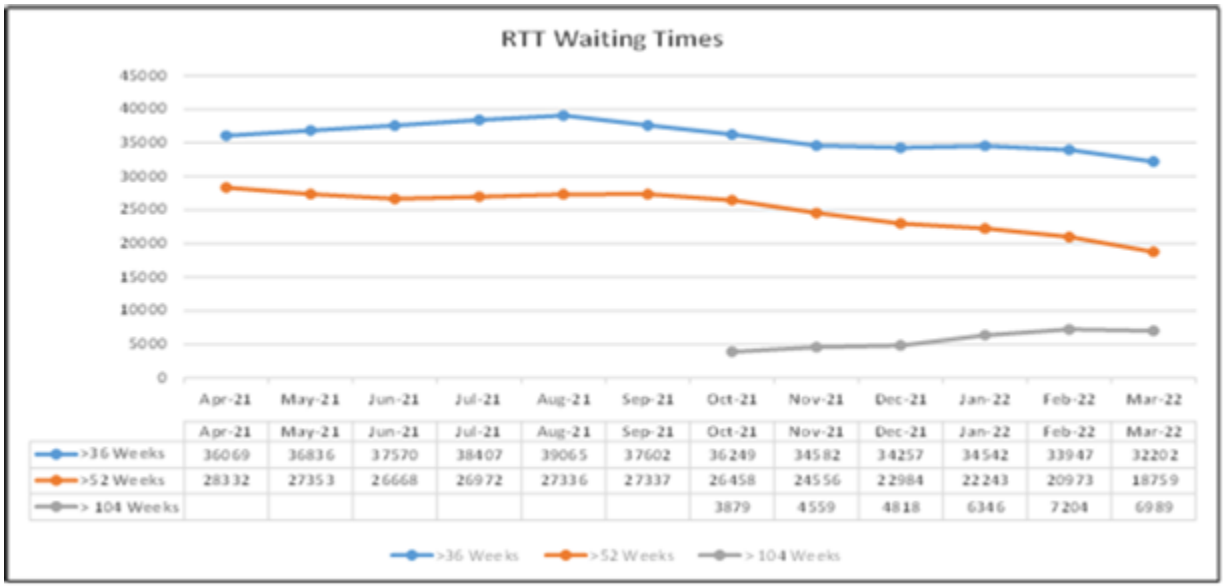
The Royal College of Surgeons (RCS) introduced guidance on how and what pathways should be prioritised. Changes to incorporate the agreed RCS risk prioritisation on the national Welsh Patient Administration System (WPAS) has enabled services to apply a risk code of P2, P3 or P4 to those patients waiting for treatment on an inpatient or daycase waiting list with P2 being the highest risk.

Waiting lists for all surgical specialities were reviewed by consultants in accordance with RCS criteria and each patient was allocated the appropriate priority.
Processes have been implemented to ensure that all patients being added to the treatment waiting list are prioritised on addition. Additionally, processes have been established for any GP requests for priority reviews to be undertaken amended where appropriate.

Capacity is planned and focused on treating those patients where they have been prioritised as being most at risk from harm. As part of the risk stratification process, patients must be re-assessed when they reach the priority target date.

Current overall compliance of a risk priority applied to the inpatient and daycase waiting lists is 93% with 9% being prioritised as P2.

Referral to Treatment Times – Elective Care



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
>36 Weeks	36069	36836	37570	38407	39065	37602	36249	34582	34257	34542	33947	32202
>52 Weeks	28332	27353	26668	26972	27336	27337	26458	24556	22984	22243	20973	18759
> 104 Weeks							3879	4559	4818	6346	7204	6989

Of the 32,202 patients waiting over 36 weeks at the end of March 2022, the table below shows that approximately 18,000 of those are at the new outpatient waiting list stage. There are also 18,759 waiting over 52 weeks with 8,390 of those at the new outpatient waiting list stage. Of the 18,759 patients waiting over 52 weeks, 6,989 of those patients have been waiting over 104 weeks with 1,606 of those at the new outpatient waiting list stage.

Week Bands	1 Outpatient WL	2 Diagnostic	2 Therapy	3 Follow Up	4 Daycase WL	4 Inpatient WL	Grand Total
0 to 25	47,528	2,589	190	4,512	8,437	2,405	65,661
26 to 35	9,585	713	37	761	1,907	648	13,651
36 to 51	9,566	575	33	486	1,672	1,111	13,443
52 to 103	6,762	450	51	612	2,055	1,840	11,770
104 +	1,606	393	42	260	2,547	2,141	6,989
Total	**75,047**	**4,720**	**353**	**6,631**	**16,618**	**8,145**	**111,514**

The Health Board continues to commission elective treatments and outpatients with St. Joseph's Hospital and ophthalmology treatments with Care UK. Opportunities continue to be explored for additional capacity, along with other outsourcing / insourcing opportunities and regional working. This will be key in ensuring that the Health Board will be able to respond to the programme of revised Ministerial Priorities that have been introduced to tackle the backlog for 2022/23 and longer term.

Whilst this position presents unprecedented challenges in terms of recovery and will require new ways of working, the new Health Board system and additional physical capacity available provides some opportunities for planned care.

Operational divisions and support teams have worked collaboratively to restart services wherever possible, embracing new ways of working to maximise capacity and treat those at greatest risk. The Elective treatment plans are evolving with capacity gradually improving as the requirement for Theatre staff to support both wards and Critical Care diminishes. In addition, the Scheduled Care Division has introduced a number of measures to support the management of a "green" pathway across our hospital sites. These measures protect some treatment capacity, but as national restrictions change over the next couple of months, these are likely to be reviewed to maintain this protection.

We have been creative in our approach to planned care with flexibility based on patient demand.

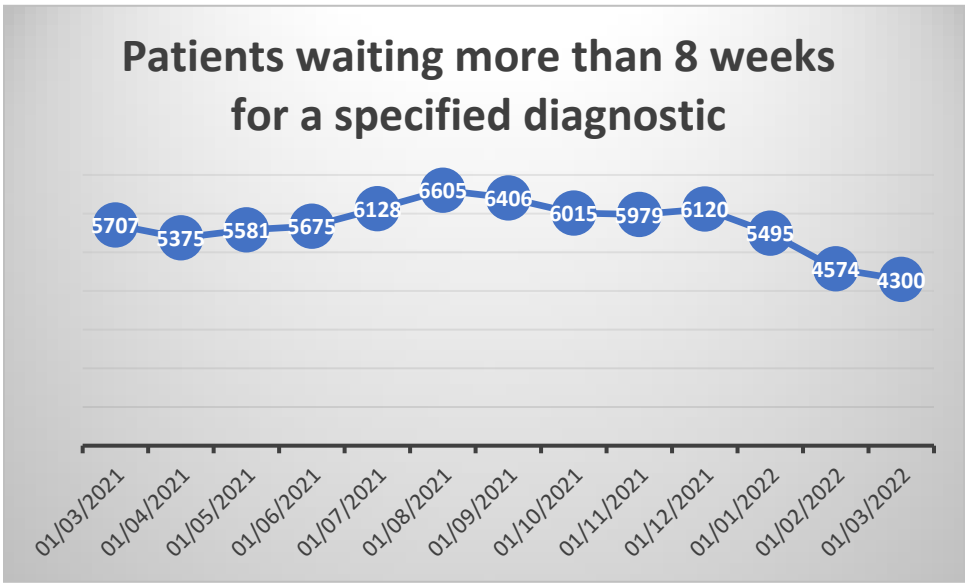
The POCU (Post Operative Care Unit) at the Royal Gwent Hospital (RGH) is established to enable increased levels of higher risk planned surgery to occur at the eLGH, with patients safely treated on site. A Transfer Practitioner model (currently running for 12 hours per day) has been approved for expansion to cover 24 hours 7 days a week, which will result in a systemwide response to a patient requiring unexpected escalated or emergency care post procedure being been bolstered.

Many planned systems are returning online and prioritising reducing waiting lists. Improvements in recent activity are beginning to show in the data, and those patients who have breached 36 weeks are being addressed, with these total numbers dropping by almost 4500 between August 2021 and December 2021, a 12% improvement in the context of all other Welsh Health Boards maintaining their position.

Diagnostic Services

Service capacity is gradually increasing for all patients, although the backlog in patients needing to be seen and consequently requiring diagnostics is putting pressure on the services. The over 8-week position decreased in March 2022.

With the early opening of the Grange University Hospital in November 2020, the Radiology Directorate gained elective scanning capacity and with further help from private provider we have been able to largely address backlog and in actual has improve on access/turnaround for routine diagnostic investigations.



Mental Health Services

Demand for Mental Health services are predicted to increase as a result of the pandemic and over the period there has been an increase in demand presenting to primary care. During this period the Health Board has developed a range of excellent community based resources to support individuals to help themselves without need of a referral through our Foundation Tier and the development of the MELO website.

During 2021/22, the Health Board has successfully continued to develop a brand new workforce to enable primary care to better meet mental health demand with the development of Psychological Wellbeing Practitioners (PWP) based around Neighbourhood Care Networks. The introduction of the PWP service was prioritised in order to support GP practices with appropriate capacity and expertise for those patients whose mental health needs could be more prudently met by allied healthcare providers. Linking these mental health professionals directly to practices, as part of the primary care team, was considered important in order to fully embed these roles and make it easier for people to access the care they require, when and where they require it. While referrals into the Primary Care Mental Health Support Services has returned to pre-pandemic levels, PWPs are now undertaking around 1400 assessments a month suggesting that this service is making a significant contribution to helping to meet increased demand.

All mental health services continued to be provided across the full range of adult and older adult mental health service throughout the pandemic with the majority of services continuing to provide face to face services throughout the last year. However a number of services adopted a hybrid model of face to face and virtual services, providing more choice to patients on how they can be seen.

Within our Primary Care Mental Health Services (PCMHSS) around 70% of all activity is still being delivered virtually. A range of group interventions have also been developed and delivered virtually in PCMHSS and Psychology. It is likely that moving

forward the virtual offer will become part of a hybrid model of service delivery for many services, dependent on patient and service needs.

The pandemic has provided workforce and service delivery challenges which has led to growing waiting times in a number of specialties and Primary Care Mental Health Service Interventions have been particularly impacted. Plans were developed to commission additional counselling capacity but the commissioned providers have also faced the same workforce challenges and the reduction in the waiting list has been much less that had been planned. Further plans are being developed for 2022/23 to reduce waiting times to enable national targets to be achieved over the next year.

Over the last twelve months the Health Board has made significant improvements to the crisis pathway to provide a range of alternatives to admission, including the development of a Sanctuary service, the opening of a crisis support house and the extension of Shared Lives across the whole of the Health Board. Each of these services has made an important contribution in managing demand for inpatient beds during the Omicron variant peak and associated pressures on our inpatient services and workforce.

A few of the highlights from Mental Health services are outlined in more detail below.

MHLD 'Sanctuary in ED' service was launched in December 2021, with funding available until early summer 2022. Peer Support Workers attend in the Emergency Department (ED) at GUH, Thursday to Sunday, between 4pm and Midnight. They provide support and information to individuals presenting in emotional distress. The outcomes are anticipated to reduce the number of patients leaving before assessment due to long waiting times and to improve the quality of information and support being received by patient requesting/ requiring mental health support. **92 patients have been supported through this service to date and feedback from patients, ED staff and peer mentors has been really positive.**
Tŷ Cynnal, our **Crisis Support House** for Gwent, opened its doors to service users in December 2021. Guests in Mental Health Crisis, for who this option is identified as safe and appropriate, stay for up to 14 days, as an alternative to an inpatient acute ward stay. Additional practical support is provided during the stay, with our Divisional Housing Team and other Partners such as Citizens Advice.

The house has hosted 13 people experiencing mental health crisis during December and January. Constructive and positive feedback has been received. A family member of one guest said *"I cannot thank you enough for your support - I feel that the house stay saved their life."*

Our **Shared Lives** service continues to expand. A collaborative service with Local Authorities, where Service Users, who are assessed as safe and appropriate for this option, stay with host families, in the family's home. **To date 86 individuals have stayed with host families,** their stays an alternative to inpatient acute ward.

The average length of stay with families is currently 13 days. 81% of users are reporting a reliable improvement in their ongoing recovery from stays. The service receives professional and general media recognition. WHO (World Health Organisation) had a recent article focus and the latest feature locally has been by Stacey Dooley, who visited a host household with longer term Guests. This is still available to download from BBC Sounds

Celebration of Professions: Nurse Mental Health Nurses Day – 21/02/2022
This was proactively recognised and celebrated. Corporate Nursing gifted a beautiful poem, to our Mental Health Nurses, written by Tanya Strange. Covid safe activities were held virtually and on wards within pandemic guidance. The Wards held collaborative activities with patients, such as coffee and cake and **Elvis was in the building** in person 'twice' sharing a little music and joy on St Cadocs Wards to celebrate.

Wellbeing Collaboration – for Colleagues and Service Users
The 'Window On the World Project' is underway. An 'Arts In Health' collaboration between MHLD & GARTH, the project is delivered with artists from Llantarnam Grange Arts Centre. This project is focussed on patient and staff wellbeing, by enhancing the corridor environments in St Cadoc's hospital with large prints reproduced from original artwork made by patients and staff in on-ward and drop-in sessions this spring. All staff and site users are encouraged to take part, and the 'picture windows' created will be printed onto sustainable anti-microbial foam board for the corridor areas in St Cadocs Hospital. It is open for contribution by all colleagues and service users who visit site.

Sessions to create artwork have taken place on wards and staff drop-ins (in safe guidance) and will continue through March and April. There are some really lovely windows so far. A key outcome from this is also around the wellbeing experienced in taking part. Feedback so far indicates people have enjoyed this activity, service users and colleagues together. Participants so far have said it made them feel 'relaxed' 'happy' they described it as 'fun' 'not scary' 'mindful' 'nice to spend time doing something different with others' respondents so far have rated it a 5star experience.

The Mental Health and Learning Disabilities division have also supported the well being of colleagues.

Developed in response to the demand to psychologically prepare and protect the NHS workforce during the COVID-19 pandemic, the **Psych PPE©** approach is focused on promoting staff wellbeing allowing individuals to construct their own personalised self-care plan and practices to protect their wellbeing. The initiative has been funded through Covid Recovery money to take forward in the Mental Health and Learning Disabilities Division. To date, this has enabled two 'PsychPPE© - Train the Trainer' workshops to be held with 25 colleagues attending. The programme has now established a cohort of trained Wellbeing Co-ordinators and

these will be facilitating a series of workshops with staff to cascade this approach to self help and wellbeing across the Mental Health & LD Division.

We have also been successful in securing funding for the **Project Wingman Well-Being Bus** and flight crews are planning to attend sites in early summer.

Project Wingman crews visited MHLD in the initial phase of pandemic. They are a charity, supporting wellbeing in NHS Workforce. A group of volunteers of current and former aircrew from all corners of aviation, they offer NHS staff first class airline cabin treatment in a luxury space where they can rest and recharge.

We have some estate challenges and are delighted that this crew now have a mobile lounge available for use. It is a specially converted and fully branded double decker bus, with a pop up garden. It provides a relaxed, informal and versatile space in which to offer the service.

The buses are limited and in great demand across the UK. We are the first to secure a visit in Wales. MHLD will lead in the activity and align other wellbeing opportunities with the visits. The visit is anticipated to take place in July, the bus will remain on our Health Board sites for use over 2 weeks.

10. Patient Experience: Listening and Learning from Feedback

People's experience during COVID-19 has been impacted by the pandemic, both in hospital and across the community. An essential component of safe and compassionate person-centred care is listening to and responding to people's experience. Since the start of the pandemic a number of patient experience surveys have been undertaken to better understand patient experience across the Health Board. These have been undertaken through direct visits (where visiting restrictions allowed), through virtual 'buddying' with the Community Health Council (where patients were connected to a CHC Member through i-Pads) and postal surveys. 782 people provided feedback through these methods.

Jan 2021	Care at Home-Complex Care	Virtual Buddying	15
Jan 2021	Community Huntington's Disease	Postal Survey	12
January 2021	District Nursing	Postal Survey	158
March 2021	GUH Wards	Virtual Buddying	32
May/June 2021	ED Attendance Snapshot over 3 days	Physical Attendance	56
June 2021	Mental Health and Learning Disabilities in Patients	Virtual Buddying	42

Oct 2021	Head and Neck Cancer-GUH	Postal Survey	27

Each of these surveys provided overwhelmingly positive feedback relating to staff attitude and compassionate care, with many respondents identifying staff going 'over and above' during very challenging times.

The main themes identified through patient feedback are:

- **Communication and information**, specifically relatives' ability to contact wards

As well as employing more ward clerks, Patient Liaison Officers for all hospital sites, with a specific role in supporting communication between wards and relatives, were introduced and have been extended to June 2022. All wards have been issued with i-wards to support relative to patient communication digital connection.

- **Loneliness and isolation** - compounded by restricted visiting and absence of ward-based volunteering

Following the All-Wales COVID risk assessments, volunteers have been reintroduced to wards. Visiting with a purpose has been implemented.

Patient Reported Experience Measures (PREMS)

The Person Centred Care Team have supported wards by speaking to patients to collect Patient Reported Experience Measure Surveys (PREMS). Any urgent matters are raised with staff at the time of the visit as well as initial feedback. A full report is then produced and shared with the ward staff. This allows staff to discover what matters to patients and what may be done to make improvements. It also provides staff with the positive feedback which is beneficial for staff morale. Analysis of the PREMs allows themes to be identified. The team have supported Holly Unit at St Woolos Hospital and B3 at RGH. There are plans to support wards at County with PREMS in April.

Proof of Concept at Ysbyty Aneurin Bevan (YAB)

In response to the observable and subjective impact that the Covid Pandemic had on patient care within the general hospital wards a Proof of Concept (PoC) and Service Evaluation commenced at Ysbyty Aneurin Bevan (YAB) on the 1st July 2021. Through locally agreed outcome measures, the PoC and Service Evaluation aimed to introduce a range of initiatives that supports dementia care. The aim is to evaluate if introducing meaningful activity, dementia learning and training for staff and the creation of Dementia Companion Volunteers would collectively improve overall quality of care, patient safety, patient experience and support transferability for this plan to be moved into other wards and departments in the Health Board.

Supporting 'visiting with a purpose', Johns Campaign has been relaunched across all 3 wards at YAB. There is clear evidence ward staff are proactively engaging with relatives and facilitating visiting. Following the uptake in training, posters indicating that each ward is now 'Dementia Friendly' and identification of the ward-based Dementia Champions are now visible. Ward staff are encouraged to ask relatives to complete the *This is Me* documentation to support person centred care. The need to promote completion of *This is Me* earlier in the persons care pathway has been identified through the evaluation and is now an action within the Memory Assessment Service and Dementia Pathway Group.

End of Life Companions (EoLC)

Patients at the end of life will have a care plan to address their clinical needs. It can be more difficult to ensure that a person's wellbeing needs are met. There is a concern that some patients are at risk of dying alone due to not having family or friends or that their loved ones are unable to be with them. The EoLCs are volunteers that have been recruited and trained specifically to provide companionship at this sensitive time. This service also provides support to relatives who may need to take a break but do not want their loved ones to be alone. 40 Companions have been recruited. The EoLCs have remained active, supporting patients across the Health Board.

Presentations on the initiative have been delivered at National End of Life groups.

Volunteering

Despite the pandemic the Person Centred Care Team have continued to recruit and train volunteers. All Wales Workforce Covid Risk Assessment, Glasgow University Roadmap and the ALAMA medical risk assessment have enabled low risk volunteers to safely return to supporting patients. There are 60 active volunteers on the wards (including befrienders, EoLC and Dementia Companions) and 100 telephone befrienders. When risks reduce the volunteers protected by the risk assessments may return to their roles and the community befrienders will be able to return to supporting people who are in need of company in their own homes. Recruitment, supported by GAVO and TVA is ongoing.

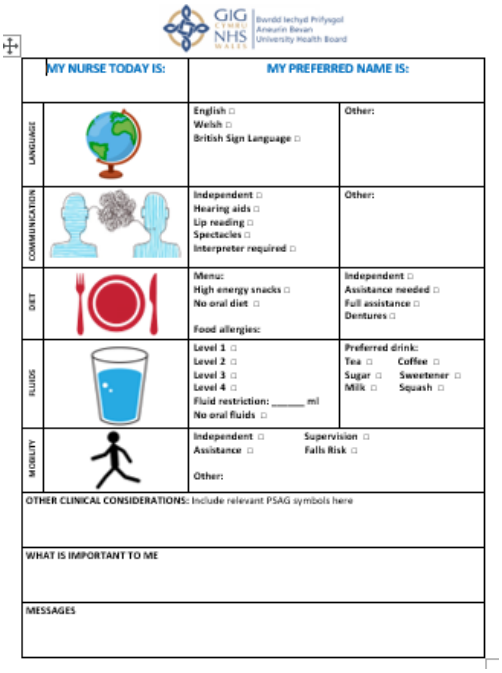
The pandemic demonstrated the needs and benefits of volunteers on the wards for patients and has also provided the opportunity to develop new roles for volunteers such as 'Dementia Companion', 'Connector Volunteer' and 'Navigator Volunteer'.

Dementia Champions

The Health Board promotes a Dementia Champion programme. These are all grades and disciplines of staff who volunteer to take on the role to support and improve dementia care within their ward or department. Dementia Companion has increased from 89 to 119 members between 2021 and March 2022. An email distribution list has been developed to enable the sharing of information, resources, and updates to and from the wards and between the Person-Centred Care Team. Champion workshops planned will build on the learning programme, raise the profile of Dementia Champions and support networking. Dementia

Champion pin badges have been designed/purchased and will be issued following dementia champion training.

Recognising Patients with Dementia on Hospital Wards (Bedside Boards)



After considerable scoping and multi-disciplinary consultation, a Patient Bedside board has been designed, costed and a plan for ordering and erecting by each bed side throughout the organisation. This plan will commence in phases in April 2022, starting with the Care of the Elderly, Trauma and Orthopedic ward, aiming to reach at least 27 wards in the 1st Phase.
At a glance, these boards will promote patients' preferences, choice, risks and individualised care. They will support carers, patient and staff communication whilst not compromising clinical care planning, dignity or respect but enhance PCC whilst on the ward.

Meaningful Activities

Feedback from patients during the pandemic indicated increased boredom due to restricted visiting and a lack of meaningful activities. Funding was secured to purchase a suite of meaningful activities that supported all patients in hospital, particularly those with cognitive impairment and sensory loss.

Resources that support person-centred ward-based activity are now in place. Online resources such as large print crosswords, reminiscence activity, Boredom Busters etc. are all accessible to staff through the Ffrind i Mi web pages. Training around the purpose and therapeutic value of meaningful activity promotes the theory and how to use the resources in practice. The PoC evaluation has identified increased use of meaningful activities/technology to support person centred care.

Meaningful activity baskets include a range of resources, as well as empathy dolls, hugs, electronic cats and dogs. The first phase of 40 baskets will commence in April 2022. This development will be measured and evaluated to identify patient and staff experience.

Digital Inclusion and Assistive Technology to Support Meaningful Activity

RITAs (Reminiscence Interactive Technology Assistance) are now available across all wards in ABUHB and are actively being used to engage with patients and reduce boredom. Training to support additional staff/volunteers in their use is ongoing. Each ward now has i-Pads to support patient/relative communication. The subgroup for assistive technology is supporting the digital inclusion agenda.

Dementia Hospital Action Plan

The ABUHB In-Patient Dementia Hospital Steering Group is now well established and includes representation from the specialities and divisions within the Health Board. The principles of person-centred dementia care are embedded within the agenda and the priorities of actions the group drives across all wards. This group will support the All Wales Dementia Pathways of Standards Dementia care specifically Workstream 4. This includes the "All Wales Hospital Friendly Charter" Premier planned for 6th April. Supporting the anticipating Hospital Charter the Grange University Hospital (GUH) has already established a 'GUH Dementia Subgroup'. 4 wards have volunteered to be part of the National Pilot of the VIP ward improvement tool.

Coloured Walking Frames

In November 2021, the Physiotherapy team at Ysbyty Aneurin Bevan agreed to pilot the introduction of the coloured walking frames to identify if this initiative had an impact of patient experience and patient falls. An evaluation of this report is on-going.

Patient Stories and Learning Events

A number of digital patient and relative stories have been developed and have been used to promote awareness of particular issues faced by patients and also used to support listening and learning events. These stories have been very powerful and galvanized the improvement agenda.

Digital Connections

The need for connection has never been greater, especially for patients and their relatives and friends at a time when visiting has been so restricted. The Person Centred Care Team has encouraged volunteers to train as Digital Companions to support patients in either using their own devices or hospital devices to connect with loved ones. The requirement for this will be on going as there will always be times when relatives/friends cannot visit such as those that live away or are unable to visit for health reasons.

Equality and Diversity Training

A number of awareness sessions around equality and diversity were undertaken in March 2022. This has included awareness around the need for people who are Deaf, people who have hearing impairment, people who have sight impairment,

the needs of people from the LGBTQ+ and minority ethnic communities as well as sessions looking at neurodiversity and autism acceptance.

The Health Board also began to run its Active Bystander training session, providing staff with the knowledge and confidence to challenge unacceptable behavior and create a more inclusive workplace culture as well as meet the Welsh Governments aim to be an Anti-racist country by 2030.

Patient Liaison Officers (PLO's)

The PLO Service is now fully established within the A&E Service with PLO's working between the hours of Mon-Sun 8am – 8pm answering patient relatives enquiries throughout this period. During Out of Hours, the Switchboard staff have introduced a call logging method to help with callers who may phone multiple times for information during the night. The details are passed to the PLO team at the start of their shift in A&E the next morning who then contact the caller. The callers appreciate that they are getting an indication that they will be getting a call-back and it reduces the continuous cycle of calling going unanswered which in turn heightens anxiety and distress causing more complaints.

Calls Taken by PLO's:

Jan 432
Feb 527
March 379 (to date)

Feedback from a patient's wife:

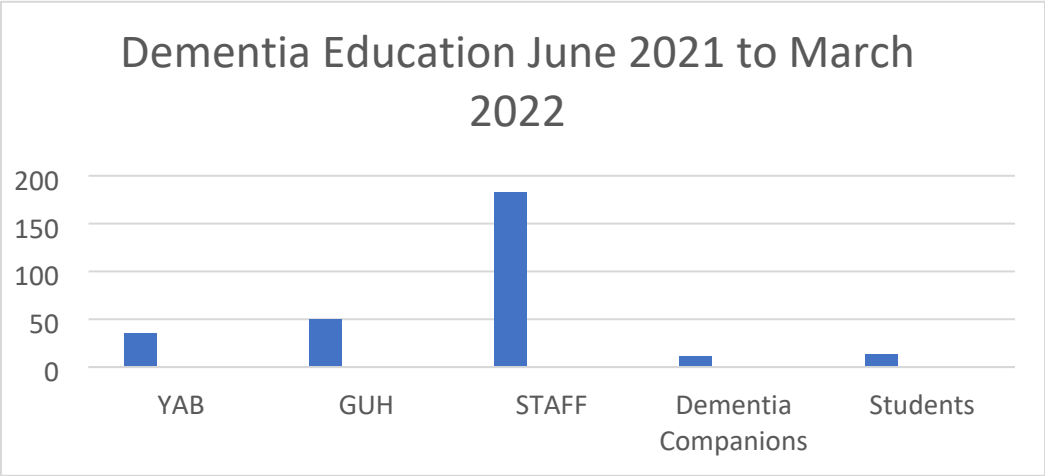
I am not sure who the PLO was on Sunday 13th March, but I needed to ring to say how amazing they were. My husband had been brought into resus at the Grange seriously unwell and I didn't know if he would have made the night, I cannot thank the PLO enough for all the help she gave yesterday. On a positive note, my husband made it through the night and although not out of the woods yet, they are hoping to move him to a ward.

Dementia Training

Due to increased training, from a baseline of 60%, staff compliance with online **All Wales mandatory dementia awareness** has increased to **83.26%.**

Additional training has been provided with Dementia and Meaningful activities and Engagement for Hospital staff 268 staff have attended these session so far, and 11 Dementia Companion Volunteers.

Training included dementia awareness, meaningful activities, behaviours that challenge, 3Ds (Dementia, Depression, Delirium). The GURT (age simulation suit) provided staff with experiential learning. Staff and volunteers evaluated the training is excellent, increasing their confidence to care for a person with dementia.



A series of learning sessions were commissioned from Cruse around Anticipatory Loss and Dementia. Three sessions took place between February and March (total of 25 attendees) with 3 further sessions booked for April.

Nutrition and Hydration (Dementia Care)

Several developments are taking place to support improvement in nutrition and hydration which include Dementia care. The use of the "Red Tray" to alert staff to patients who require support around mealtimes have been re-introduced to the ward. Training incudes raising staff awareness of the benefits of snacks and finger foods to support people who like to eat little and often, often whilst walking, was limited.

The Nutrition and Hydration Group are now auditing this aspect of care, as well as supporting training around nutrition and hydration for staff and the Red Robin Volunteers.

Citizen Feedback Portal (CIVICA)

A number of Patient Reported Experience Measure Surveys (PREMS) have been undertaken across the Health Board. However, there is no structured approach collecting, actioning or reporting them and relies on a physical presence of staff to ask the survey questions. There is a business case in progress to request that the Health Board adopt the Once for Wales Patient Feedback System, Civica, which will allow real time feedback from patients across all divisions of the Health Board. The software will enable patients to feedback and reports to be generated instantly.

Options, Advice and Knowledge (OAK) Patient Education

People need reliable information in order to be able to manage their conditions or to be involved with shared decision making. The Person Centred Care Team manage the Options, Advise and Knowledge (OAK) sessions for Osteoarthritis of the Knee and Menopause.

OAK Knee has moved from face to face sessions prior to the pandemic to remote (Teams) sessions and now runs twice a month. 61 patients have attended an OAK OAK Knee session this year (April 2021 to March 2022). OAK Menopause was

developed in 2021 as a remote session, commencing in October. This also runs twice a month and 97 people have attended an OAK Menopause session. Both sessions have evaluated well.

Casglu

Casglu is a card game, created and designed by the Person Centred Care Team in collaboration with the Welsh Language Unit. The design of the pictures and sentences came from children in Welsh medium education in Torfaen and Newport supported by our partners Menter Iaeath. Funding for the development and production was provided by the RCN Foundation and Welsh Language Unit.

The game was developed to:

- Support learners including staff, students and volunteers. The game will aid in learning the language and also in putting it into practice
- Be a resource for Volunteers in ABUHB to support patients with meaningful activities
- Be part of the resources available for Intergenerational Activity in Care Homes and Community Wards.
- Provide a Welsh Language resource on Children's ward in ABUHB hospitals

We look forward to seeing the game played across our communities and generations, bringing a little bit of joy and promoting and enhancing the use of the Welsh language.

Mental Capacity Act and Liberty Protection Safeguards Consultation and Engagement

We have been proactively engaging with professionals, service user groups, paid carers and families in relation to the forthcoming implementation of Liberty Protection Safeguards, and the revised Mental Capacity Act code of practice.

Working with our Local Authority partners, we have arranged and hosted a series of virtual conferences to support participation in the long awaited consultation on a new MCA code of practice and regulations for LPS implementation, as well as providing substantial regional briefings for staff and stakeholders.

In addition to a programme of regional briefings ABUHB has recorded 2 podcasts in relation to LPS implementation and developed several Mental Capacity Act training films.

Following the official launch of the consultation on the regulations and code of practice for the revised Mental Capacity Act and Liberty Protection Safeguards we will continue our work consulting on LPS implementation.

11. Putting Things Right

Patient experience and listening and learning from feedback is a key element of evaluating services and outcomes and a measure of the impact of how we are performing. One way of evaluating patient experience is via formal complaints data.

Throughout 2021–2022, Aneurin Bevan University Health Board complied with the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011 regarding the Putting Things Right process.

We received 3,295 complaints in 2021-22 (including, in the case of Welsh NHS bodies, concerns reported under Part 7 of the Regulations relating to cross border services). This is a 48% increase when compared with 2020/21, when 2,224 complaints were received.

- 1,937 individuals were classified as CONCCO (formal complaints)
- 1,351 had an Early Resolution
- 7 CONCLA (Redress)

The top three themes raised during this period were:
1. Waiting times/delays/cancellations
2. Communication/Information
3. Clinical treatment/assessment

Waiting times/delays/cancellations

Concerns about hospital wait times, delays, and cancellations were raised in response to national guidance issued and restrictions enacted. These remained constant throughout the reporting period as the Covid-19 picture shifted and evolved.

The Mass Vaccination programme was established in response to complaints received regarding housebound patients' access to Covid vaccines during the initial vaccine rollout. This resulted in modifications to the subsequent planning and delivery of the booster programme.

Communication/Information

In January 2021, a pilot telephony support line was initially established to alleviate the pressures placed on clinical teams by the Covid-19 Pandemic.

A further review of concerns managed through ‘early resolution’ identified that communication issues continued. This has led to increasing anxiety for relatives who are unable to visit loved ones. During discussions with Switch Board leads, they indicated a significant increase in calls from relatives, especially during times when families would have been visiting.

We recognised the need for additional support on the wards and actively recruited ward clerks and ward assistants.

Putting Things Right has also been identified as a pilot site for Sign Live. This is a video relay service with dedicated British Sign Language interpretation that is available 24/7, 365 days a year. It is an 'on demand' service that would enable us to connect to a qualified and experienced interpreter in less than a minute. Being able to trial would allow us to prove the concept that accessibility for Deaf people is improved and that it is a value based, cost efficient system.

However, there are ongoing issues with the Sign Live pilot which was scheduled to commence in February 2022. We are continuing to explore solutions to enable this pilot to take place.

Clinical Treatment/Assessment

Waiting times remain a key concern for patients both for planned and unplanned care. The pandemic impact on waiting lists is a key concern for those waiting, along with the challenges in accessing urgent care for Covid and non-Covid reasons.

The establishment of a formal Planned Care recovery oversight Programme will focus on Planned Care recovery and support for patients whilst awaiting surgery including optimising their health pre surgery. The Urgent Care Board continues to focus on patient's assessments and ambulance waiting times. Optimising Planned Care recovery through green/protected eLGH spaces will be led by the newly formed Planned Care Transformation Board.

Redress

During 2021/22, the Redress Panel heard 36 cases, seven of which were historical in nature.

3085 complaints were resolved in total during the reporting period, with 1,804 being formal and 1281 being early resolution. The number of resolved complaints will not equal the number received, as some may not be resolved during the reporting period.

Public Services Ombudsman Wales (PSOW)

The Health Board received notification of 121 complaints that had been referred to the Public Services Ombudsman Wales (PSOW) for 2021/22. Of these, 33 were anonymous (All anonymous cases are closed on receipt).

Of the 88 identifiable complaints, 52 related to complaints received by the Health Board during 2020/2021 and 6 from 2020/21. This is due to the time it takes for concerns to be referred to the PSOW by a complainant and then notification received by the Health Board from PSOW. As of 31 March 2022, 28 cases remained open on the Health Board's Datix reporting system.

Improving Safety - Learning from Serious Incidents

From 14th June 2021, the National Reporting Framework replaced the Welsh Government Serious Incident reporting criteria. Historically, the focus of incident reporting at a national level has been to examine in detail specific Serious Incidents as set out NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations), primarily through the use of Root Cause Analysis. The new National Patient Safety Incident Reporting Policy (May 2021) aims to bring about a number of key changes to national incident reporting. In 2021/22, there were 25 reportable incidents. 21 incidents were managed through the Serious Incident Process as Red 1 (Corporate-led) investigations, while the remaining four were managed as Red 2 (Division-led) investigations. An additional 241 incidents that would have met reporting criteria in the past were reviewed and thoroughly investigated as if they had been reported.
A robust internal investigative process, in collaboration with external partners, is maintained across the Health Board, ensuring that actions and, more importantly, learning continues.

Learning

Despite the Pandemic, learning events and thematic analysis of concerns have been strengthened.

A work programme has been developed for 2022/23 based on the issues identified in 2021/22. In July 2022, a PTR Annual Report will be published.

12. Delivering in Partnership

In response to the Covid-19 pandemic, the Gwent Test, Trace and Protect Service and ABUHB Covid-19 Mass Vaccination Programme have been delivered in an integrated, collaborative approach with partners and with the involvement of local communities across the Health Board area to prevent transmission of infection and serious illness and enable long term recovery.

The formation of a single **Gwent Public Services Board (PSB)** has brought together the Health Board, the five local authorities in Gwent and wider partners to work in partnership to improve well-being. By bringing together what were previously five smaller local authority PSB's into one regional PSB, the work of Gwent PSB has demonstrated **integration** and **collaboration** by accelerating partnership arrangements to develop integrated approaches to wellbeing in the Gwent region. **Involvement** has been demonstrated in 2021/22 through the development and public consultation on the Gwent Well-Being Assessment report and findings.

A copy of the final Gwent PSB Well-being Assessment is available at: https://www.gwentpsb.org/en/well-being-plan/well-being-assessment/.
The Assessment provides an analysis of social, economic, environmental and cultural wellbeing in Gwent. It recognises positive features in the region, such as Gwent's diverse economy and rich culture, but also some of the challenges in

terms of inequalities associated with socio-economic deprivation and the pressure on natural resources.

To respond to the findings of the Well-being Assessment, Gwent PSB is working on the development of a Well-being Plan. In producing the plan, it has been agreed that there will be a focus on three themes: health inequalities (inc housing), the environment, and community cohesion.

Thinking **long term** and **prevention** are being taken forward through the decision of Gwent PSB to become a 'Marmot Region' and accelerate a journey to go further and faster on addressing the social determinants of health which are the 'causes of the causes' of poor health.

The health inequalities response analysis is being led by the ABUHB Director of Public Health, with the analysis being undertaken by Gwent Local Public Health Team. It is being drafted to align with the decision of Gwent PSB to become a Marmot Region. This means that the actions to address health inequalities will be viewed through a social determinants of health model as expressed through eight Marmot principles. These principles are:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill-health prevention;
- Respond to climate change;
- Address structural racism.

Gwent plans to be the first area in Wales to become a Marmot Region, following on from other cities and regions, including Manchester, Coventry, and Cheshire and Merseyside. By becoming a Marmot Region Gwent PSB is committing to a determined and joint effort to true partnership working across of number of areas to improve the lives of all, but in a way that is proportionate to the level of need. The Health Board is funding the initial phase of the proposal by partnering with University College London Institute of Health Equity.

Over the course of 2022/23, a programme of work will be established under Gwent PSB to explore each of the eight principles and agree where action is required to address the underlying socioeconomic differences in life expectancy and healthy life expectancy in Gwent. This work is being facilitated and supported by the UCL Institute of Health Equity with involvement from Professor Sir Michael Marmot. An update paper on the Marmot Region work will be presented to the next meeting of Gwent PSB on 30th June 2022.

Gwent Regional Partnership Board (RPB), established under the Social Services and Wellbeing Act (Wales) 2014, brings together ABUHB, the five local authorities of Gwent along with regional third sector representation to meet the care and support needs of people in their area. RPBs are tasked with improving the well-being of the population, and the way in which health and care services are delivered.

Our continued collaborative response has also brought about additional mechanisms bridging statutory partnership functions of the Local Resilience Forum and Regional Partnership Board. The Community Care Sub-Group provided a vehicle for joint oversight for operational pressures across the health and social care system, and a key mechanism for the governance of the Gwent Regional Winter Plan.

Gwent Regional Winter Plan

The Health Board winter plan was developed in alignment with the All Wales Health and Social Care Winter Plan 2021-22, following the priorities established. This was then integrated with the social care response to that plan, to develop a Gwent Regional Winter Plan under the governance of the Regional Partnership Board.

Whilst the plan is outlined against the national priorities below, thematically there were three key components to the plan:

1. Additional human resource within our system
2. Additional bed capacity (hospital/community)
3. Additional third sector contracts

Priority 1 within the plan focussed on the vaccine and immunisation booster programme, and the revised approach to test, trace and protect services. COVID-19 vaccine uptake rates by care staff were reviewed on a weekly basis by the Community Care Sub Group to ensure health and social care collaboration to achieve high uptake by the care workforce.

Priority 2 and 7 centred round prevention and keeping people well. Communications in this respect were undertaken via ABUHB and through the Gwent Warn and Inform Group under the Gwent Strategic Co-ordination Group that was standing for much of the winter period. As a key component of the Health Board's restart and recovery, and to support respiratory pathways as part of winter resilience, a spirometry hub was successfully established in December 2021 to provide direct access via GP referrals.

Activity to support **Priority 3** – maintaining safe health services – provided for additional capacity across the system, ensuring mental health support was available in our emergency department at GUH and extended working hours to provide additional Older Adult Psychiatric Liaison. In recognition of the system pressures and workforce constraints within the system, there was emphasis within Priority 3 on creating additional capacity to support flow within the system. The

ability to discharge patients from hospital was significantly impacted by the capacity constraints faced by social care.

A Step Closer to Home pathway was established to utilise available care home capacity to provide step down care for patients who were unable to return home without support. A pathway was developed with social care colleagues to support decision making for patients suitable for the pathway. On average 12 patients have been supported via this pathway every month. It was intended patients would be placed on this pathway for approximately 6 weeks, in alignment with existing step down utilisation, but the social care capacity constraints in the community resulted in an average length of stay of 12 weeks for patients.

This pathway was established complimentary to the Step Closer to Home Unit and Direct Admission Pathways developed and tested by Primary & Community Services over the winter period. Furthermore, the recruitment of community reablement assistants enabled some patients to be discharged home for further assessment, along with the Health Board's complex care team providing assistance with the commissioning of community packages of care to further support patient discharge.

A review of the Step Closer to Home pathway is currently underway by colleagues from health and social care to define the optimum model aligned with the wider step up/down capacity across the region. The outcome of this review will be reported to the Health System Leadership Group early July, followed by the Gwent Adult Strategic Partnership.

Priority 4 –the Gwent Regional Winter Plan placed significant emphasis on improving the resilience of the domiciliary care sector in support of the 'Maintaining our Social Care Services' priority in the All Wales Winter Plan. Existing packages of care were reviewed to release capacity where possible along with Gwent Regional Partnership Board providing over £1million to support an increased salary for community care staff. This additional payment was intended to mitigate further loss of workforce capacity over the Christmas retail period, when retail sector pay rates are significantly higher than that of the care sector. In partnership, a number of alternative approaches were tested, such as a micro enterprise pilot within one of our localities, and support for additional specialist equipment via our regional GWICES service.

Priority 5 – Supporting the wellbeing of our Health and Social Care Workforce has been a key consideration of the plan and regularly discussed within the Community Care Sub-Group. ABUHB has implemented additional wellbeing support for its workforce.

Priority 6 – Supporting unpaid carers was a key component of the social care restart and recovery programmes, and reflects the existing work and commitments of the Regional Partnership Board. Additional grants have been

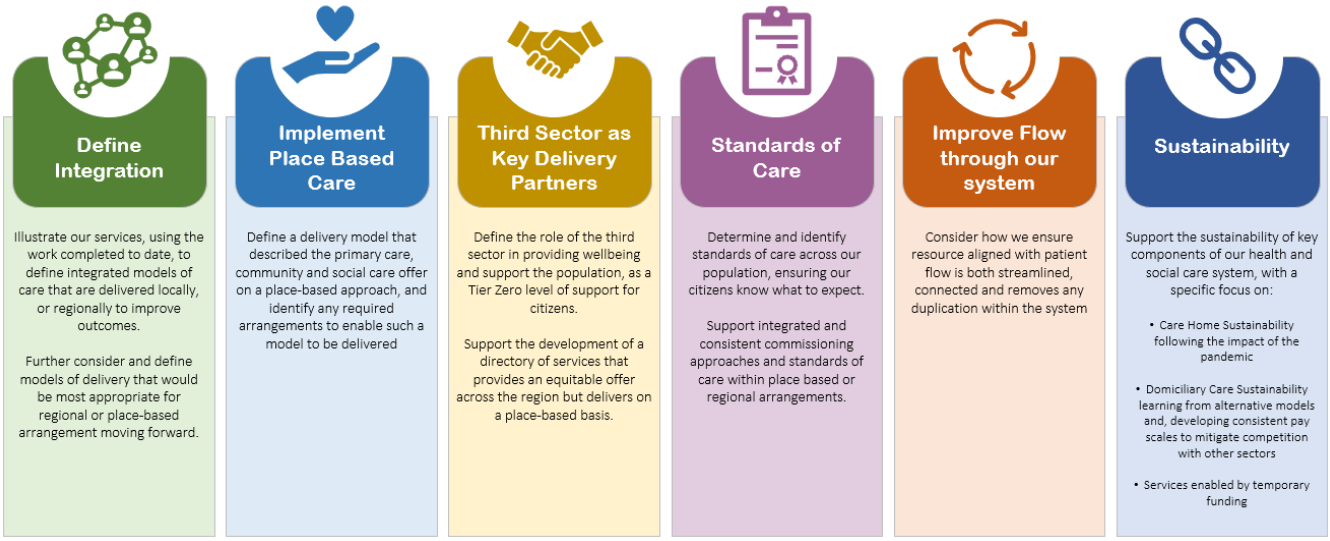
made available to unpaid carers, and alternative respite solutions offered where viable.

Priority 8 – Working in partnership – The Community Care Sub-Group reviewed weekly figures regarding the workforce position within social care, and sought to maximise the use of the Step Closer to Home Pathway to support discharge from hospital.

Gwent RPB Programme

2021-22 marked a transition period for Regional Partnership Boards across Wales, with the impending cessation of the current partnership funding model in March 2022, due to be replaced by a single coherent source of revenue funding to support transformation and integration. Gwent Regional Partnership Board have discussed and considered its priorities to support longer term planning during this transition period. These new priorities place significant emphasis on care closer to home for all priority groups for integration, and enabling an infrastructure within our partnership that supports delegated tiers of delivery, shown as figure 1 below.

Figure 1. RPB Strategic Priorities [July 2021]



To facilitate this transition period, and to support continuous efforts to address the challenges within our system, Gwent Regional Partnership Board endorsed a programme transition plan for 2021-22 to support both partnership and organisational financial planning, and the consideration of an established portfolio of funded activity.

This work identified over £19million of services that needs to be sustained across the RPB system, with recognition that work is needed to improve the joint and seamless care pathways across the system to achieve better outcomes and whole system performance.

Welsh Government has made a 5-year commitment of revenue funding for Regional Partnership Boards. This revenue funding, now known as the Regional

Integration Fund (RIF), brings together previous funding streams provided to RPBs into one source of strategic revenue funds, providing £26.8m for Gwent annually, from April 2022 to March 2027. The funding model comprises four key elements introducing a tapering approach during the course of the 5-year programme, intended to promote sustainability.

The key message identified within the Welsh Government RIF guidance is the requirement for Regional Partnership Boards to utilise funding to deliver a programme of change over the next 5 years. There is emphasis on the learning from both the Integrated Care Fund and the Transformation Fund, and the desire to create sustainable system change through the integration of health and social care services. The Regional Integration Fund is described as a key lever to drive change and transformation within the health and social care system, with Regional Partnership Boards tasked to consider how they deploy their collective resources, including both partnership funding and wider core resources to meet their objectives.

The key features and values of the Regional Integration Fund are identified as:

- A strong focus on prevention and early intervention
- Developing and embedding national models of integrated care (also referred to as models of care within the guidance)
- Actively sharing learning across Wales through communities of practice
- Sustainable long-term resourcing to embed and mainstream new models of care
- Creation of long-term pooled fund arrangements
- Consistent investment in regional planning and partnership infrastructure

The models of care referenced within the guidance have been developed with the intention of ensuring citizens experience an effective and seamless service, with the intention of nationally embedded models of care as an output of the Regional Integration Fund. The models of care are identified as:

- Community based care – prevention and community coordination
- Community based care – complex care closer to home
- Promoting good emotional health and wellbeing
- Supporting families to stay together safely, and therapeutic support for care experienced children
- Home from hospital services
- Accommodation based solutions

Significant work has been undertaken within the Regional Partnership Board to develop plans for use of the Regional Integration Fund. These plans reflect the learning from the existing funded portfolio (from both the Integrated Care Fund and Transformation Fund) and wider system challenges and will bring to fruition 18 strategic regional programmes aligned with both the priorities of the Regional Partnership Board and the models of care established within the RIF Guidance.

Given the broad scale development work needed across the partnership to develop and deliver new programmes of transformational change, Gwent RPB has agreed to use the time up to December 2022 as a development period to enable outcomes focussed planning across all programmes, to provide clear benefits realisation plans and financial sustainability plans.

13. Workforce Management and Wellbeing

Ensuring safe staffing levels

Safe staffing levels across all professions remained a priority albeit this has been challenging at times due to the ongoing impact of the Covid-19 pandemic. The workforce data in the Remuneration and Staff Report at page XXX demonstrates increased levels of staff absence and staff required to self-isolate as a result of contracting Covid-19 or being contacted by track and trace as a close contact.

Staffing levels are monitored daily by professional teams to ensure the ratio of staff: patients remains as safe as possible at all times. Vacancies are also regularly reviewed and recruited to as quickly as possible, often using a variety of recruitment strategies relevant to different roles and professions. As of March 2022, there were 195 WTE Registered Nursing vacancies and 154 Medical vacancies (this includes all medical grades). This is a slight increase on the vacancies for the previous year due to an increased demand for staff and turnover, although the opening of the Grange University Hospital in 2020 increased the headcount of staff by 373 overall.

On an annual basis, we forecast future vacancies and plan the future workforce requirements through educational commissioning submission to HEIW. This requires careful consideration of likely turnover and retirement rates to ensure that the clinical workforce (e.g., nurses, therapists and scientists) remain future proofed. This is a complex task that also reflects the changes in workforce models as a result of increased Multi-Disciplinary Team (MDT) working, skill mix and other service changes.

In September 2021, the Executive Team endorsed the review of medical junior rotas in consideration of published safer staffing principles from the Royal College of Physicians (RCP) to meet the minimum threshold for safer medical staffing. This review included the impacts of additional beds (inpatients) and inpatients requiring increased levels of care. Investment was approved to recruit an additional 21 doctors and to date, 15 doctors have been recruited successfully by internal recruitment methods and working with recruitment partners such as NHS Professionals. The newly recruited doctors will support safe levels of care across the hospital sites, especially during the night and at weekends.

We have also invested in additional Registered Nurses and support staff for the Emergency Department at GUH as well as Reablement Assistants to provide care for patients within community settings.

Nursing staffing establishments have been reviewed against the agreed anticipated expansion or extension of Nurse Staffing Levels Act (Wales) 2016. This year the paediatric nursing staffing establishments have been reviewed and endorsed by the Health Board.

A number of reviews continue to be undertaken to support service improvement and right sizing of the workforce through safe staffing levels. These include therapies and pharmacy services.

Identifying and training staff to undertake new roles

The Health Board is committed to supporting all staff to achieve their career aspirations and to be an employer of choice for new and existing staff.

An exciting new apprenticeship scheme was implemented in the Autumn/Winter of 2021 with the first cohort of Aneurin Bevan Apprentices recruited. There are now 28 apprentices supporting clinical and non-clinical teams across the Health Board in both hospital and primary care settings. The apprentices study an NVQ qualification whilst 'training on the job' as a Health Care Support Worker (HCSW), Apprentice Administrator or Facilities Apprentice. The ambition is for apprentices to grow their career with Aneurin Bevan University Health Board and become the clinical registrants and/or managers of the future. In addition to the HCSW apprentices, we have supported over 100 HCSW's to complete, or work towards a nursing degree to become a registered nurse and develop their career, in some cases these staff have progressed to a ward manager role.

In addition to apprentices, we have worked in partnership with employability schemes such as Kickstart and Restart, with the intention of securing long term employment for those living in the local community and seeking work. Kickstart works with those under the age of 25 and so far, we have supported 12 kickstart placements in a variety of departments. In addition, there have been a small number of additional staff recruited through the Restart scheme and we will continue to develop this work throughout 2022/23.

We have introduced a number of new roles including Psychological Wellbeing Practitioners in Primary Care who are the first point of contact for people with mild to moderate health concerns. We have also extended the scope of practice in a number of areas such as nurse specialists in endometritis and advanced practitioners in radiology to support enhanced radiology reporting and interventional/screening procedures. The role of the Physician Associate (PA) has also been expanded across a range of specialties which has been invaluable throughout the pandemic. Pharmacy Assistants have also been introduced to support the management of medicine across wards and Paediatrics has recently incorporated Assistant Practitioners to support clinical teams.

Throughout the period, ward teams were strengthened by the 'Core Care Team' which included new roles such as Roster Creators, Ward Assistants and Assistant Practitioners. This supported safe staffing levels and also provided that critical

communication between the patient, clinician and the family, this was particularly important when hospital visiting was suspended.

Staff who supported the administration of the Covid-19 vaccine completed additional training on-line and fulfilled a practical competency-based assessment. This included clinical staff who were trained to administer vaccines (e.g., flu vaccine) as they required a thorough understanding of the Covid-19 vaccine. The training pathway was delivered in partnership between Workforce and Organisational Development and the clinical immunisation lead.

Talent and succession planning plays an important role in identifying and supporting leaders to develop their capability to lead effectively in their roles and across the complexities of the organisation. We continued to work closely with HEIW to develop role profiles to enable us to support effective talent and succession planning work including being the first Health Board to use the Gwella talent digital tool. The Health Board's Leadership and Management Framework has also been reviewed and is designed to maximise the potential for talent and succession planning across all leadership and management roles, including clinical and medical leadership. The Framework is accessible to all staff via the Health Board intranet pages.

In addition to open access programmes, an Academy and Alumni for Senior Nurses and Midwives has been developed. This is underpinned by a competency framework, and 7-month development programme and alumni network. The first cohort is planned for April 2022.

We continue to review our performance management processes to support staff. The current PADR (Personal Appraisal Development Review) document supports individuals planning a change of role and strategic PADR forums are held quarterly, with nominated PADR Leads across the Health Board. The forum aims to enhance quality and continuous improvement of PADRs.

Training and use of retired staff

The Coronavirus Act 2022 has supported staff returning to clinical practice by joining a temporary register to support patient care throughout the pandemic. There is also an opportunity for those staff to re-join a permanent register to continue working in a clinical capacity if they wish.

The NHS Pension Scheme regulations were extended to allow staff to access their pension and return to work immediately (whilst in receipt of their full pension benefits) and this will remain in place until 31 October 2022. This has allowed staff to return to work immediately after retirement and continue their existing working commitments, or increase them, while still receiving their full pension benefits.

During this period, 123 staff retired and were supported to return to work with the relevant training and registration.

Wellbeing initiatives for staff

Staff Health and Wellbeing continues to be a key priority for us to ensure that our staff feel supported, healthy, engaged, and proud to work for us and is front and centre of our workforce and organisational development strategy for 2022-2025; our People Plan. The Staff Wellbeing service is underpinned by the data collected within the Quarterly Wellbeing Survey which has been deployed 5 times with the next being deployed at the end of April 2022. The current data sets encompasses ~15,000 responses to date.

There have been several key staff surveys which resulted in a reduction in staff wellbeing scores and the Board sponsored the design and launch of the #PeopleFirst project. This project is designed to support staff re-engaging and re-connecting with their work and colleagues to maximise their experience at work. The project has currently facilitated 25 engagement sessions where the Executive Team, members of Wellbeing and OD team have met with over 200 staff with 140 issues being actioned.

We have continued to support staff at the start, during and towards the end of the pandemic, with 2021/22 culminating in a number of new initiatives which puts staff experience and well-being at the forefront of everything that we do. We do not underestimate the impact that the past two years have had on staff from both a personal and work perspective. We are determined to ensure that the support mechanisms in place will continue into the next year as the pandemic becomes endemic in society. The demand for wellbeing services has increased in a linear fashion since 2017 (312 referrals) to this year (575 referrals) as shown in the graph below.

We have invested in the employee wellbeing team to provide additional psychological support and is combined with a new website accessible to all staff, which delivers bilingual and evidence-based reference materials. Targeted support

is also provided to individuals, teams and Divisions for those staff dealing with excessive workload. The pathways for support include:

- Psychoeducation
- Counselling
- Clinical Psychology intervention
- Clinical Psychology and Counselling

In addition, the team have recently launched a Psychological Trauma service, the first of its kind in Wales. For context, within the Health Board there are 59 members of staff who meet the criteria for this service, of which 40% are Covid-19 related, and 93% reaching recovery (as a comparison the like for like data in England is 50% to 60%).

As a further extension to support to staff, we have moved closer to the development of a Wellbeing Centre of Excellence model with work underway to renovate and create the Centre, completion is expected in autumn 2022. This 'Centre' will lead the way in NHS Wales and supports the priority placed on employee engagement and Wellbeing within 'A Healthier Wales'. The intention is:

- To offer ABUHB staff the best quality evidenced based psychological care in the NHS.
- To focus on employee experience, thriving and prevention.
- To develop national expertise in supporting teams / systems to recover from the pandemic.
- To support innovation and research in collaboration with local Universities.
- To work closely with OD, ABCi and ABUHB Leadership.
- To offer expertise to other Welsh public sector organisations.

The Occupational Health Team also provide support to staff and volunteers as well as providing advice on long term conditions, including long covid to support staff remain and return to work. Particular focus has been made to supporting staff to return to work on adjusted duties and/or a phased basis as well as seeking alternative roles for those staff where it has been deemed that the likelihood of resuming their substantive role could put them at risk of harm.

"Chill out in the Chapel" has continued this year, supported by the Chaplaincy Service who provide pastoral, spiritual and religious care for all staff, and offer a confidential listening ear at a number of our key sites. This includes spiritual and/or religious care for everyone, leading worship and offering prayer.

We recognise that wellbeing may be driven by, or associated with, different forms of poverty and exclusion and this is included as part of our equality, diversity and inclusion programme. In response we have developed a range of activities as part of our People Plan 2022-2025 which are aimed at ensuring the workforce is more reflective of the population we serve and opening up the NHS as an employer to communities who have not historically identified the NHS as a potential place of

employment. As part of our Socio-Economic Duty this supports communities of interest and those where socio economic disadvantage is prevalent.

As part of our equality, diversity and inclusion work, we have undertaken a range of approaches with our staff which includes, listening exercises and ensuring that their experiences and views are taken into account. This approach also includes providing safe spaces for staff to raise any concerns about protected characteristics via staff networks and Menopause cafes. We have successfully run a suite of diversity networks, engaging with staff on topics and the development of a fortnightly newsletter along with supporting an understanding of inclusion matters through awareness, training sessions and video resources. This will be further supported by the review of a range of evidence from local and national sources and we are proud to have pledged to commit to the Zero Racism Wales Policy.

We are delighted to have recently been awarded both the Platinum and Gold Corporate Health Standard Award. The Health Board has now held the Platinum Award since 2015 and the Gold Award since 2011. The Corporate Health Standard is a continuous journey of good practice and improvement. The latest Platinum assessment in September 2021 acknowledged the excellent progress the Health Board is making in its sustainability agenda and the vision for the Health Board to contribute to the wellbeing of the future generations of Wales.

Risk assessments and shielding of staff

During the first and second Covid-19 pandemic waves, guidance on shielding was provided by Welsh Government. This had an impact on our staff, as well as our local communities and volunteers i.e., those who were clinically vulnerable should no longer attend the workplace. Whilst shielding formally ended on 1st April 2021, we have continued to support those staff who had previously been shielding to return to work safely and in some instances to a different role to reduce risks associated with contracting the virus.

The Covid-19 Risk Assessment was an important tool to assess the individual risk posed by Covid and over 80% of the staff completed the assessment which resulted in a variety of adjustments including working in Covid secure areas (where the risk of Covid was low). The safety of our staff remains our primary concern and we continue to work with Divisional teams, staff side representatives and bank and agency workers to support completion of the Covid-19 workforce risk assessment.

Review of Covid-19 staff deaths

Sadly, there were three staff deaths due to Covid-19. A review has been undertaken which confirmed that two of the staff were likely to have contracted Covid within the community and based on the high positivity rates at the time, the review could not determine whether the third member of staff contracted the virus as a result of workplace exposure or within a community/social setting. The families of the staff were supported by the Health Board and the relevant policies adhered to, with learning measures progressed immediately.

Training Staff to support COVID-19

It is recognised that during the previous year and in response to wave 1 and wave 2 of the pandemic services adapted ways of working and connecting with patients. This resulted in the requirement of training and deployment of staff according to skill and greatest need. This required intense programmes of clinical skills training for new and existing staff which we have continued to consolidate over this period.

During this year services have focused on recovery plans with staff returning to work in their substantive roles where this has been possible. This has been an incremental approach and has not lost sight of the advances made regarding different models of working which have emerged during the pandemic such as virtual appointments and consultations for patients.

In addition, staff have continued to work in an agile way, working at home or in various locations whilst making greater use of technology to support the delivery of services. This has included the rollout of Microsoft 365 software package which has been supported by staff training and tutorials.

The rollout of the COVID vaccine booster programme has continued to require additional staff to work in mass vaccination centres. This has been achieved through a combination of overtime, additional hours and a significant redeployment exercise to support the requirement to "surge" the delivery of the booster in December 2021. This meant that nearly 600 staff were redeployed, many of whom required urgent training to ensure competence in administering the vaccine. Staff training was scheduled 7 days per week with online and practical modules delivered.

It was acknowledged that asking our staff to work differently and to be redeployed once more would be difficult for some. Supporting staff wellbeing during redeployment has been a core feature of our redeployment principles and processes.

Staff and Partner Engagement

The Health Board has a variety of forums and processes to support staff and partner engagement, both formally and informally. The Trade Union Partnership Forum (TUPF) reports directly to the Board and provides the formal mechanism for consultation, negotiation and communication between our staff and the Health Board, embracing the Trades Union Congress principles of partnership. A strengthened partnership approach with TUPF and the Local Negotiating Committee (LNC) established early in the pandemic and continued to date has meant that changes and urgent decisions were discussed and agreed at pace.

14. Communications & Engagement

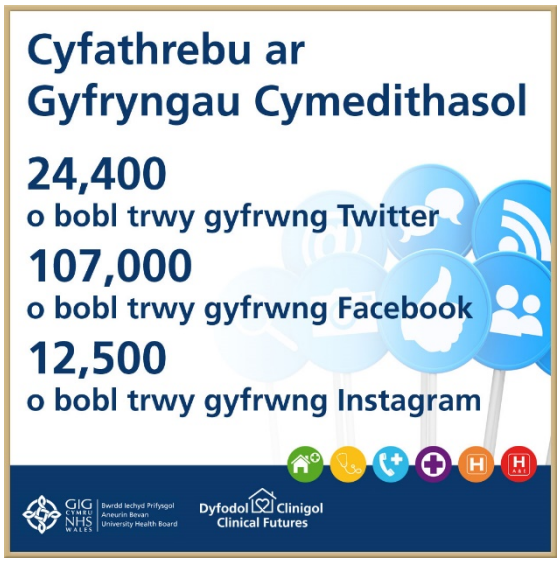
In 2021/22, we have strengthened our Communications and Engagement activities with our staff, the public we serve, and our partners. This has been of real benefit during the COVID-19 Pandemic, and we have also continued to develop and innovate during this period. Our Communications and Engagement activities are described below.

The Health Board has continued to lead the way on the use of Engagement and Digital Communications, as well as more traditional methods of sharing important messages.

During the past year, the Health Board's Communications and Engagement Team has focused on:

- Helping local residents understand the recent changes to our healthcare system;
- Providing a 'trusted voice' to convey timely and accurate information;
- Increasing face-to-face and digital engagement with local people;
- Reaching more people with important public messaging;
- Improving our engagement with diverse and hard-to-reach communities;
- Responding to comments and concerns, helping and reassuring people throughout the Covid-19 pandemic; and
- Ensuring our staff are well informed and supported in their roles.

During the past year, we have seen the numbers of our Facebook, Twitter, Instagram and Youtube followers continue to grow, with more and more people communicating with us through these social media channels. The Health Board has also launched a TikTok account to reach different audiences.



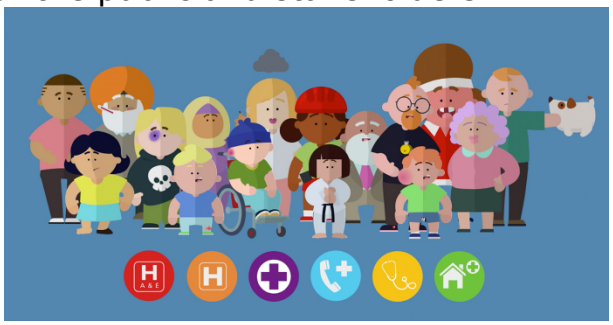
We have undertaken a series of high-profile Social Media campaigns through our Communications and Engagement Team, but also in partnership with other NHS bodies in Wales and wider Community Partners, such as Local Authorities and Third Sector bodies. These have included a particular focus this year on accessing the right healthcare services, the COVID-19 Pandemic response and vaccination programme, recruitment, and celebrating our staff. We also continued and

developed our Clinical Futures campaign to inform and engage people on the changes to NHS health services in the Health Board area. In March 2022, we sent an updated information booklet to every home in the region.
To view this booklet in a variety of formats and languages, please visit our website: https://abuhb.nhs.wales/clinical-futures

Our 'Digital First' approach has continued to develop significantly in the last year. The Health Board actively engages and interacts with our patients, the public and stakeholders through Social Media. This is done in real time, through patient and public questions on services, their current experience of our services, and the quality of their care. The Communications and Engagement Team has invested significant time in co-ordinating and responding to patient and public approaches on a day-to-day basis.

This year we have further expanded our use of graphics, video clips, patient and staff stories, and live Question and Answer sessions to support our more traditional forms of Communication and Engagement with the public and stakeholders.

A new animated video was produced to explain how best to access our services. As well as being shared online and on waiting room screens, the video was used as a trailer in cinemas in the Health Board area.



However, we know that not all local residents want to receive information through digital platforms, so the Health Board has focused on more traditional ways of communicating, as well as finding new ways to reach people. We have produced advertising banners, posters and television screen content for GP surgeries and hospital waiting areas. Our posters have also been displayed in local pharmacies and on buses. We also ran a successful poster campaign targeting people through pubs, taxis and takeaways which helped to direct ill or injured people to appropriate health services. We have also used our Health Board delivery vans as 'moving billboards' by producing eye-catching ads to display on them as they drive around Gwent on a daily basis.

We also formed partnerships with local organisations such as Dragons Rugby, who shared our messages on pitch advertising during live broadcast matches.

During 2021, the Health Board launched a 'Work With Us' Engagement & Recruitment Roadshow to ensure equitable geographical engagement with communities to improve understanding of access to health care services, with a key focus on the use of the Emergency Department at The Grange University Hospital and Minor Injuries Units. The roadshow also provided an opportunity to promote a range of job roles within the Health Board and accept expressions of interest for a variety of vacancies.

Recognising the diverse communities that live within the Health Board area much work has been undertaken to ensure that all communities are engaged and communicated with in the most appropriate way. A Diverse Communities Health Forum was developed in early 2021 to strengthen relationships with partner organisations who support and already work with diverse communities and to develop initiatives to engage with all our communities.

A dedicated web page and social media plan were created, communication with stakeholders and distribution of posters displayed at locations in advance of attendance. Over the course of the 88 locations visited by our specially commissioned double decker bus or pop-up gazebo, 2,000 face-to-face conversations with visitors have taken place and 360 expressions of interest received for job roles within the Health Board.

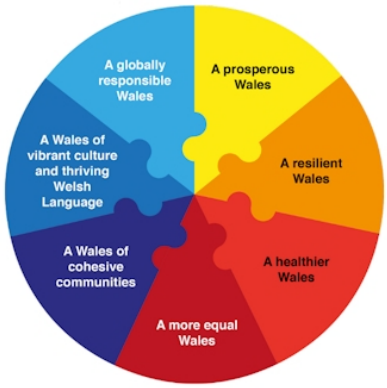
Geographical spread of events was well balanced with a focus to capitalise on routine, established events (market days), attendance at natural high footfall venues (supermarkets and town centre locations) and a presence at high profile events. The team also attended four Coleg Gwent campuses. The roadshows were supported by partners from local authorities and third sector organisations.

The Communications & Engagement Team has also been able to assist the Health Board's drive to recruit new staff into vital roles through Digital Marketing, Advertising and the 'Work With Us' Roadshows. This approach provides the Health Board with a reach that we could not achieve through traditional means and media.

Our roadshow and other engagement events around Gwent enable us to speak directly to residents and seek their views. Any feedback given is recorded by our Engagement Team and fed back directly to the Health Board through a reporting system. Details of our engagement events are published and shared beforehand to ensure local people in each area are given the opportunity to come along and speak with us face-to-face. This helps to build mutual understanding and relationships with the communities we serve.

15. Well-being of Future Generations (Wales) Act 2015

The Wellbeing of Future Generations (Wales) Act is about improving the social, economic, environmental and cultural wellbeing of Wales. It has seven well-being goals and tells organisations how to work more sustainably together to meet their duties under the Act by following five ways of working.



During 2021/22, the Health Board has continued to work in partnership and adopt the five ways of working to deliver the Well-being of Future Generations (Wales) Act (2015) ('the Act')

In response to the Covid-19 pandemic, the Gwent Test, Trace and Protect Service and ABUHB Covid-19 Mass Vaccination Programme have been delivered in an integrated, collaborative approach with partners and with the involvement of local communities across the Health Board area to prevent transmission of infection and serious illness and enable long term recovery. New and more sustainable ways of engaging and treating patients have continued, such as virtual appointments/consultations for GPs and Consultants and enabling staff to work in a more flexible and agile way, including use of electronic meeting platforms.

The formation of a single Gwent Public Services Board (PSB) in 2021/22 has brought together the Health Board, the five local authorities in Gwent and wider partners to work in partnership to improve well-being. By bringing together what were previously five smaller local authority PSB's into one regional PSB, the work of Gwent PSB has demonstrated **integration** and **collaboration** by accelerating partnership arrangements to develop integrated approaches to wellbeing in the Gwent region. At its meeting in October 2021, the Gwent PSB set out its future work programme to assist in discharging its duties and priorities.

Involvement has been demonstrated in 2021/22 through the development and public consultation on the Gwent Well-Being Assessment report and findings. Thinking **long term** and **prevention** are being taken forward through the decision of Gwent PSB taken in March 2022 to become a 'Marmot Region' and accelerate a journey to go further and faster on addressing the social determinants of health which are the 'causes of the causes' of poor health.

The review of the Health Board's Well-Being Objectives and the reporting and monitoring approach is still evolving – a process which has been understandably affected in 2021/22 by the COVID-19 pandemic. However, the Health Board continues to make positive progress in delivering against its existing ten Well-Being objectives. The Health Board's self-assessed progress against its ten Well-Being Objectives for 2021/22 financial year can be seen in the table below.

Our Well-Being Objectives	*Where we are now*
1 – Support every parent expecting a child and give every child in Gwent support to ensure the best start in life	**Being More Adventurous**
2 – Support adults and children in Gwent to live healthily and to age well, so that they can retain independence and enjoy a high quality of life into old age	**Making Simple Changes**
3 – Promote Mental Well-Being as a foundation for health, building personal and community resilience	**Being More Adventurous**
4 – Encourage involvement of people who use our services and those they support, in jointly owned decisions regarding their own health and care plans, and in wider service planning and evaluation, so that we, with our partners, deliver the outcomes that matter most to people	**Making Simple Changes**
5 – Ensure that we maximise the effective use of NHS resources in achieving planned outcomes for services and patients, by excellent communication, monitoring and tracking systems in all clinical areas	**Owning Our Ambition**
6 – Promote a diverse Workforce able to express their cultural heritage, with opportunities to learn and use Welsh in the workplace	**Making Simple Changes**
7 – Develop our staff to be the best that they can be with high levels of employee well-being and, as the largest employer in Gwent, promote NHS careers and provide volunteering and work experience opportunities	**Being More Adventurous**
8 – Reduce our negative environmental impact through a responsible capital building programme and a sustainable approach to the provision of building services including; carbon and waste management, undertaking procurement on a whole life cycle cost basis and support local souring, promoting sustainable and active travel, and advocating improvements in environmental health	**Making Simple Changes**
9 – Plan and secure sustainable and accessible healthcare services ranging from prevention through to treatment, rehabilitation and recovery that meet current and future needs and address health inequalities and differing levels of need across our communities	**Owning Our Ambition**
10 – Continue to integrate our actions with wider public, independent and voluntary sector partners with the aim of developing streamlined, whole system services for people who use our services and those they support.	**Owning Our Ambition**

2021/22 remained a challenging year due to the pandemic. Nevertheless, the Health Board continued on its journey to embed the Act into its decision making. Whilst the Health Board is taking a proactive approach to embed the principles of the Act in how it plans, designs and delivers its services, it recognises that there is still much more to do.

The Act remains a leadership priority for the Health Board, and over the next few years, there are a number of steps that will further enable it to continue to deliver against the aspirations of the Act, embed the five ways of work across its functions, and demonstrate progress against its Well-Being Objectives.

16. Welsh Language

In accordance with Welsh Language Standard 120, the Welsh Language Annual Report 2020/21 was published in September 2021, addressing the statutory duty of the Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011. The report was well received by the Commissioner's Office and stakeholders.

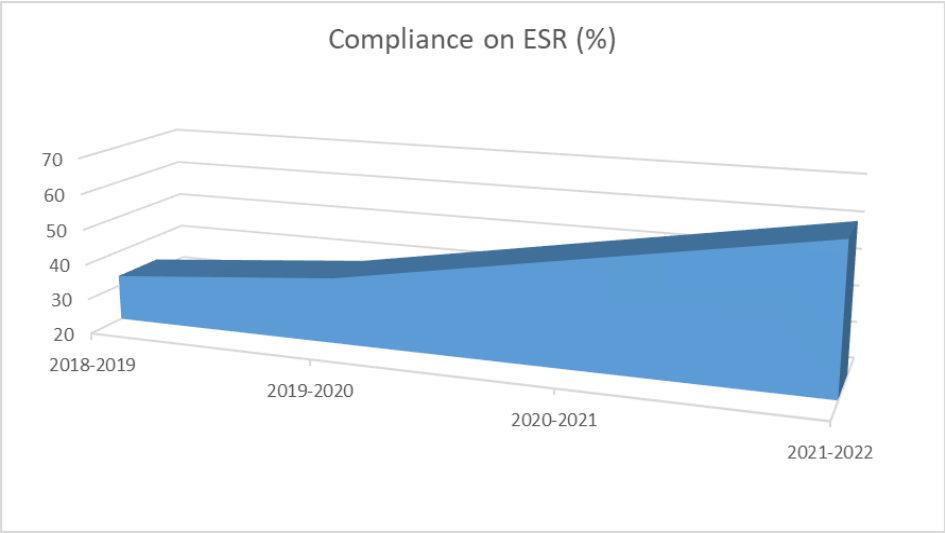
The Health Board has made noteworthy progress in developing working practices and systems to assist in compliance together with facilitating and monitoring the implementation of the Welsh Language Standards and good bilingual practice.

Internal auditing processes undertaken in the reporting period have highlighted those inconsistencies remain across various service areas. Service area action plans have been devised to address these inconsistencies.

Workforce Welsh Language Skills

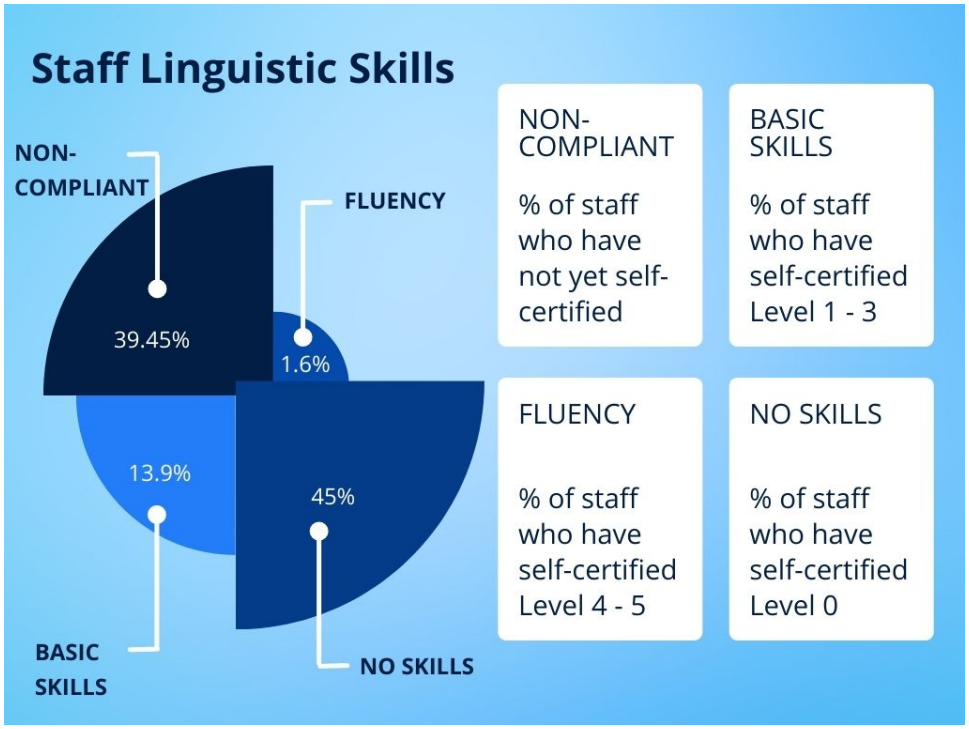
Staff are required to self-certify their Welsh language competencies via the Electronic Staff Register (ESR). We are pleased to report a 10% increase in organisational compliance during 2021/22, with an overall increase of 27.92% since the implementation of the Standards (see dataset below). We recognise that progress will be incremental and will continue to promote the importance of completion via targeted communication campaigns and divisional audits.

Overall Health Board compliance is currently at 61.08%.



Current Workforce Language Skills

Data collated from the ESR system is used to analyse workforce linguistic skills and should be used to inform workforce planning.



Complaints

The Health Board's formal demonstration of dealing with Welsh language complaints can be read within the Welsh Language Complaints Procedure.

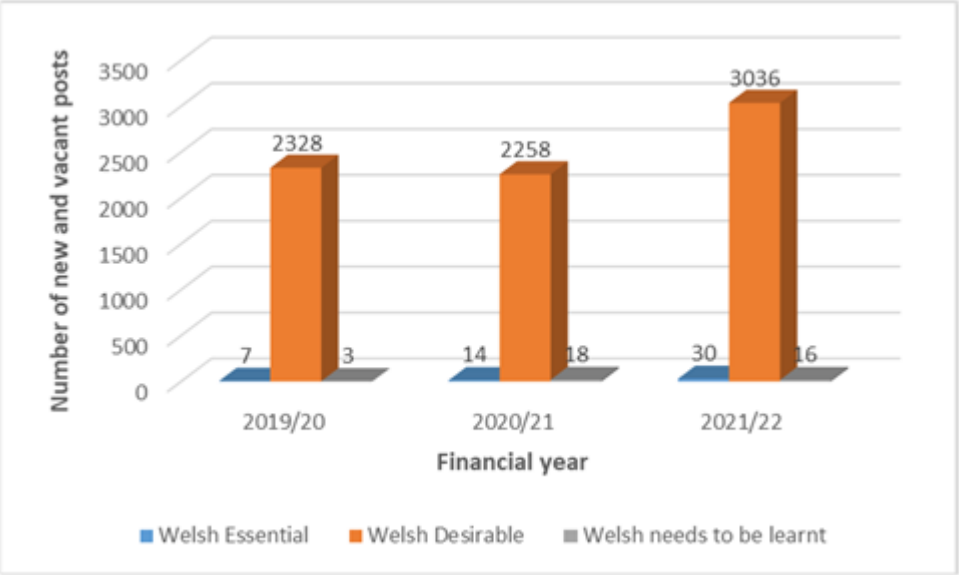
No external investigations were held during the reporting period.

We received eleven complaints directly and resolved with the cooperation of the associated service leads and in line with the *Putting Things Right* Regulations. Eight

of the complaints relate to performance against the service delivery Welsh Language Standards, two in relation to performance against the operational Welsh Language Standards and one in relation to Primary Care.

Bilingual Workforce Planning: Recruiting to New and Vacant Posts

In line with the objectives of the Bilingual Skills Strategy, we have demonstrated a steady increase in the number of new and vacant posts advertised with the criteria: Welsh Essential, Desirable and Welsh needs to be learnt (see below dataset).



This is a positive step towards ensuring our workforce can both meet our legal requirements and increase capacity, developing a truly bilingual workforce.

17. Value Based Healthcare

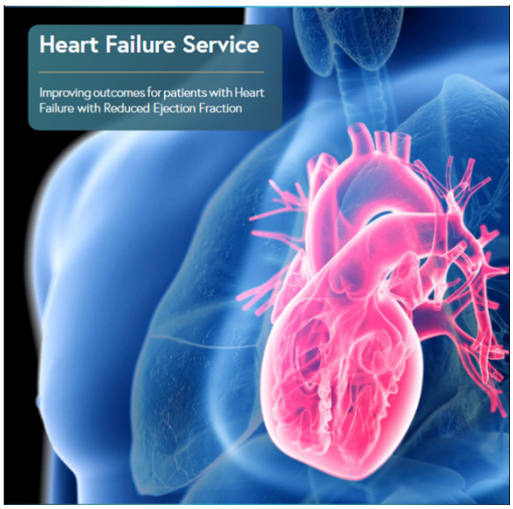
The Health Board has a well-established Value-Based approach to health and care services, measuring and acting on what matters to people, using the finite resources available.

The Value-Based Healthcare programme provides the capability to ensure innovative and transformative ways of organising and delivering care around the patient, families and carers. Re-designed models will be data and evidence-driven, with a clear focus on patient outcomes.
We focus on the following specialities to deliver better outcomes and experiences for patients while enabling service to deliver sustainable and efficient services.

- Patient-Centred Care
- Health Informatics & Data Analytics
- Project Management
- Communication & Engagement
- Research & Innovation
- Strategic Industry Partnerships

Heart Failure Service: Improving outcomes for patients with Heart Failure with Reduced Ejection Fraction (HFrEF)

During 2021/22, Heart Failure nurse specialists develop a Value-Based approach, improving patient wellbeing, enhancing outcomes and reducing hospital admissions, saving lives. The service was receiving an increase in the number of patients presenting with HFrEF, were unable to meet NICE guidelines around access, optimisation of medication and timely follow-up appointments.



A multi-disciplinary approach working with a range of healthcare professionals and the Value-Based Healthcare Team they develop a new patient pathway with a focus on outcomes for patients discharged from acute cardiology with a diagnosis in the last 12 months. An e-referral system was implemented, appointments were prioritised based on the outcome data, and complex and urgent cases were passed onto cardiologists for specialist care. The new Value-Based approach has streamlined the entire process, cutting down waiting times and freeing up capacity, which ultimately improves the experience and outcomes for patients and their families.

Key results included:

- Reduction in the average wait time for 1st appointment from 8 weeks to 2weeks
- Reduction in the average wait time for 1st and 2nd appointment from 75 days to 35 days
- Medication optimisation reduced from 384 days to 143 days (average)
- 97% of patients during that period were not re-admitted with a primary diagnosis of Heart Failure

18. Emergency and Business Continuity Planning

The Civil Contingencies Act (CCA) 2004 and accompanying non-legislative measures, delivers a statutory framework of roles and responsibilities for organisations involved in civil protection at the local level.

The Health Board Major Incident Plan provides the Framework by which the organisation, as a Category 1 Responder under the Civil Contingencies Act (CCA) 2004, will respond to a Major Incident or an Emergency (as defined within the CCA). The CCA defines an emergency as "an event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place

in the UK, or war or terrorism which threatens serious damage to the security of the UK".

The Business Continuity Policy of the Health Board outlines roles, responsibilities and processes to respond to an adverse event and is supported by corporate and divisional plans to safely maintain essential services until 'business as usual' is restored.

Throughout the pandemic a command-and-control structure was established within the Health Board and co-ordinating with partner organisations in Gwent and across Wales. This structure provided a governance framework for decision making and response at strategic, tactical and operational level, and working with partners to work in collaboration to meet local population needs.

19. Financial Management and Performance

The Annual Accounts 2021/22, at Section 3 of the Annual Report and Accounts 2021/22, Page XX, sets out the detailed accounts for the full year to 31 March 2022 for Aneurin Bevan University Health Board. These accounts are prepared under International Financial Reporting Standards (IFRS).

The Health Board has two statutory financial duties:

- To breakeven over a rolling three-year period; and
- To submit an Integrated Medium-Term Plan (IMTP) to secure compliance with breakeven over three years.

Under the rolling 3-year duty, introduced with the NHS (Wales) Act 2014, the first assessment of the first statutory financial duty took place at the end of 2016/17 when it was achieved. The target has again been achieved, subject to audit, in 2021/22.

In relation to the second duty the Health Board did secure WG approval to the IMTP on 27th March 2019. The note in the accounts shows that this duty was achieved. (*Note 2.3 of the Annual Accounts 2021/22).*

Revenue Resource Performance

The Health Board met its Revenue Resource Limit for the year and delivered a surplus of £249k. Against the breakeven duty over a rolling there year period, the Annual Accounts 2021/22 report a surplus of £526k as shown in the table below:

3-year revenue breakeven duty	2019/20 £000	2020/21 £000	2021/22 £000	Total £000
Underspend against allocation	32	245	249	526

Capital Resource Performance

In addition to a revenue resource limit the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The target of £48.9m was met in 2021/22 with a small underspend of £50k. The target is measured over a 3-year period as shown in the table below:

3-year capital breakeven duty	2019/20 £000	2020/21 £000	2021/22 £000	Total £000
Underspend against allocation	28	13	50	91

Other Related Targets

- Public Sector Payment Policy
  This target for the Health Board relates to the payment of 95% of its trade creditors within 30 days. In 2021/22, the target was achieved with full year figure of 95.0%.
- Cash Balance
  Welsh Government sets a notional target for Health Boards in Wales to have end of period cash balances not exceeding £6m. For 2021/22, the Health Board ended with an actual cash balance of £1.7m and was therefore within the target.

20. Conclusion and Forward Look

There has been substantial learning across the Health Board over the past twelve months which will inform how we respond and make progress during 2022/23. This does not simply consider how we responded to the direct challenges of the changing variants of concern and successive waves of Covid-19, or the wider impact of the last two years on our population and services delivered. We have also learnt how a crisis can enable transformation to flourish across the system.

As an organisation our mission is to improve population health, and, through doing this, reduce the health inequality that exists across our communities. The current 18-year gap in healthy life expectancy between our wealthiest and poorest communities is significant. It is the consequences of inequality that mean a greater number of citizens require our services. Sadly, the pandemic has worsened the gap, therefore, as we look to the future, we must relentlessly focus on reducing health inequality as part of improving overall population health.

Our Integrated Medium-Term Plan (IMTP) 2022/25 was approved by the Board in March 2022 and is a natural progression from our Annual Plan 2021/22. It builds on the life course approach, whilst recognising the current operational demand and then focussing on realistic, sustainable recovery.

The plan is based on a realistic assessment of delivery over the next three years; it is optimistic in its outlook, recognising the need to build on the service changes achieved over the last few years, and it focusses on making those changes sustainable, to meet the long-term needs of our communities.

It is only right to end by reiterating the comments made at the start of this report and to say thank you to our staff for the way they have responded to the continued challenges of the past year, showing resilience, bravery, dynamism, resourcefulness and great skill.

Glyn Jones
Interim Chief Executive **Date: XX June 2022**

Aneurin Bevan University Health Board
Section 2: Accountability Report
1st April 2021 – 31st March 2022

INTRODUCTION TO THE ACCOUNTABILITY REPORT

Aneurin Bevan University Health Board is required to publish, as part of our annual reporting, an Accountability Report. The purpose of the Accountability Report section of the Annual Report has been designed to demonstrate the ways in which the Health Board is meeting its key accountability and reporting requirements.

This Accountability Report has three sections:

1. Corporate Governance Report

This explains the composition of the Health Board, its governance structures and arrangements and how the Health Board seeks to achieve its objectives and responsibilities to meet the needs of the people we serve. The Corporate Governance Report includes:

A. The Directors' Report
B. The Statement of the Chief Executive as the Accountable Officer and the Statement of Directors' Responsibilities in respect of the Accounts
C. The Annual Governance Statement.

2. Remuneration and Staff Report

This section contains information about the staff of the organisation, particularly focusing on the remuneration of its Board and senior management, fair pay ratios and other staff information, such as sickness absence rates.

3. Parliamentary Accountability and Audit Report

This section contains a range of disclosures on the regularity of expenditure, fees, charges, compliance with cost allocation, material remote contingent liabilities, long-term expenditure trends and charging requirements set out in HM Treasury guidance.

Corporate Governance Report 2021/22

SECTION A: THE DIRECTORS' REPORT

Aneurin Bevan University Local Health Board is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under *The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778), "the Establishment Order".*

The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations") set out the constitution and membership arrangements of Local Health Boards, the appointment and eligibility requirements of members, the term of office of non-officer members and associate members. In line with these Regulations the Board of Aneurin Bevan University Health Board comprises:

- a chair;
- a vice-chair;
- officer members; and
- non-officer members.

The members of the Board are collectively known as "the Board" or "Board members"; the officer and non-officer members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All members have full voting rights.

In addition, Welsh Ministers may appoint up to three associate members. Associate members have no voting rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations")*, and continue to fulfil the relevant requirements throughout the time that they hold office. The Regulations can be accessed via the Government's legislation website:
http://www.legislation.gov.uk/wsi/2009/779/contents/made

Further detail on the Board's membership and composition during 2021/22 is available within Section C: The Annual Governance Statement.

Board Members' Interests

Details of company directorships and other significant interests held by members of the Board which may conflict with their responsibilities are maintained and updated on a regular basis.

The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Aneurin Bevan University Health Board, and staff across the organisation, in line with the Standards of Business Conduct Policy, as at the 31st March 2022. This information is

available on the Health Board's Internet site and can be accessed by following this link.

Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed on page 31 of the Annual Governance Statement at Section C.

Environmental, Social and Community Issues

The Board is aware of the potential impact that the operation of the Health Board has on the environment and it is committed to wherever possible:

- Ensuring compliance with all relevant legislation and Welsh Government Directives;
- Working in a manner that protects the environment for future generations by ensuring that long term and short-term environmental issues are considered; and
- Preventing pollution and reducing potential environmental impact.

The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the Health Board's estate.

The Board's Annual Report for 2021/22 and Integrated Medium Term-Plan 2022-25 (approved March 2022) sets out the Board's strategic priorities which have been set within the context (environmental, social and community issues) in which the Health Board is operating within.

The Performance Report (Part A) of the Annual Report and Accounts 2021/22 provides greater detail in relation to the achievement of the Health Board in delivering the Annual Plan 2021/22.

COVID-19 Pandemic

COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020. This subsequently led to NHS organisations, including Aneurin Bevan University Health Board, needing to focus on preparations and plans for responding to the pandemic. Throughout 2020/21 and 2021/22, the nature and scale of the response was ever-changing and required an agile response.

During this time, the Board's fundamental role and purpose did not change. The Board continued to require and receive ongoing assurance, not only on service preparedness and response but also on clinical leadership, engagement and ownership of developing plans in respect of the health and wellbeing of staff; on proactive, meaningful and effective communication

with staff and the public at all levels; and on health and care system preparedness.

The Health Board's governance arrangements during this time are set out further in Section C: The Annual Governance Statement.

Statement of Public Sector Information Holders

As the Accountable Officer of Aneurin Bevan University Health Board, and in line with the disclosure requirements set out by the Welsh Government and HM Treasury, I confirm that the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the year.

SECTION B: STATEMENT OF THE CHIEF EXECUTIVE AS THE ACCOUNTABLE OFFICER OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer for Aneurin Bevan University Local Health Board. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer. As Accountable Officer, I confirm that, as far as I am aware, there is no relevant audit information of which the Health Board's Auditors are unaware, and I have taken all the steps that ought to have been taken to make myself aware of any relevant audit information and that the Health Board's auditors are aware of that information.

As Accountable Officer, I confirm that the Annual Report and Accounts 2021/22 as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and that the judgements required for determining that they are fair, balanced and understandable.

As Accountable Officer, I am responsible for authorising the issue of the financial statements on the date they are certified by the Auditor General for Wales.

Name: Glyn Jones, Interim Chief Executive **Date:** XX June 2022

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2021/22

The Directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Local Health Board and of the income and expenditure of the Local Health Board for that period.

In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The Directors confirm that they have complied with the above requirements in preparing the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board

Signed:

Ann Lloyd, Chair
Dated: XX June 2022

Glyn Jones, Interim Chief Executive
Dated: XX June 2022

Robert Holcombe, Interim Director of Finance, Procurement and VBHC
Dated: XX June 2022

SECTION C: ANNUAL GOVERNANCE STATEMENT, 2021/22

SCOPE OF RESPONSIBILITY

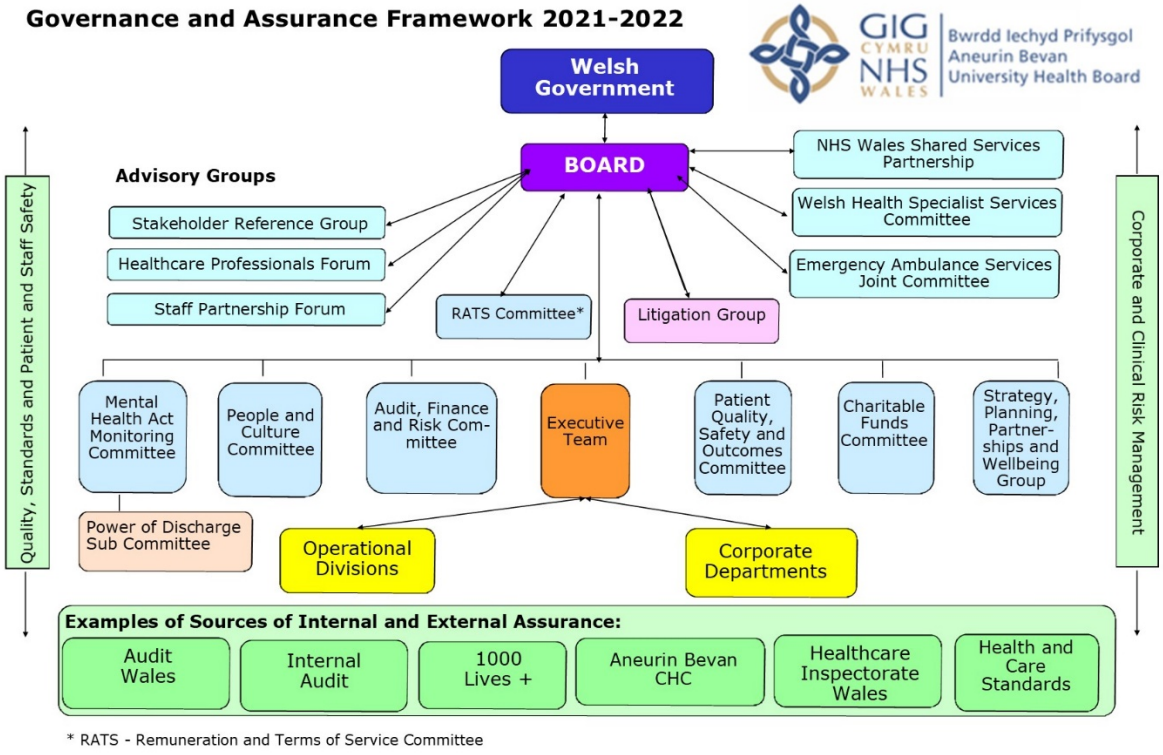
The Board is accountable for Governance, Risk Management and Internal Control. As Chief Executive of the Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated and assurance has been sought and provided. Where necessary additional information is provided in the Governance Statement, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement (GS).

OUR GOVERNANCE AND ASSURANCE FRAMEWORK

Aneurin Bevan University Health Board has agreed Standing Orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and together with the adoption of a scheme of matters reserved to the Board, a scheme of delegation to officers and others and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These documents, together with the Board Assurance Framework and a range of corporate policies set by the Health Board make up the Governance and Assurance Framework and arrangements of the organisation.

The diagram overleaf outlines the governance and assurance framework in place during 2021/22:



Membership of the Health Board and its Committees

Attachment 1 provides the Board's membership during 2021/22 and attendance at Board and Committee meetings respectively for this period.

There has been significant change to the membership of the Board during 2021/22, as outlined in Table 1 below:

TABLE 1		
Name	**Designation**	**Dates (if less than full year)**
Executive Directors		
Judith Paget	Chief Executive	Until 31st October 2021
Glyn Jones	Interim Chief Executive	From 1st November 2021
Glyn Jones	Director of Finance and Performance/Deputy Chief Executive	Until 31st October 2021
Rob Holcombe	Interim Director of Finance, Procurement and Value Based Healthcare	From 1st November 2021
Dr James Calvert	Medical Director	Full Year
Geraint Evans	Director of Workforce and OD	Until 31st August 2021
Sarah Simmonds	Director of Workforce and OD	From 22nd July 2021
Nicola Prygodzicz	Director of Planning, Digital and IT	Until 31st October 2021
Nicola Prygodzicz	Director of Planning, Performance, Digital and IT/ Interim Deputy Chief Executive	From 1st November 2021

Rhiannon Jones	Director of Nursing	Full Year
Nick Wood	Director of Primary, Community and Mental Health	Until 5th December 2021
Peter Carr	Director of Therapies and Health Sciences	Full Year
Dr Sarah Aitken	Director of Public Health and Strategic Partnerships	Full Year
Dr Sarah Aitken	Interim Director of Primary, Community and Mental Health Services (in addition to substantive role of Director of Public Health and Strategic Partnerships)	From 6th December 2021 to 28th February 2022
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services	From 28th February 2022
Independent Members		
Ann Lloyd	Chair	Full Year
Emrys Elias	Vice Chair	Until 30th September 2021
Pippa Britton*	Independent Member (Community)	Until 17th October 2021
Pippa Britton	Interim Vice Chair	From 18th October 2021
Katija Dew	Independent Member (Third Sector)	Full Year
Shelley Bosson	Independent Member (Community)	Full Year
Louise Wright	Independent Member (Trade Union)	Full Year
Richard G Clarke	Independent Member (Local Authority)	Full Year
Professor Helen Sweetland	Independent Member (University)	Full Year
Paul Deneen	Independent Member (Community)	Full Year
Vacant	Independent Member (Finance)	Full Year
Vacant	Independent Member (Digital)	Full Year
Vacant (Pippa Britton's Substantive position)	Independent Member (Community)	From 18th October 2021
Directors in Attendance**		
Claire Birchall	Director of Operations	Until 2nd May 2021
Leanne Watkins	Interim Director of Operations	From 12th April 2021 to 16th March 2021
Leanne Watkins	Director of Operations	From 17th March 2022

Special Advisors to the Board***		
Chris Koehli	Special Advisor to the Board	Until 17th July 2021
Phil Robson	Special Advisor to the Board	Full Year
Associate Members**		
Keith Sutcliffe	Chair, Stakeholder Reference Group	Full Year
Vacant	Chair, Health Professionals Forum	Full Year
Vacant	Director of Social Services	Full Year
Board Secretary/Director of Corporate Governance***		
Richard Howells	Board Secretary	Until 30th November 2021
Rani Mallison	Board Secretary/Director of Corporate Governance	From 28th November 2021

** In October 2021, Emrys Elias, Vice Chair, began a temporary role as Chair of Cwm Taf Morgannwg University Health Board in October 2021. Whilst interim arrangements have been put in place, the Health Board has been advised by Welsh Government not to appoint a permanent replacement for 18 months. Pippa Britton has therefore been appointed Interim Vice Chair, leaving her substantive role as Independent Member (Community) vacant on a temporary basis.*

***The Director of Operations is not an Executive Post. The Director of Operations is therefore not a Board Members and attends meetings of the Board without voting rights.*

****The Board has discretion to appoint Special Advisors to support it in achieving its responsibilities. Special Advisors are not Board Members and therefore attend meetings of the Board without voting rights.*

*****Associate Members are Members of the Board but do not hold voting rights.*

****** Independent of the Board, the Board Secretary acts as the guardian of good governance within the LHB. The Board Secretary is responsible for providing advice to the Board as a whole and to individual Board members on all aspects of governance.*
On 14th March 2022, the Remuneration and Terms of Service Committee approved a change of operating title for the Board Secretary role to Director of Corporate Governance.

Following Ministerial Public Appointment campaigns, the Minister for Health and Social Services has confirmed the appointment of Iwan Jones as Independent Member (Finance) in April 2022; and the appointment of Dafydd Vaughan, Independent Member (Digital), in May 2022.

Whilst roles on the Board were vacant, responsibilities were covered by other Board members to ensure continuity of business and effective governance arrangements. Independent Members attended Board Committee meetings where necessary to ensure meetings remained quorate and the Board's duties could be discharged.

Due to the number of interim positions within the Board, the Chair with the Remuneration and Terms of Service Committee is working to stabilise changes within the Executive Team and ensure robust induction, development and succession planning for Board Members.

The Role of the Board

The Board, chaired by Ann Lloyd CBE, has been constituted to comply with the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

The Board is made up of individuals from a range of backgrounds, disciplines and areas of expertise. The Board comprises the Chair, Vice Chair and nine other Independent Members and the Chief Executive and eight Executive Directors. There are also Associate Independent Members, Special Advisors and other senior managers who routinely attend Board Meetings. The full membership of the Board and their lead roles and committee responsibilities are outlined in **Attachment 1**.

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide strategic direction and control. The Board is accountable for governance and internal control in the organisation and I, as the Chief Executive and Accountable Officer, am responsible for maintaining appropriate governance structures and procedures.

In summary, the Board:

- Sets the strategic direction of the organisation within the overall policies and priorities of the Welsh Government and the NHS in Wales;
- Establishes and maintains high standards of corporate governance;
- Ensures the delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility;
- Monitors progress against the delivery of strategic and annual objectives; and
- Ensures effective financial stewardship by effective administration and economic use of resources.

The Health Board must agree Standing Orders for the regulation of proceedings and business which are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegations to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define - its 'ways of working'. These documents, together with the range of corporate policies set by the Board make up the Governance Framework.

Committees of the Board

Section 3 of Aneurin Bevan University Health Board's Standing Orders provides that "*The Board may and, where directed by Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance in the exercise of its functions*". In line with these requirements, the Health Board had in place a Committee Structure for 2021/22.

In December 2020, the Board acknowledged the importance of learning from the lean, agile, transformative culture that the NHS and partners developed during the pandemic and approved a revised Committee Structure which came into effect on 1st April 2021. These revised arrangements promoted a leaner structure, whilst maintaining effective scrutiny and assurance around the Health Board's strategic decision making, financial accountability and patient outcomes.

During 2021/22, the following Committees were in place:

- Audit, Finance and Risk Committee
- Charitable Funds Committee
- Patient Safety, Quality and Outcomes Committee
- Mental Health Act Monitoring Committee
- Remuneration and Terms of Service Committee
- People and Culture Committee

The Terms of Reference and Operating Arrangements, meeting agendas and papers for each of these Committees can be found on the Health Board's website.

These Committees were Chaired by Independent Members of the Board. The Chair of each Committee reports regularly to the board on the committee's activities. This contributes to the board's assessment of risk, level of assurance and scrutiny against the delivery of objectives. In addition, and in-line with Standing Orders, each committee is required to produce an annual report.

In addition, the Health Board established a Strategy, Planning, Partnerships and Wellbeing Group. This had a different model of membership, which includes all Independent Members and Executive Members of the Board. This recognises that the Group is constituted to focus on strategic development and medium- and longer-term planning matters, rather than acting as an assurance group for scrutiny purposes.

Throughout the COVID-19 pandemic, the Board has continued to review its governance arrangements to ensure that they remain appropriate whilst agile enough to meet the demands placed upon the organisation. The Board is aware of the increasing pressures that have been placed on the health and social care system, as a direct and indirect result of the pandemic, and the significant ongoing challenges that the organisation faces in responding to these. It is therefore essential that the Board's business, and that of its committees, remains focussed on its key priorities and strategic risks, ensuring an appropriate balance between strategy, delivery and performance, and culture.

In recognition of the Board's strategic priorities for 2022/23 and the strategic risks it currently holds, a revised committee structure for 2022/23 was considered and agreed by the Board in March 2022. This revised structure will enable an appropriate balance between strategy, delivery and performance, and culture and takes into consideration feedback from Board Members and Audit Wales in respect of effectiveness. Further detail on the Committee Structure for 2022/23 can be found on the Health Board's website.

Conducting Business with Openness and Transparency

In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings, and it has not therefore been possible to allow the public to attend meetings of our board and committees throughout 2021/22. This has therefore meant that the Health Board has not complied with its Standing Orders in this regard.

To ensure business was conducted in as open and transparent manner as possible during this time the following actions were taken:

- All Board and Committee meeting agenda packs have been published to the Health Board's website in advance of meetings;
- Meetings of the Board were livestreamed between June 2020 and September 2021. Work is ongoing to ensure that the Health Board is able to resume livestreaming of its Board meetings by Autumn 2022;
- Since September 2021, meetings of the Board have been recorded and published to the Health Board's You Tube Channel within 24 hours.

The Board is expediting plans to enable its Board and Committee meetings to be held in public and to be made available to the public via live streaming, wherever possible. In the meantime, meeting agendas will be issued with a statement advising the public that should they wish to observe a virtual meeting of the board or a committee, then they should make contact the Board Secretary in advance of the meeting in order that the request could be considered on an individual basis. This statement will also available for members of the public on the Health Board's website.

The Health Board and its Committees have sought to undertake a minimum of its business in private sessions and ensure business, wherever possible, is published into the public domain. The Committees that do not publish information publicly is either because of the confidential nature of their business, such as the Remuneration and Terms of Service (RATS) Committee, or they are informal developmental type meetings such as the Strategy, Planning, Partnerships and Wellbeing Group discussing plans and ideas often in their formative stages.

Meetings of the Board and its Committees are formally recorded with minutes considered for approval at the next available meeting, respectively. In addition, the Board Secretary maintains Decision Logs for all decisions taken by the Board and the Executive Team.

Items considered by the Board in 2021-22

During 2021-22, the Board held 8 meetings:

- 6 routinely scheduled bimonthly meetings
- 1 additional meeting in June 2021 to formally approve the Annual Report and Accounts for 2020/21, following detailed consideration by the Health Board's Audit, Finance and Risk Committee.
- 1 extraordinary meeting in October 2021 to consider and approve the investment proposals for the South East Wales Vascular Network Business Case

In addition, the Board held its Annual General Meeting on 28th July 2021. This was held via Microsoft Teams and streamed on the Health Board's YouTube Channel.

Board Members are also involved in a range of other activities on behalf of the Board, such as Board Development sessions, COVID-19 Board Briefing sessions, attending partnership meetings, shadowing and a range of other internal and external

All the meetings of the Board in 2021/22 were appropriately constituted and quorate. The key business and risk matters considered by the Board during 2021/22 are outlined below:

Business Cases:

- Approved the **Ysbyty Ystrad Fawr Unified Breast Unit Full Business Case.**
- Approved the direction of travel set out in the **South East Wales – Acute Oncology Service Business Case** and supported the development of the phases 2 and 3 through the regional Acute Oncology programme.
- Approved the **Newport East Health and Wellbeing Centre Full Business Case** for submission to Welsh Government.

- Approved the **South East Wales Vascular Network Business Case** and supported the establishment of the Network, the host of which is yet to be determined.
- The Board agreed it was important to invest in projects that would transform patient experience and outcomes and endorsed a letter of support for the **All Wales Positron Tomography Programme.**
- The Board agreed that it was a vital development for diagnostic and therapeutic interventions and approved the **Endoscopy Business Justification Case** to support the proposed redevelopment and expansion of Endoscopy services at Royal Gwent Hospital.

Plans/Strategies/Policies/Service Change

- Received the outcome of an engagement and consultation process regarding **Transforming Adult Mental Health Services in Gwent** and supported taking forward the transformation agenda.
- Noted progress on the development of **Neighbourhood Care Network Annual Plans.**
- Approved the **Winter Plan 2021/22 -** an overarching plan which set out a range of actions and priorities.
- Received update on progress against the strategic objectives included in the **Estates Strategy**
- Approved the **Annual Plan 2021/22** which set out the Board's annual strategic priorities**.**
- Approved the **Pharmaceutical Needs Assessment** as required by Regulation 7 of the NHS (Pharmaceutical Services) (Wales) Regulations 2020.
- Considered and commented on the **Gwent Public Service Board Wellbeing Assessment Consultation**
- Supported requests from the NHS Wales Health Collaborative for WHSSC to:
  - Commission Hepato-Pancreato-Biliary Services;
  - Commission the Hepato-Cellular Carcinoma (HCC) MDT and;
  - Develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service.
- Approved the **Policy for the Management of Policies and other written control documents.**
- Approved the **Integrated Medium-Term Plan 2022-2025.**
- Approved the **Capital Programme 2022/23.**

Governance and Assurance

- Approved the **Board Assurance Framework.**
- Adopted revised **Standing Orders and Standing Financial Instructions.**
- Received assurance in respect of arrangements for compliance with the **Nurse Staffing Levels (Wales) Act.**
- Approved revised **Standing Orders for WHSSC and EASC.**
- Reviewed **Committee Membership** in light of continued Independent Member vacancies
- Approved the **Annual Report and Accounts 2020-21.**

- Approved the **Charitable Funds Annual Accounts and Annual Report 2020-21**
- Received the following **Annual Reports**:
  - Trade Union Partnership Forum
  - Cancer Services
  - Welsh Language Standards
  - Equality Report
- Received the **Audit Wales Annual Audit Report and Structured Assessment.**

Patient Experience and Public Engagement

Throughout 2021/22, the **Aneurin Bevan Community Health Council** attends meetings of the Board to provide an overview of recent issues of concern and positive observations or public feedback being addressed by the Community Health Council in relation to the planning and delivery of health services in Gwent.

The Board is also committed to hearing and learning from the experience of staff and patients and during 2021/22 received patient/staff stories in respect of:

- Core Care Team Model
- Shared Lives for Mental Health Crisis
- Therapies support in Intensive Care Units.

Routine Business

- Ratified actions taken by the Chair, on behalf of the Board, to seal documents affixing the Health Board's Common Seal.
- Considered and discussed the Health Board's financial performance and the related risks being managed by the organisation.
- Considered the Board's performance against key local and national targets and the actions being taken forward to improve performance.
- Received assurance reports from the Committees and Advisory Groups of the Board.
- Received update reports from the Executive Team in respect of key issues locally, regionally and within NHS Wales.
- Reviewed the Corporate Risk Register and sought assurance on the management of mitigating actions.

Further information can be obtained from the published Board meeting papers on the Health Board's website via the following link.

Items considered by Committees of the Board

During 2021/22, Board Committees considered and scrutinised a range of reports and issues, in line with the matters delegated to them by the Board. These included a range of internal and external audit reports and reports from other review and regulatory bodies including Healthcare Inspectorate Wales.

As was the case in previous years, the Committees' consideration and analysis of such information has played a key role in my assessment of the effectiveness of internal controls, risk management arrangements and assurance mechanisms. The Committees also considered and advised on areas of local and national strategic developments and new policy areas.

An overview of the key areas considered by the Committees of the Board is outlined below:

Audit, Finance and Risk Committee	• Continued to focus on ensuring that the Health Board obtained value for money and the best use of resources, receiving specific updates on:
	  ○ Musculoskeletal Pathway Redesign Programme
	  ○ Integrated Eyecare Pathway
	  ○ Outpatient Transformation
	  ○ Agile Working
	  ○ Estates Efficiency Framework
	  ○ Digital Systems, Efficiencies and Benefits Realisation
	• Maintained a focus on improvements in the financial systems and control procedures and monitored payments and trending processes.
	• Received regular update reports from the Counter Fraud Service and approved the Counter Fraud Annual Plan and Annual Report.
	• Approved an Internal Audit Plan for 2021/22, although this remained flexible to respond to changing demands and resources; and received the resulting Internal Audit Reports, noting key areas of risk and tracked the management responses made to improve systems and internal control.
	• Endorsed and adopted a revised approach and delivery framework for the management of corporate risk.
	• Monitored compliance with the Freedom of Information Act.
	• Continued to work with Audit Wales as part of its work to determine the accuracy of financial statements and its programme of performance audits and assurance reports including its Annual Structured Assessment.
	• Received specific updates on Consultant Job Planning, Direct Engagement, Overview of Legal Services processes related to Losses and Special Payments.
	• In committee meeting held April 2021 to receive the informatics response to the Audit Wales Cyber Resilience confidential report issued in January 2021,

Patient Quality, Safety and Outcomes Committee	• Continued to monitor organisational performance against a range of key quality indicators and identified emerging themes, areas of concern and mitigation, as well as good practice. In particular, the Committee considered ongoing risks and concerns regarding emergency and urgent care, ambulance handover delays and extreme pressure in Emergency Departments. • Received and discussed Annual Reports on Infection Prevention and Control, Putting Things Right and Safeguarding. The Committee also reviewed the Health Board's performance against established Cleaning Standards. • In line with the regulations for the management of concerns in Wales, the Committee continued to monitor organisational and divisional performance against the 20 and 30 day compliance targets for response and to receive assurance that there is learning from each complaint and/or incident and that this is communicated across the Health Board. • Any adverse incidents that have occurred within our Health Board or other health bodies, have been considered by the Committee to ensure that the Health Board's arrangements are safe and to consider recommendations for further improvement. • In particular, the Committee received and considered the outcome of the Brithdir Inquests, the lessons learned and received assurance regarding the governance processes in place within complex care and continuing health care. • Continued to monitor performance and progress against a number of key areas of activity and service developments including, prevention and management of falls, CHC/ABUHB Facetime Buddying Project, New Dementia Standards and revised ABUHB Plan, Dementia Companions and Meaningful Occupation model. The Committee also received assurance regarding access arrangements in primary care and the way in which primary care is managing its recovery and resumption of services • Oversight of implementation of the Health and Care Standards, and annual assurance reports received in relation to Nutrition and Hydration and Blood Management. • Received updates on all Healthcare Inspectorate Wales (HIW) reports to ensure recommendations made are being progressed across the organisation to enable learning. • Received assurance regarding participation in National Clinical Audit noting that the Health Board contributes to all mandated audits.
Charitable Funds Committee	• Scrutinised applications for charitable funds • Reviewed charitable funds income and expenditure • Considered and endorsed the Charitable Funds Accounts and Annual Report 2021/22
Mental Health Act Monitoring Committee	• Reviewed the use of the Mental Health Act within the Health Board and received assurance on compliance with the legislative requirements of the Mental Health Act.

People and Culture Committee	• Monitored how the Health Board was addressing key workforce priorities, noting in particular the challenges to the workforce presented by the continuing pandemic whilst recovering services and winter pressures. • Regularly reviewed the COVID-19 Workforce Dashboard which provided data on workforce supply, absence, GUH and mass vaccination recruitment and COVID-19 Workforce Risk Assessment compliance. • Kept under review the Health Board's approach to, and progress with, Agile Working, Workforce Planning and Talent and Succession planning.

Board Development

Board members took part in a number of development and briefing sessions through 2021/22. Topics covered at these sessions included:

- Restart and Recovery
- Digital Health and Care Wales – Introductory session
- Developing an integrated Research, Improvement, Innovation and Value (RIIV) approach for the Health Board
- Measuring/Reporting Outcomes
- HIW Annual Report
- Agile Working, Employee Wellbeing and Welsh Language
- Risk Management Approach
- Resource Briefing
- Primary Care Access
- Delivering Care Closer to Home
- Integrated Medium Term Plan development
- Clinical Futures/Grange University Hospital
- People Plan
- People First

Board members also received briefings on:

- The Omicron Variant and incidence rates
- Delivering the Mass Vaccination Programme
- Urgent and Emergency Care Pressures
- Surge Planning and use of the Local Options Framework

In-line with Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. In March 2022, the Board undertook an assessment of its effectiveness, including its committee structure, and identified areas for strengthening and improvement. These included, but are not limited to:

- Establishment of a Board Development Programme for 2022/23
- Establishment of a Board Member Induction Programme for 2022/23

- The need for dedicated time for the Board to undertake horizon scanning and discuss strategic development
- The need for a strengthened focus on outcomes, using intelligence and analytics
- The need for a strengthened focus on the work delivered through partnerships and joint committees
- The development of an Organisational Accountability Framework
- Ongoing development of risk management and assurance mapping.

Advisory Groups and Joint Committees

Advisory Groups

Aneurin Bevan University Health Board's Standing Orders require the Board to establish three advisory groups. These allow the Board to seek advice from and consult with staff and key stakeholders. They are the:

- Stakeholder Reference Group;
- Local Partnership Forum; and
- Healthcare Professionals' Forum.

Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board's website.

Stakeholder Reference Group (SRG)

The purpose of the SRG is to encourage full engagement and active debate amongst stakeholders from across the communities served by Aneurin Bevan University Health Board. By doing so, it aims to use the balanced opinions of its stakeholders to inform the Health Board's decision-making processes. The SRG is made up of a range of partner organisations from across the Health Board area and is chaired by an Associate Member of the Board who is also the Veterans Representative. The SRG held a development session in October 2021 to review its purpose, direction and determined future discussions and links with the Board and other groups. The Group discussed how it could provide advice and feedback regarding the Health Board's strategic objectives; an insight about community demands; and a holistic perspective across the communities.

Local Partnership Forum (Known as the Trade Union Partnership Forum [TUPF])

The TUPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues. The TUPF is co-chaired by the Chair of Staff Representatives and the Chief Executive of the Health Board. Members are Staff Representatives (including the Independent Member for

Trade Unions), the Executive Team and Chief Executive, the Director of Corporate Governance, the Assistant Directors of Workforce and OD and the Head of Workforce Governance. The Forum meets 6 times a year.

Healthcare Professionals' Forum (HPF)

The purpose of the HPF is to facilitate engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the Health Board's decision making.

During 2021/22, the Board did not have in place its Healthcare Professionals Forum. In the absence of this Group, the Board has continued to engage clinical professionals through its professional executive directors (Medical Director, Director of Nursing, Director of Therapies and Health Sciences and Director of Public Health) and existing professional management groups. The Board also engages with primary care providers through its cluster arrangements. It is the intention to take forward arrangements in respect of the Healthcare Professional's Forum in 2022/23.

Joint Committees

As set out within the Health Board's Standing Orders, the Board is required to establish, as a minimum, the following joint Committees:

- The Welsh Health Specialised Services Committee (WHSSC) and
- The Emergency Ambulance Services Committee.

Welsh Health Specialised Services Committee (WHSSC)

The Welsh Health Specialised Services Committee (WHSSC) is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales.

WHSSC was established in 2010 by the Local Health Boards (LHBs) in Wales to ensure that the population of Wales has fair and equitable access to the full range of specialised services. In establishing WHSSC to work on their behalf, the seven LHBs recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

WHSSC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board is represented on the Committee by the Chief Executive and reports of the Joint Committee's activity are regularly reported to the Board.

Emergency Ambulance Services Committee (EASC)

Emergency Ambulance Services in Wales are provided the Welsh Ambulance Services NHS Trust (WAST) and commissioning of Ambulance Services in Wales is a collaborative process underpinned by a quality and

delivery framework. The framework provides for clear accountability for the provision of emergency ambulance services with the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Services Committee (EASC) acting on behalf of Health Boards and holding WAST to account as the provider of emergency ambulance services. EASC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board is represented on the Committee by the Chief Executive and reports of the joint committee's activity are regularly reported to the Board.

Partnership Working

Aneurin Bevan University Health Board is committed to working constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for the population of Gwent. This is delivered in accordance with the Health Board's statutory duties and any specific requirements or directions made by the Welsh Ministers, which includes the development of population assessments and area plans.

Gwent Regional Partnership Board

The Gwent Regional Partnership Board (RPB) is established under the Partnership Arrangements (Wales) Regulations 2015, within which local authorities and local health boards are required to establish Regional Partnership Boards to manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services, and care and support is in place to best meet the needs of their respective population. The objectives of the Gwent Regional Partnership Board is to ensure the partnership bodies work effectively together to:

- Respond to the population assessment carried out in accordance with section 14 of the Act;
- Develop, publish and implement the Area Plans for each region covered as required under section 14A of the Act;
- Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act; and
- Promote the establishment of pooled funds where appropriate.

Welsh Government has distributed an Integrated Care Fund across Wales to the seven Regional Partnership Boards (RPBs) in Wales. The aim of the fund is to drive and enable integrated working between social services, health, housing and the third sector and independent providers to develop sustainable services.

The Integrated Care Fund is hosted by Aneurin Bevan University Health Board on behalf of Gwent Regional Partnership Board.

Integrated Care Fund is a standing agenda item on the Regional Partnership monthly meetings. All matters in relation to ICF are discussed and approved within the partnership forum. Information is cascaded

throughout the partnership structures for transparency. Where needed, the RPB accommodates special meetings to sign off ICF investment plans where meetings schedules do not align with reporting or development timeframes.

Aneurin Bevan University Health Board Members included in the membership of the Regional Partnership Board are:

- Ann Lloyd, Health Board Chair
- Glyn Jones, Interim Chief Executive Officer
- Sarah Aitken, Director of Public Health & Strategic Partnerships
- Chris O'Connor, Interim Director of Primary, Community Care & Mental Health
- Katija Dew, Independent Member

Further detail in respect of the Gwent RPB can be found on the RPB's website.

Gwent Public Services Board

The Gwent Public Services Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Gwent to meet the needs of Gwent citizens present and future. The aim of the group is to improve the economic, social, environmental and cultural well-being of Gwent. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan.

The Health Board contributes to achieving these objectives through the delivery of the Clinical Futures Strategy and the Integrated Medium-Term Plan (IMTP).

Aneurin Bevan University Health Board Members included in the membership of the Public Services Board are:

- Ann Lloyd, Health Board Chair
- Glyn Jones, Interim Chief Executive Officer
- Sarah Aitken, Director of Public Health & Strategic Partnerships

Further detail in respect of the Gwent PSB can be found on the PSB's website.

NHS Wales Shared Services Partnership

NHS Wales Shared Services Partnership (NWSSP) was established in November 2010 to deliver economies of scale; efficiencies and consistency of quality and process for the business and professional services that were directly managed and delivered by local NHS bodies.

As a hosted organisation, NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing

Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General / CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by Professor Tracy Myhill OBE. The membership is comprised of representatives from each NHS organisation, including Aneurin Bevan University Health Board.

The Partnership Committee is responsible for exercising the Velindre National Health Service Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to Local Health Boards, Special Health Authorities and National Health Service Trusts. Several committees and advisory groups have been established to help support the governance arrangements that underpin how NWSSP operates.

Further detail in respect of NHS Wales Shared Services Partnership can be found on NWSSP's website.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts."

CAPACITY TO HANDLE RISK

As Accountable Officer, I have overall responsibility for risk management and report to the Board on the effectiveness of risk management across the Health Board. My advice to the Board has been informed by executive officers and feedback received from the Board's Committees, in particular the Audit, Finance and Risk Committee and the Patient Quality, Safety and Outcomes Committee.

Executive Team meetings present an opportunity for executive directors to consider, evaluate and address risk, and actively engage with and report to the Board and its committees on the organisation's risk profile. The Health Board's lead for risk is the Director of Corporate Governance (the Board Secretary), who is responsible for establishing the policy framework and systems and processes that are needed for the management of risks within the organisation. Depending on the nature of risk, other Directors will take

ownership for management and mitigation, for example, patient safety risks fall within the responsibility of the Medical Director, the Director of Nursing and Midwifery and the Director of Therapies and Health Science.

The Risk Management Framework

The Health Board revised its approach to risk management in 2021 which resulted in a substantial revision of the Risk Management Strategy. The revised approach is predicated on a risk-based assessment of organisational, life course objectives as described within the approved Health Board IMTP, identifying the risks to delivery. The approach also takes into consideration previous findings from Audit Wales' Structured Assessment Reviews and Internal Audit's recommendations in relation to risk management.

This approach is a hybrid model of best practice risk management frameworks including COSO Enterprise Risk Management Framework, ISO 31000 and usual Health systems risk management approaches.

At each Board meeting, the Health Board receives a Strategic Risk Report which provides a high-level account of all risks included on the corporate risk register and the principal risks outlined within the Board Assurance Framework (with a score of 15 or greater). This report is published in the public domain, ensuring transparency and honesty around the strategic risks the Health Board has identified as obstacles to delivery of the IMTP. Members of the public and any other stakeholders have the opportunity to comment or raise queries on these risk reports, in line with the Health Board Standing Orders.

The Health Board's electronic risk management system and associated functionality provides a useful mechanism for operational teams to record risks, raise and escalate risks to a Strategic level via an alert to the Corporate Risk Register and subsequently the Head of Corporate Services, Risk and Assurance. In addition to this, the Executive Directors of the Health Board hold assurance meetings with their respective Divisions to discuss management of ongoing risks that Divisions hold and provides a further opportunity to escalate risks.

In relation to Quality, Patient Safety risks, the Health Board has a well-established Quality Patient Safety Operational Group that reports to the Patient Quality Safety and Outcomes Committee (PQSO). This meeting is chaired by the Director of Therapies and Health Science and extends its membership to other clinical Executive colleagues. The Terms of Reference and membership of this Group is currently under review to ensure it remains fit for purpose.

At each Executive Team meeting there is a dedicated, standing risk section on the agenda to provide the opportunity for any horizon scanning, strategic risks to be raised and for any Divisional risks to be escalated from relevant Directors. These mechanisms enhance and offer further structure

and support to the revised organisational risk management approach outlined above and endorsed by the Health Board in 2021.

The approach allows for risks to be escalated from an operational level if they are identified as themes across the organisation but conversely enables a strategic, horizon scanning avenue for Executives and Board members to highlight risks and escalate to the Corporate Risk Register. It also lends itself to be laterally informed by legislation and Welsh Government directives.

The Health Board will continue to embed its Risk Management Strategy throughout 2022/23 supplemented by a risk management strategy realisation plan which was recently endorsed at the Audit, Risk and Assurance Committee in April 2022. The Audit, Risk & Assurance Committee will remain responsible for monitoring implementation of the plan to ensure the organisation reaches its full potential in relation to the revised Risk Management Strategy. In monitoring the ongoing implementation, any risks to delivery or gaps in assurance can be identified with remedial actions agreed and implemented to mitigate and ensure the plan continues to progress. It is anticipated that delivery of the risk management realisation plan will be complete by April 2023.

To further support this work, a Risk Management Community of Practice has been established within the Health Board to allow for organisational learning, examples of best practice and challenges and issues regarding risk management to be raised. This group has met twice and has bi-monthly dates scheduled for meetings to continue throughout 2022 and into 2023, supplemented through an agreed programme of topics to discuss at each meeting. A copy of the adopted Terms of Reference for the Risk Management Community of Practice is available here.

The Risk Management Community of Practice has a good level of attendees from a broad cross-section of the organisation, these attendees have become 'risk champions' for their areas and provide a vital link between corporate, strategic risk management and operational implementation. It is anticipated that as this Community of Practice continues to establish, training and competencies can be shared across Divisions and Directorates enabling a coherent and consistent approach to risk management and provide a mechanism for levering a shift in risk management culture.

Board Assurance Framework

The Board Assurance Framework provides the Board with an overview of the Principal Risks to achievement of its Strategic Objectives, along with a position on the level of assurance that it can reasonably take in relation to each risk. The Board Assurance Framework is aligned to the Health Board's Risk Management System and Quality Governance System to ensure that the Board is focussed on risk management and performance at an integrated strategic and operational level.

The Board Assurance Framework is used to identify gaps in assurance and therefore drives the focus of the Board and its Committees in seeking required assurance and thus ensuring the delivery of strategic objectives and the management of strategic risks. The Board Assurance Framework is underpinned by a risk based Internal Audit Programme as a means of ensuring objective assurance to the Board is also available.

The Board received the revised Board Assurance Framework at its May 2021 meeting, and a half year review was presented at its November 2021 meeting.

During 2021/22, Internal Audit undertook a review of the Board's arrangements for utilising its Board Assurance Framework and concluded that the Board could take reasonable assurance that it had robust arrangements in place, in this regard. In 2022/23, the Health Board will work to mature its assurance management approach, integrating further strategic risk and assurance mapping. This will be supplemented with a programme of training and support for the organisation to embed integrated risk and assurance systems and processes at all levels of the organisation. This forms an integral aspect of the risk management strategy realisation plan that was presented to Audit, Risk and Assurance Committee in April 2022.

COVID 19 Pandemic – Risk Management

The need to plan and respond to the COVID-19 pandemic presented the Health Board with a number of challenges to the organisation and a number of new and emerging risks were identified. Continuous monitoring and review of these risks informed action plans for mitigation and contributed to the Health Board's plans and priorities during 2020/21/22.

Whilst the organisation did have a major incident and operational business continuity plans in place, as required by the Civil Contingencies Act 2004, the scale and impact of the pandemic has been unprecedented. Significant action has been taken at a national and local level to prepare and respond to the likely impact on the organisation and population. This has also involved working in partnership on the multi-agency response as a key member of the Strategic Co-ordination Group. There does remain a level of uncertainty about the overall longer-term impact this will have on the delivery of services by the organisation, however, based on the intelligence and information provided, as Accountable Officer, I am confident that all appropriate action is being taken.

The organisation continues to work closely with a wide range of partners, including the Welsh Government, as it continues with its response and planning into the recovery phase. It will be necessary to ensure this is underpinned by robust risk management arrangements and the ability to identify, assess and mitigate risks which may impact on the ability of the organisation to achieve their strategic objectives.

Further detail on the Health Board's Emergency Planning arrangements is provided within Part 1: The Performance Report.

Management of Risks During 2021/22

The Health Board made progress during 2021/22 in relation to risk management and this is evidenced through the reasonable assurance rating obtained from Internal Audit on organisational risk management processes. However, it is recognised that further development work is required, and this is planned to be taken at pace over the course of the next 12-18 months. An outline of the key deliverables described within this plan is available here.

The main areas of organisational risks during 2021/22 related to COVID-19 and sustained pressure on acute/secondary, primary and tertiary services impacted from COVID itself, compounded by previous societal actions undertaken due to the pandemic, the impact from which is yet to be fully understood and won't be for some time.

The most recent risk to be added to the Corporate Risk Register reflects the current conflict position in Ukraine and makes an assessment as to any potential impacts on the Health Board. A copy of the risk profile, inherent, current and target score assessment, risk appetite, internal controls and action plans to mitigate the risk is available here.

The Health Board's Risk Profile

As at end of May 2022 there are **23** Organisational Risk Profiles, of which **13** form Principal Risks due to the scoring being 15 or greater and are included and monitored via regular strategic risk reports to the Board and included in the Board Assurance Framework. The following table provides a breakdown of the risks and level of severity:

High	13
Moderate	8
Low	2

The **23 risks** which comprise the Corporate Risk Register are broken down into the following themes:

Theme Area	Number of Risks on Corporate Risk Register
Quality, Patient Safety	9
Financial	2
Environmental	1
Reputational/legislative	2
Workforce	1
ICT	2
COVID (Specific VoC)	1
Staff Well-being	1

A copy of the latest Strategic Risk Report presented to Board in May 2022 which includes an overview of all risks on the corporate risk register is available here. Within the high-level risk description for each risk profile, an assessment has been made to determine if the risk has occurred as a result of the pandemic. The Health Board took the decision in early 2021 to amalgamate the corporate risk register with the COVID risk register as it became clear that COVID would become part of core business and needed to be managed as such.

Risk Appetite

As part of its risk management arrangements, the Health Board has agreed a set of definitions in relation to risk appetite and attitude which is outlined in the table below. The risk ***Appetite*** can be applied to shorter term risks and can be more dynamic; however, the risk ***Attitude*** is usually applied to longer term risks and tends to be more fixed. It is noted, however, that the risk Appetite and Attitude definitions will be reviewed in order for the Health Board to progress its organisational approach to risk management.

Assessment	Description of potential effect
Very High ('hungry' for risk) Risk Appetite Level 5	The Health Board accepts and tolerates some risks because of the potential short and long term benefits that might arise. However, it recognises that this might result in reputational damage, financial impact or exposure, major breakdown in services, information systems or integrity problems, significant incidents of regulatory and/or legislative compliance issues, potential impact on staff/service users.
High (open to risk) Risk Appetite Level 4	The Health Board is willing to Tolerate or Treat risks that may result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users. This level of appetite is predicated on the benefits being anticipated to be significantly advantageous to the Health Board.
Moderate (cautious risk taking) Risk Appetite Level 3	The Health Board is willing to Treat, Tolerate, Transfer (upon a balance of residual risks) risks in certain circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users.

Assessment	Description of potential effect
Low (averse to risk) Risk Appetite Level 2	The Health Board aspires to Treat, Transfer or Terminate (except in very exceptional circumstances) risks that may result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users.
Zero (avoid taking risks) Risk Appetite Level 1	The Health Board aspires to Terminate risks under any circumstances that may result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users or public.

Changes to standard reporting templates has enabled the Board to become more aware of risk appetite in relation to the risk profiles it is responsible for. The revised template for cover reports for Committees and the Board provides a high-level overview of the risks being managed within the Committee or Board's portfolio and whether they are being managed within the agreed risk appetite level. Further work is now required to ensure that where risks are not managed within agreed limits, robust plans and objectives are in place to de-escalate. This will lead to a greater sense of control amongst the risk management culture within the Health Board.

A Board Development session specifically in relation to risk appetite is planned for 22nd June 2022 to refresh and ensure understanding of the agreed risk appetite levels currently in use within the Health Board (previously agreed in 2020).

THE CONTROL FRAMEWORK

Quality Assurance Framework

Ensuring patients and their families receive high quality, safe, compassionate care from staff who are supported to work in a culture of openness and transparency is a fundamental objective of the Board. The Board is accountable for ensuring the quality and safety of the services it provides and commissions.

The Board has an approved Quality Assurance Framework 2020-23. The specific purpose of the Framework is to realise the vision of care, which is:

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

with systematic, continuous and sustained improvement in the quality of care provided by Aneurin Bevan University Health Board.

The Quality Assurance Framework forms an essential element of the overall system and controls that are in place within the Health Board; whose purpose is to mitigate and manage risk which may occur with regard to the achievement of our strategic objectives and priorities as set out in the Health Board's Integrated Medium-Term Plan. The Framework is aligned to the Board's Assurance Framework and has inherent links to the Risk Management Strategy.

The Health Board's Quality Assurance Framework Domains are set out as:

1. Staff engagement and feedback
2. Service user engagement and feedback
3. Leadership and learning
4. Risk Management
5. Improvement methodology
6. Quality intelligence and performance reporting.

The Health Board's Quality Assurance Framework Structure comprises a range of groups, each of which focus on an aspect of quality and safety with all ultimately reporting to the Board's Quality & Patient Safety Committee, via the Quality and Patient Safety Operational Group (QPSOG).

The Quality and Patient Safety Operational Group is chaired by the Executive Director for Therapies and Health Sciences and brings together the corporate leads for an aspect of quality with senior representatives from every Division. The Terms of Reference and membership of this Group is currently under review to ensure it remains fit for purpose.

In May 2022, Audit Wales, published its review of Quality Governance arrangements within Aneurin Bevan University Health Board. The review examined the organisation's governance arrangements to support delivery of high quality, safe and effective services and focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. The Review concluded:

"Overall, we found that the Health Board has clearly articulated the corporate arrangements for quality governance and its key areas of focus for quality and safety. However, there remain weaknesses at a divisional and directorate level which could impact the flow of assurance from floor to board."

The Review set out eight areas for improvement which the Health Board will work to address in 2022/23. The Board's Patient Quality, Safety and Outcomes Committee will monitor delivery of the required actions.

Health and Care Standards

The Wales Health and Care Standards (HCS) came into force from 1 April 2015 and provides the "…basis for improving the quality and safety of healthcare services by providing a framework which can be used in

identifying strengths and highlighting areas for improvement." (NHS Wales Health and Care Standards. Welsh Government, 2015).

The Health and Care Standards are grouped into 7 themes and provide the framework against which the Health Board assesses all services, to identify gaps, risks and areas for improvement.

The Health Board's Quality Assurance Framework is mapped to the Health and Care Standards and covers the themes of Patient Safety, Clinical Effectiveness, Dignified Care and Individual Care. The Health Board's Quality and Patient Safety Operational Group reports to each meeting of the Board's Patient Quality, Safety and Outcomes Committee (PQSOC) and escalates issues to it as appropriate. For each standard, a Corporate Standard Holder is identified who has expertise in that standard and provides an overview of what, should be in place to meet the standard. The overview lays out both the corporate systems and processes for the standard and what the Health Board's Divisions need to do to meet the standard. The Board's Patient Quality, Safety and Outcomes Committee receives an annual report setting out compliance with each standard, ensuring the Health and Care Standards remain at the heart of the Health Board, as the main quality assurance framework for the NHS in Wales.

Information Governance

The Health Board has a range of responsibilities in relation to the information that it holds, uses, and shares. The Medical Director is the Health Board's Caldicott Guardian and the Director of Planning, Performance, Digital and IT is the Senior Information Risk Owner (SIRO).

During 2021/22, the Health Board continued to implement processes and communications around information asset tracking, General Data Protection Regulations (GDPR) and data protection. The information governance e-learning training material was revised and made available on the intranet for staff. Revision of privacy notices at a national and local level have taken place and are being deployed. Information governance policies continue to be reviewed on an all-Wales basis as part of the collaborative work required in light of GDPR to ensure consistency of policy content and context across organisations.

The Health Board continues to be proactive in using the NHS Wales Information Governance management support framework to ensure consistency of policy, standards and interpretation of the law and regulation across NHS Wales' organisations.

During 2021-22, the Health Board received just over 5,000 Data Protection Act Subject Access Requests (SARs); this is a 10% increase since 2020-2021. The largest proportion of requests received continues to be made by solicitors and legal services. Compliance rate with Subject Access Requests has varied over the year, with a maximum compliance of 95% achieved and a compliance rate of 92% for March 2022.

The Wales Accord on the Sharing of Personal Information (WASPI) framework is embedded in the way in which the Health Board shares relevant information with its partner organisations. This was important when sharing personal information between partners as part of the COVID-19 response.

A personal data incident is a breach of security leading to the accidental or unlawful destruction, loss, alteration, un-authorised disclosure of, or access to personal data. In line with GDPR requirements, all personal data incidents must be reviewed daily, and any incidents deemed significant must be formally reported to the Information Commissioner's office (ICO) within 72 hours. During 2021/22, there were no personal data incidents formally reported to the ICO. During 2021/22, there were no material lapses of data security, other than trivial ones.

During 2021/22, six complaints were made to the Information Commissioners Office (ICO) by complainants, with none upheld. The Health Board provided supportive evidence to the ICO in all cases to demonstrate that it was acting within the law and had provided the complainants with an effective service regarding their information. As a result, no action was taken by the ICO against the Health Board.

During 2021/22, there were 722 information governance incidents recorded by staff on the Health Board's DATIX Incident Reporting System: an increase of 62 from the previous year. These incidents are of varying levels of concern, such as missing pages in a paper record, to ICT systems being unavailable for a period, but none were reported as major incidents.

The Corporate Governance Code

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include Self-assessment; Internal and External Audit; and Independent Reviews.

The Board is clear that it is complying with the main principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales. A copy of the current self assessment against the code is provided as Attachment Three.

PLANNING ARRANGEMENTS

The NHS Wales Finance Act 2006 requires the submission to Welsh Government of Integrated Medium-Term Plans (IMTP) for approval. In April 2020, the Welsh Government wrote to all Health Boards and Trusts to formally pause the IMTP process in light of the Covid-19 pandemic. Subsequently, in December 2020, the Welsh Government issued the NHS Wales Annual Planning Framework for 2021 to 2022. This confirmed that the full IMTP process remained paused and that NHS organisations were required to submit Board approved Draft Annual Plans to Welsh Government by the 31st March 2021. The Welsh Government would not be formally assessing the plans submitted. The Health Board submitted a Board approved Annual Plan on 31st March 2021.

In December 2021 Welsh Government confirmed the resumption of the formal IMTP process following the decision in 2020 to pause this requirement in the light of the COVID-19 pandemic. At that same time Welsh Government issued the NHS Wales Annual Planning Framework for 2022 to 2025.

At its meeting in March 2022, the Board approved its IMTP for 2022-25 for submission to Welsh Government. Confirmation of Welsh Government approval is awaited at the time of writing.

The Health Board's Integrated Medium-Term Plan 2022-25 is a natural progression from the Annual Plan 2021/22, building on the life course approach, whilst recognising the context within which the Health Board now operates is different from the one recognised in 2020/21. This being a renewed focus on sustainable recovery, which is characterised by a fundamental shift that encompasses the wider role of Health and Social Care in reducing health inequalities, delivering the foundational economy, and protecting the environment for future generations with the Net Zero 2030 ambition.

MANDATORY DISCLOSURE STATEMENTS

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Further detail in this regard is included within the provisions note within the 2021/22 Financial Statements (Note 20).

Equality, Diversity & Human Rights

At its meeting in March 2022, the Board received its Annual Equality report for 2020/21, which set out the work that was undertaken from 01 April 2020 - 31 March 2021 within the Health Board to meet Health Board objectives that were identified and agreed within the Strategic Equality Objectives. The report also included the Equality Monitoring data based on a snapshot as of 31 March 2021.

Progress has been made in the delivery of the Health Board's equality objectives and the range of information the organisation is increasingly able to draw on. The Health Board recognises that due to the entrenched nature of some inequalities stronger progress must continue to be made and these have been carried forward via the Strategic Equality Objectives for 2020 – 2024, integrated into the Health Board's IMTP and response to the Regional Partnership Board's Population Needs Assessment 2022-2027.

The pandemic has further highlighted existing inequalities and has widened others. Older people, ethnic minority people and some disabled people, particularly those in care homes, have been disproportionately impacted by the pandemic. The Health Board will keep the Strategic Equality Plan 2020-2024 under review to ensure that as more evidence continues to emerge the action plan will reflect what needs to be done to address inequalities.

The Health Board's Annual Equality Report 2020/21 can be found on the Health Board's website.

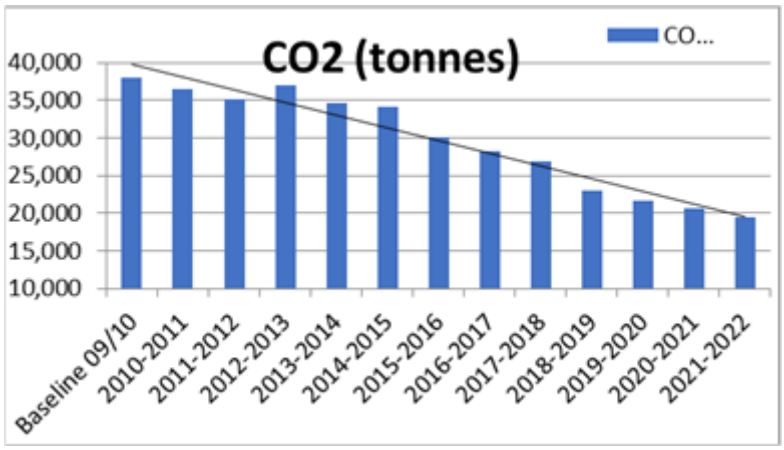
Sustainability and Carbon Reduction Plans

Risk assessments are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Health Board continues to align its activities to complement and make progress towards the objectives and targets set out in the NHS Wales Decarbonisation Strategic Delivery Plan, published by Welsh Government in 2021. The Plan responds to the declaration of the climate emergency in 2019 and the ambition of Welsh Ministers for the Welsh public sector to be net zero by 2030. In 2022/23, the Health Board will establish its Decarbonisation Framework in response to the national plan.

In the last decade the Health Board has made consistent progress with reducing both energy consumption and carbon emissions from its estate.

Since the original baseline in **2009/10** the Health Board has cut carbon emissions by **18,663 tonnes CO2**, equating to a **49%** reduction. For 2021/22 the Health Board reports carbon emissions from its buildings as **19,400 tonnes** (excluding the Grange University Hospital).



The Health Board continues to work towards introducing more sustainable and resource efficient methods of processing waste generated from health care activities. The Health Board continues to work towards implementing a zero to landfill approach in collaboration with external contractors.

The Health Board continues to operate a third party certified Environmental Management System (EMS) to the international standard ISO 14001:2015. The EMS has been developed to become the focal point for driving forward continual environmental improvement. It provides a joined-up approach for the management of waste minimisation initiatives, recycling, energy and carbon management, sustainable procurement and sustainable travel initiatives. The Health Board places high importance on continued certification to ISO 14001 and the assurance it provides to the Board and our stakeholders.

The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the estate. To this end a number of local initiatives are in place including wildflower planting in conjunction with external art installations at the Grange University Hospital, the continued success and development of the Walled Garden at Llanfrechfa Grange by the charitable organisation 'Friends of Llanfrechfa Grange Walled Garden' and the Cardiff University Pharma-Bees project at Ysbyty Ystrad Fawr.

The Board's Partnerships, Population Health and Planning Committee received a presentation on the Health Board's Decarbonisation Plans at its meeting in April 2022. The Board will receive its Annual Sustainability Report in September 2022, which will be published to the Health Board's website.

Quality of Data

The Health Board makes every attempt to ensure the quality and robustness of its data and has regular checks in place to assure the

accuracy of information relied upon. However, it is recognised that the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement. We have an on-going data quality improvement approach which routinely assesses the quality of our data across key clinical systems. Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

The Board relies upon independent and objective assurances, such as those provided by auditors and inspectors, to comment upon the effectiveness of the Board's assurance system. This assurance system includes reporting on financial performance, operational performance and quality of and associated outcomes.

Ministerial Directions & Welsh Health Circulars

The Welsh Government has previously issued Non-Statutory Instruments and reintroduced Welsh Health Circulars (WHCs) in 2014/15. Details of these and a record of any ministerial directions given is available on the Welsh Government website. A full detail of the WHCs issued to the Health Board in 2021/22 and the Health Board's responding action is included at **Attachment 2**.

There have been no Ministerial Directions issued in 2021/22. There was one Ministerial Direction issued in December 2019, to address the operational challenges arising as a consequence of pension tax arrangements. Further detail in this regard is included under Contingent Liabilities within the 2021/22 Financial Statements (Note XX).

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation.

During 2021/22, the Board's Audit, Finance and Risk Committee and Quality, Patient Safety and Outcomes Committee has played a key role in monitoring the effectiveness of internal control and the process for risk management. Work will continue in 2022/23 to strengthen the reporting of

risks to the Board and its Committees. We will ensure that the work of all regulators, inspectors and assurance bodies is mapped and evidenced in our assurance framework so that the Board is fully aware of this activity and the level of assurance it provides. We will also continue to strengthen arrangements for monitoring and reporting progress in implementing recommendations arising from the work of auditors.

The Health Board also uses reports from Healthcare Inspectorate Wales, the Welsh Risk Pool and other inspectorates and regulatory bodies to inform the governance and assurance approaches established by the organisation. A tracking mechanism for these recommendations is also in place and progress in delivering these recommendations is overseen by the Patient Quality, Safety and Outcomes Committee via updates in respect of Inspections.

INTERNAL AUDIT

Internal audit provides me as Accountable Officer and the Board through the Audit, Finance and Risk Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Finance and Risk Committee and is focussed on significant risk areas and local improvement priorities.
The overall opinion by the Head of Internal Audit on governance, risk management and control, is a function of this risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The programme has been impacted by the need to respond to the COVID-19 pandemic with some audits deferred, cancelled or curtailed as the organisation responded to the pandemic. The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

Head of Internal Audit's Opinion for 2021/22

The Head of Internal Audit Opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control for 2021/22 is set out below:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

Due to the ongoing impact of COVID-19 on the organisation, the internal audit plan during 2021/22 needed to be agile and responsive to ensure that key developing risks were covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed schedule. Changes required during the year have been approved by the Audit, Risk and Assurance Committee. In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, Internal Audit has confirmed that sufficient audit work has been undertaken during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2021/22 year was initially presented to the Committee in March 2021. The audit coverage in the plan was deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore have highlighted control weaknesses that impact on the overall assurance opinion.

Overall, the Head of Internal Audit was able to provide assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas as set out in the table below.

The Head of Internal Audit's Opinion confirms that, where a Limited Assurance has been given, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. In addition, and in part reflecting the impact of COVID-19, Internal Audit also undertook a number of advisory and non-opinion reviews to support the overall opinion. A summary of the audits undertaken in the year and the results are summarised in the table below.

Substantial Assurance	Reasonable Assurance
• Clinical Negligence Costs • Charitable Funds • Occupational Health	• Financial Sustainability (Draft) • Gifts, Hospitality and Declarations of Interest • Putting Things Right

• GUH: Financial Assurance (Follow-up) • GUH: Technical Assurance	• Operational Plan for Resumption of Services (Draft) • Pathology • Medicines Management (Draft) • Falls Management • Facilities – Care after Death • Corporate Governance (Draft) • Mental Capacity Act • Flu Immunisation • Flow Centre (Draft) • Risk Management • IT System Controls • Tredegar Health and Wellbeing Centre • GUH: Follow-up • GUH: Quality • Waste Management (Draft) • Network and Information Systems (NIS) Directive
Limited Assurance	**Advisory & Non-Opinion**
• Continuing Healthcare •	• Datix (Support of Incident Management) • Follow-up of High Priority Recommendations • Medical Equipment and Devices
No Assurance	
N/A	

Limited Assurance Rated Reviews

Continuing healthcare

The purpose of this review was 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.

In determining a limited level of assurance, Internal Audit identified a number of matters which required management attention, including:

- ensuring sustainable improvements in terms of accountability and scrutiny for commissioned services is undertaken;
- ensuring wider Divisional attention and oversight of CHC / S117 commissioning activity is in place;
- the need for assessing the quality of services delivered by providers on the All Wales Framework (AWF) is completed; and
- 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.

In undertaking the review, Internal Audit recognised that the Division had already identified the need for work in these areas and whilst some progress had been made, the impact of the Pandemic had further progress.

The Audit, Risk and Assurance Committee considered the management action plan at its meeting on 7th April 2022 to respond to the weaknesses identified and will monitor progress in line with agreed timescales via the Audit Recommendations Tracker. The process for which was also set out in a paper to the Audit, Finance and Risk Committee on 7th April 2022.

Network and Information Systems (NIS) Directive
The purpose of this review was to seek assurance on the effectiveness of arrangements in place for the implementation of the NIS (Network and Information Systems) Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.
To be included when report received

EXTERNAL AUDIT: AUDIT WALES STRUCTURED ASSESSMENT

The Audit Wales Structured Assessment Report for 2021, examined the arrangements the Health Board has in place to support good governance across key areas of the Health Board's business and the efficient, effective, and economic use of resources. The Report concluded with the following assessment:

Overall, we found the Health Board maintains adequate Board and Committee arrangements and is embedding its new governance structure alongside its assurance mechanisms, but there are opportunities to assess the effectiveness of these arrangements. 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 has effective financial management arrangements enabling it to meet its financial duties over the last three years. However, its underlying deficit presents a risk to financial sustainability going forward. Arrangements for developing and submitting the Annual Plan are effective. Whilst the Annual Plan provides clarity on strategic objectives and has informed Board and Committee business, there has been limited oversight and scrutiny on overall delivery of the Annual Plan at Board-level.

The Health Board has committed to undertake a number of improvement actions during 2022 to respond to this assessment. The progress against these actions will be monitored by the Executive Team and the Health Board's Committees, with the overall organisational response to these actions will be kept under review through the Audit, Risk and Assurance Committee's reporting and tracking mechanisms.

The Structured Assessment 2021, along with the Health Board's response, is available on the Audit Wales website.

CONCLUSION

As Accountable Officer for Aneurin Bevan University Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the board and its Executive Directors are alert to their accountabilities in respect of internal control and the Board has had in place during the year a system of providing assurance aligned to corporate objectives to assist with identification and management of risk. I am pleased to note that, as a result of our internal control arrangements, Aneurin Bevan University Health Board continues to be on 'routine' monitoring as part of NHS Wales Escalation and Intervention arrangements.

During 2021-22, the Health Board proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Further work will be undertaken in 2022/23 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will also continue in 2022/23 to embed risk management and the assurance framework at a corporate level. Implementation of the Board's Annual Governance Priorities, set out within the IMTP 2022-25, will see a further strengthening of the Board's effectiveness and the system of internal control in 2022/23.

This Annual Governance Statement confirms that Aneurin Bevan University Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board and the Executive Team has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board, I will continue to drive improvements and will seek to provide assurance for our citizens and stakeholders that the services we provide are efficient, effective and appropriate, and are designed to meet patient needs and expectations.

As indicated throughout this statement, the need to plan and respond to the COVID-19 pandemic and its longer-term implications has had a significant impact on the organisation, wider NHS and society as a whole. It has required a dynamic response that has presented a number of opportunities in addition to the risks. The need to respond and recover from the pandemic will be with the organisation and wider society throughout 2021/22, 2022/23 and beyond. I will ensure our Governance Framework considers and responds to this need.

Signed:

Glyn Jones, Interim Chief Executive
Dated: XX June 2022

MODERN SLAVERY ACT 2015 – TRANSPARENCY IN SUPPLY CHAINS

The Health Board is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds.

The code of practice sets out a number of commitments and Procurement Services on behalf of the Health Board has commenced the preparation of an action plan so that it can monitor progress against these. As an example, The Health Board have included the requirement for all suppliers to meet the Act in our standard NHS Terms and Conditions of contract.

Also, following the Transparency in Supply Chains consultation (2019), the UK Government has committed to extend section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales with a budget of £36m or more – This requires organisations to produce annual statements by 30th September of each financial year, that provide details of steps taken to prevent modern slavery in their operations and supply chain. A draft statement is being compiled by Procurement Service and Legal/Risk in readiness for the 30th of September deadline, reflecting the work to date, any further and emerging risks and appropriate mitigations.

The procurement function is a key area for ethical employment in supply chains. This is run by NHS Wales Shared Services Partnership (NWSSP) which is hosted by Velindre University NHS Trust (Velindre). More information can be found on the work done on the Health Board's behalf by NWSSP on the Shared Services Partnership website.

Attachment One

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil Champion roles where they act as ambassadors for these matters.

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Independent Members					
Ann Lloyd	Chair		Chair of the Board	6 out of 7	
			Chair, Remuneration and Terms of Service Committee	3 out of 3	
			Chair, Strategy, Planning Partnerships and Wellbeing Group	5 out of 5	
Emrys Elias	Vice Chair	Until 30th September 2021	Vice Chair of the Board	4 out of 4	Mental Health (until 30/9/21)
			Member Audit, Finance and Risk Committee (until 30/9/21)	4 out of 4	
			Chair, Mental Health Act Monitoring Committee (until 30/9/21)	1 out of 2	
			Chair, Patient Quality, Safety and Outcomes Committee (until 30/9/21)	3 out of 3	
			Member, Remuneration and Terms of Service Committee (until 30/9/21)	1 out of 1	
			Member, Strategy, Planning Partnerships and Wellbeing Group	2 out of 2	
Pippa Britton	Independent Member (Community)	Until 17th October 2021	Interim Vice Chair of the Board (from 18/10/21 – previously	6 out of 7	Mental Health (from

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Independent Member(Community) of the Board		18/10/21) Putting Things Right
	Interim Vice Chair	From 18th October 2021	Chair, Mental Health Act Monitoring Committee (from 28/10/21)	2 out of 2	
			Chair, Patient Quality, Safety and Outcomes Committee (from 28/10/21) (previously Vice Chair)	4 out of 6	
			Chair, People and Culture Committee (until 8/10/21)	3 out of 3	
			Vice Chair, Remuneration and Terms of Service Committee	3 out of 3	
			Member, Strategy, Planning Partnerships and Wellbeing Group	4 out of 5	
Katija Dew	Independent Member (Third Sector)		Member of the Board	7 out of 7	Older Persons
			Member of Audit, Finance and Risk Committee	7 out of 7	
			Vice Chair, Mental Health Act Monitoring Committee	4 out of 4	
			Chair, Charitable Funds Committee	4 out of 4	
			Member, Strategy, Planning Partnerships and Wellbeing Group	5 out of 5	
Shelley Bosson	Independent Member (Community)		Member of the Board	7 out of 7	Infection Prevention and Control
			Chair, Audit, Finance and Risk Committee	7 out of 7	
			Member, Patient Quality, Safety and Outcomes Committee	5 out of 6	
			Member, Remuneration and Terms of Service Committee	3 out of 3	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Member, Strategy, Planning Partnerships and Wellbeing Group	5 out of 5	
Louise Wright	Independent Member (Trade Union)		Member of the Board	5 out of 7	Children and Young People
			Member Patient Quality, Safety and Outcomes Committee (from 28/10/21)	3 out of 3	
			Vice Chair, Charitable Funds Committee	4 out of 4	
			Chair, People and Culture Committee (from 28/10/21), previously Vice Chair	3 out of 3	
			Member, Remuneration and Terms of Service Committee (from 8/10/21)	2 out of 2	
			Member, Strategy, Planning Partnerships and Wellbeing Group	5 out of 5	
Richard G Clarke	Independent Member (Local Authority)		Member of the Board	6 out of 7	
			Vice Chair, Audit, Finance and Risk Committee	6 out of 7	
			Member, Strategy, Planning Partnerships and Wellbeing Group	3 out of 5	
Professor Helen Sweetland	Independent Member (University)		Member of the Board	6 out of 7	
			Member, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Member, People and Culture Committee	2 out of 2	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Member, Strategy, Planning Partnerships and Wellbeing Group	4 out of 5	
Paul Deneen	Independent Member (Community)		Member of the Board	7 out of 7	Equality
			Member of Audit, Finance and Risk Committee (from 8/10/21)	3 out of 3	
			Member, Mental Health Act Monitoring Committee	3 out of 4	
			Member, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Member, People and Culture Committee (from 28/10/21)	0 out of 1	
			Member, Strategy, Planning Partnerships and Wellbeing Group	5 out of 5	
Keith Sutcliffe	Chair, Stakeholder Reference Group		Associate Member of the Board	3 out of 7	Armed Forces & Veterans
			Member, Charitable Funds Committee	1 out of 4	
			Member, Strategy, Planning Partnerships and Wellbeing Group	1 out of 5	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Executive Directors					
Judith Paget	Chief Executive	Until 1st November 2021	Member of the Board	4 out of 4	
			Member, Charitable Funds Committee (until 1/11/21)	0 out of 1	
			Member, Strategy, Planning Partnerships and Wellbeing Group	2 out of 3	
			Attendee as requested at all Board Committees		
Glyn Jones	Interim Chief Executive	From 1st November 2021	Member of the Board	3 out of 3	
			Member, Charitable Funds Committee	1 out of 2	
			Member, Strategy, Planning Partnerships and Wellbeing Group	2 out of 2	
			Attendee as requested at all Board Committees		
Glyn Jones	Director of Finance and Performance/Deputy Chief Executive	Until 1st November 2021	Member of the Board	4 out of 4	
			Member, Charitable Funds Committee	1 out of 2	
			Member, Strategy, Planning, Partnerships and Wellbeing Group	1 out of 3	
			Attendee as requested at all Board Committees		
Rob Holcombe	Interim Director of Finance, Procurement and Value Based Healthcare	From 1st November 2021	Member of the Board	3 out of 3	
			Member, Charitable Funds Committee	3 out of 3	
			Member, Strategy, Planning Partnerships and Wellbeing Group	1 out of 2	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Required Attendee: Audit, Finance and Risk Committee		
			Attendee as requested at all Board Committees		
Dr James Calvert	Medical Director		Member of the Board	7 out of 7	Caldicott
			Member, Strategy, Planning Partnerships and Wellbeing Group	2 out of 5	
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Geraint Evans	Director of Workforce and OD	Until 31st August 2021	Member of the Board	1 out of 1	Raising Concerns Welsh Language
			Member, Strategy, Planning Partnerships and Wellbeing Group	2 out of 2	
			Required attendee: People and Culture Committee		
			Attendee as requested at all Board Committees		
Sarah Simmonds	Director of Workforce and OD	From 22nd July 2021	Member of the Board	6 out of 6	Raising Concerns Welsh Language
			Member, Strategy, Planning Partnerships and Wellbeing Group	2 out of 3	
			Required attendee: People and Culture Committee		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Attendee as requested at all Board Committees		
Nicola Prygodzicz	Director of Planning, Digital and IT	Until 1st November 2021	Member of the Board	3 out of 4	Emergency Planning
			Member, Strategy, Planning Partnerships and Wellbeing Group	3 out of 3	
			Attendee as requested at all Board Committees		
Nicola Prygodzicz	Director of Planning, Performance, Digital and IT / Interim Deputy Chief Executive	From 1st November 2021	Member of the Board	3 out of 3	
			Member, Strategy, Planning Partnerships and Wellbeing Group	2 out of 2	
			Attendee as requested at all Board Committees		
Rhiannon Jones	Director of Nursing		Member of the Board	7 out of 7	Children and Young People Infection Prevention and Control Putting Things Right
			Member, Strategy, Planning Partnerships and Wellbeing Group	1 out of 5	
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Nick Wood	Director of Primary, Community and Mental Health	Until 5th December 2021	Member of the Board	4 out of 5	
			Member, Strategy, Planning Partnerships and Wellbeing Group	4 out of 4	
			Required attendee: Mental Health Act Monitoring Committee		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Attendee as requested at all Board Committees		
Peter Carr	Director of Therapies and Health Sciences		Member of the Board	5 out of 7	Fire Safety Violence and Aggression
			Member, Strategy, Planning Partnerships and Wellbeing Group	3 out of 5	
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Dr Sarah Aitken	Director of Public Health and Strategic Partnerships Director of Public Health and Strategic Partnerships / Interim Director of Primary, Community and Mental Health Services	From 6th December 2021 to 28th February 2022	Member of the Board	6 out of 7	
			Member, Strategy, Planning Partnerships and Wellbeing Group	3 out of 5	
			Required attendee: Mental Health Act Monitoring Committee (6/12/21-28/2/22)		
			Attendee as requested at all Board Committees		
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services	From 28th February 2022	Member of the Board	0 out of 1	
			Member, Strategy, Planning Partnerships and Wellbeing Group		
			Required attendee: Mental Health Act Monitoring Committee		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Attendee as requested at all Board Committees		
Directors in Attendance					
Claire Birchall	Director of Operations	Until 2nd May 2021	Attendee at the Board	0 out of 0	
			Attendee as requested at all Board Committees		
Leanne Watkins	Interim Director of Operations	From 12th April 2021 to 16th March 2022	Attendee at the Board	4 out of 6	
	Director of Operations	From 17th March 2022	Attendee at the Board	1 out of 1	
			Attendee as requested at all Board Committees		
Board Secretary / Director of Corporate Governance					
Richard Howells	Interim Board Secretary	Until 30th November 2021	Attendee at the Board	5 out of 5	
			Attendee as requested at all Board Committees		
Rani Mallison	Board Secretary/Director of Corporate Governance	From 28th November 2021	Attendee at the Board	2 out of 2	
			Attendee as requested at all Board Committees		

Following the departure of the Vice Chair in September 2021, amendments were made to committee membership to enable quoracy.

Quoracy of Meetings

Board/Committee	Date						
Board	26th May 2021	28th July 2021	22nd September 2021	13th October 2021	24th November 2021	26th January 2022	23rd March 2022
Patient Quality, Safety and Outcomes Committee	13th April 2021	15th June 2021	1st September 2021	19th October 2021	7th December 2021	8th February 2022	
Audit, Risk and Finance Committee	8th April 2021	18th May 2021	8th June 2021	12th August 2021	7th October 2021	2nd December 2021	3rd February 2022
Charitable Funds Committee	10th June 2021	9th November 2021	11th January 2022	3rd March 2022			
Strategy, Planning, Partnership and Wellbeing Group	21st April 2021	29th June 2021	21st October 2021	10th November 2021	4th January 2022		
Remuneration and Terms of Service Committee	9th September 2021	10th March 2022					

Quorate	Non-Quorate

Attachment Two

Welsh Health Circular/Date of Compliance	Date/Year of Adoption	Action to demonstrate implementation/response
WHC 2021/005 National Health Service Directions on cross border healthcare and reimbursement of costs of treatment within the EU	6th April 2021	The new directive has been reviewed and implemented, and the previous guidance/procedure updated and followed accordingly.
WHC 2021/008 Revised national steroid treatment card	27th May 2021	The WHC covering letter was circulated to secondary and primary care departments including independent pharmacist and GP practices. The primary care Scriptswitch system is updating both Primary Care IT systems to ensure alerts are triggered on the initiation of steroid prescribing and on the issue of repeat prescriptions. This work is complete with respect to oral and injected steroids but continues in relation to topical and inhaled steroids. In addition, community pharmacist dispense steroid cards on the initiation of prescribing and intermittently thereafter. The Health Board has declared compliance with *PSN057 – Emergency Steroid Therapy Cards*.
WHC 2021/10 Review of standing orders, reservation and delegation of powers	16th September 2021	Standing Orders and Scheme of Delegation amended and approved by the Board.
WHC 2021/11 Health boards and trusts financial monitoring guidance 2021 to 2022	23rd April 2021	Actioned on a monthly basis via signed returns monitoring returns to WG & FDU.
WHC 2021/12 Protocol for dealing with violence and aggression towards NHS staff	22nd April 2021	WHC issued and implemented
WHC 2021/19 The national influenza immunisation programme 2021 to 2022	4th August 2021	WHC issued and implemented: As at 15/03/22 flu vaccination uptake in ABUHB among those 65 years and older and in clinical risk groups aged 6 months to 64 years was the highest in Wales. Uptake in 2 and 3 year olds and Health Board staff was broadly in line with the All Wales average. Focus for the 2022/23 campaign will be 2 and 3 year olds, specific clinical risk cohorts under 65 and care home staff.

Welsh Health Circular/Date of Compliance	Date/Year of Adoption	Action to demonstrate implementation/response
WHC 2021/021 Introduction of Shingrix® for immunocompromised individuals from September 2021	1st September 2021	All practice managers and practice nurses were sent the WHC with specific information and links to the relevant Shingles slide sets for training.
WHC 2021/022 Publication of the quality and safety framework	17th September 2021	The Wales Q&S Framework was presented at a recent QPSOG meeting attended by all Divisions, with a particular focus on the Duty of Quality and the implementation of a Quality Management System approach. The Health Board has recently procured a digital platform to support a quality management system for clinical audit and improvement. The revision of the clinical audit strategy to support a programme of divisional local audit designed to meet quality and safety priorities is currently underway. The QPS team are currently exploring options to recruit a QPS informatics lead who will support improved use of data in line with the framework with a particular focus on supporting Divisions. Key individuals from the Health Board have been identified to support all 5 workstreams for the quality and engagement act. Implementation of stage one of the national reporting framework is now complete.
WHC 2021/023 Care decisions for the last days of life	23rd September 2021	A new End of Life Care Board has been established where the CDG will be monitored. The WHC was disseminated across the Health Board and to partners with a request for immediate implementation.
WHC 2021/024 NHS Wales' contribution towards a net-zero public sector by 2030	8th September 2021	WHC issued and implemented

Welsh Health Circular/Date of Compliance	Date/Year of Adoption	Action to demonstrate implementation/response
WHC 2021/025 All Wales Carpal tunnel syndrome pathway	15th September 2021	WHC issued and implemented
WHC 2021/028 Healthcare associated infections and antimicrobial resistance improvement goals	27th September 2021	The HCAI Welsh Government expectations against the nationally reportable infections are reported at every PQSO Committee, with performance oversight via RNTG.
WHC 2021/026 Overseas visitors' eligibility to receive free primary care	6th October 2021	WHC issued and implemented
WHC 2021/027 NHS Wales blood health plan	27th September 2021	ABUHB endorses the principles of Patient Blood Management as set out in the Blood Health Plan using the following strategies: 1. Pre-optimisation of patient's haemoglobin via pre-operative assessment clinics with use of oral and IV iron as appropriate 2. Minimising blood loss using improved surgical techniques and using Tranexamic Acid for appropriate patients 3. Blood conservation by using intra-operative cell salvage for appropriate patients where moderate blood loss is expected and using single unit transfusions in the stable non-bleeding patient.
WHC 2021/031 NHS Wales Planning Framework 2022 to 2025	9th November 2021	WHC issued and implemented
WHC 2021/032 Role and provision of dental public health in Wales	16th November 2021	Dental Public Health team is employed by Public Health Wales. At national level, 3 Consultants in Dental Public Health have national lead roles on Oral Health Improvement, Dental Services Innovation and Oral Health Intelligence and thus provide dental public health leadership to programmes like Designed to Smile, General Dental Services Reform Programme and Dental Epidemiology Programme in Wales.

Welsh Health Circular/Date of Compliance	Date/Year of Adoption	Action to demonstrate implementation/response
WHC 2021/033 Role and provision of oral surgery in Wales	14th December 2021	Primary Care Oral Surgery and Primary Care Oral Surgery Sedation service was established in substantially in 2014. This is funded via the GDS budget. Contracts are to be reviewed in 2022/23. Service is provided in accordance with the WHC.
WHC 2021/34 Health Board Revenue Allocations 2022023	9th February 2022	WHC issued and implemented
WHC 2022/05 Welsh Value in Health Centre Data Requirements	24th March 2022	WHC issued and implemented
WHC 2022/07 Recording of Dementia Read Codes	15th February 2022	WHC issued and implemented
WHC 2022/10 Reimbursable vaccines and eligible cohorts for the 2022 to 2023 NHS seasonal influenza (flu) vaccination programme	29th March 2022	WHC issued and implemented
WHC 2022/14 Healthcare associated infections and antimicrobial resistance improvement goals	1st March 2022	The HCAI Welsh Government expectations against the nationally reportable infections are reported at every PQSO Committee, with performance oversight via RNTG.

Ministerial Directions (MDs)	Date/Year of Adoption	Action to demonstrate implementation/response
2021. No.41 – Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2021	April 2021	Implemented as required. Payment adjustments via SSP.
2021. No.59 – The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021	July 2021	Implemented as required.
2021. No.65 – The Primary Care (PfizerBioNTech Vaccine COVID-19 Immunisation Scheme) Directions 2021	July 2021	Implemented as required as part of COVID vaccination programme.
2021. No.70 –	August 2021	Implemented as required as part of COVID vaccination programme.

The Primary Care (Contracted Services: Immunisations) Directions 2021		
2021. No.75 – Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2021	September 2021	Implemented as required.
2021. No.77 – The National Health Service (General Medical Services – Recurring Premises Costs during the COVID-19 Pandemic) (Wales) (Revocation) Directions 2021	September 2021	Implemented as required. Revocation applied.
2021. No.83 – The Pharmaceutical Services (Fees for Applications) (Wales) Directions 2021 SI/SR Template (gov.wales)	October 2021	Actioned by Shared Services via service agreement
2021. No.84 – The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2021	October 2021	Implemented as required.
2021. No.85 – The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2021	October 2021	Implemented as required.
2021. No.88 – The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No. 3) Directions 2021	October 2021	Implemented as required. All GDS/PDS contracts managed in accordance with the requirements.
2021. No.89 – The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No. 3) Directions 2021	October 2021	Implemented as required. All GDS/PDS contracts managed in accordance with the requirements.
2021. No.90 – The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) (Wales)	November 2021	Implemented as required as part of Flu/pneumo vaccination programme.

(No. 2) (Amendment) Directions 2021		
2021. No.93 – Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No.3) Directions 2021	December 2021	Implemented as required. Practice declarartion.
2021. No.97 – The Primary Care (Contracted Services: Immunisations) (Amendment) Directions 2021	December 2021	Implemented as required as part of COVID vaccination programme.
2022. No.06 – The Pharmaceutical Services (Clinical Services) (Wales) Directions 2022 SI/SR Template (gov.wales)	March 2022	Actioned by Shared Services and ABUHB Community Pharmacy Team
2022. No.13 – The Wales Infected Blood Support Scheme (Amendment) Directions 2022	March 2022	N/A- for action by Velindre University NHS Trust.

Attachment Three

Corporate governance in central government departments: code of good practice 2017

Aneurin Bevan University Health Board Assessment 2021/22

Chapter 2 The Role of the Board	
Applicable Paragraphs	**Assessment**
Principle: ***2.1 Each department should have an effective board, which provides leadership for the department's business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the department.***	
2.2 The board forms the collective strategic and operational leadership of the department, bringing together its ministerial and civil service leaders with senior non-executives from outside government, helping the department to operate in a business-like manner. The board's role includes appropriate oversight of ALBs. 2.3 The board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance • Accountability – promoting transparency through clear and fair reporting • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there	Aneurin Bevan University Health Board has a Board, which comprises Independent Members appointed by the Minister for Health and Social Services, and Executive Members appointed by the organisation. The Board is headed by a Chair appointed by the Minister and a Chief Executive, who is the Accountable Officer to the Chief Executive of NHS Wales/Director General for Health and Social Services, Welsh Government. The work of the Board is guided and determined by its Standing Orders, Standing Financial Instructions and Schemes of Delegation. This provides the framework for delegation and decision making within the Health Board. The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. The Board seeks an open culture and high standards in the ways in which its work is conducted. Board Members share corporate responsibility for all decisions and undertake a key role in monitoring the performance of the organisation.

2.4 The board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. It advises on five main areas: • Strategic Clarity – setting the vision and/or mission and ensuring all activities, either directly or indirectly, contribute towards it; long-term capability and horizon scanning, ensuring strategic decisions are based on a collective understanding of policy issues; using outside perspective to ensure that departments are challenged on the outcomes • Commercial Sense – approving the distribution of responsibilities; advising on sign-off of large operational projects or programmes; ensuring sound financial management; scrutinising the allocation of financial and human resources to achieve the plan; ensuring organisational design supports attaining strategic objectives; setting the department's risk appetite and ensuring controls are in place to manage risk; evaluation of the board and its members, and succession planning • Talented People – ensuring the department has the capability to deliver and to plan to meet current and future needs • Results Focus – shaping the single departmental plan, including strategic aims and objectives; monitoring and steering performance against plan; scrutinising performance of ALBs; and setting the department's standards and values • Management Information – ensuring clear, consistent, comparable performance information is used to drive improvements 2.7 The board also supports the accounting officer in the discharge of obligations set out in *Managing Public Money1* for the proper conduct of business and maintenance of ethical standards. 2.12 Where board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes. This might occur, for example, in the rare	The Board meets at least six times a year and in addition holds an Annual General Meeting. Discussions, actions and decisions of all meetings of the Board and its Committees are formally recorded as minutes or action notes. The Board's role, as set out in its Standing Orders, is to: • Set the strategic direction for the organisation • Hold the organisation to account for performance and delivery • Set the tone and culture of the Board and the organisation The Board's business is therefore structured in this way and encompasses the five main areas set out in point 2.4.

circumstance in which the lead minister, as chair of the board, considers it necessary to depart from the collective view of the board.	
Chapter 3 Board Composition	
Applicable Paragraphs	**Assessment**
Principle: *3.1 The board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size.* ***3.2 The roles and responsibilities of all board members should be defined clearly in the department's board operating framework.***	
3.5 Non-executive board members will exercise their role through influence and advice, supporting as well as challenging the executive, and covering such issues as: • support, guidance and challenge on the progress and implementation of the single departmental plan • performance (including agreeing key performance indicators), operational issues (including the operational and delivery implications of policy proposals), adherence to relevant standards (e.g. commercial, digital), and on the effective management of the department • the recruitment, appraisal and suitable succession planning of senior executives, as appropriate within the principles set out by the Civil Service Commission. 3.10 The board should provide collective strategic and operational leadership to the departmental family, helping it to operate in a business-like manner. 3.11The board should include people with a mix and balance of skills and understanding to match and complement the department's business and its strategic aims, typically including: • leadership • management of change in complex organisations • process and operational delivery • knowledge of the department's business and policy areas	The Board has a range of skills and expertise. Individuals are appointed to Independent Member or Executive roles based on their particular backgrounds and specialist knowledge. Independent Members are appointed by the Minister for Health and Social Services advised by the Chair of the Board through a rigorous appointment process. It is acknowledged that there has been significant change to the Board membership, in terms of both Independent Members and Executive Directors during 2021/22. All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. The appointment panels for all Executive appointments, although organisation appointments, will have external independent assessors and Welsh Government representation. All Executive Directors are appointed to permanent NHS contracts. Independent Members are appointed for up to four years at any one time and can be re-appointed up to a maximum of eight years in the organisation. This is controlled by Welsh Government as they are Ministerial appointments.

• corporate functions, such as finance, human resources, digital, commercial and project delivery 3.12 The mix and balance of skills and understanding should be reviewed periodically, at least annually as part of the board effectiveness evaluation (see paragraph 4.12 below), to ensure they remain appropriate for the department's board. 3.13 The search for board candidates should be conducted, and appointments made, on merit, with due regard for the benefits of diversity on the board, including gender, on which the Government has an aspiration that half of all new appointees made to public bodies are women. This includes non-executive appointments to departmental boards. However, this is not just about gender; diversity is about encouraging applications from candidates with the widest range of backgrounds. 3.15 The board should agree and document in its board operating framework a *de minimis* threshold and mechanism for board advice on the operation and delivery of policy proposals.	There is a national programme of induction, in which all members are asked to participate. This is organised by Academi Wales and Welsh Government. Tailored programmes of induction have commenced for new Independent Members, however there is further work to do on building a comprehensive programme for future use. There is also a programme of Board Development Sessions and Board Briefings and other training made available to the Board. The Board is provided with a range of information including performance information at Board and Committee Meetings. The format and content of these is informed by national standards and requirements and also locally requested information.

Chapter 4: Board Effectiveness	
Applicable Paragraphs	**Assessment**
Principle: 4.1 The board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: formal procedures for • ***the appointment of new board members, tenure and succession planning for both board members and senior officials*** • ***allowing sufficient time for the board to discharge its collective responsibilities effectively*** • ***induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date*** • ***timely provision of information in a form and of a quality that enables the board to discharge its duties effectively*** • ***a mechanism for learning from past successes and failures within the departmental family and relevant external organisations*** • ***a formal and rigorous annual evaluation of the board's performance*** • ***and that of its committees, and of individual board members*** • ***a dedicated secretariat with appropriate skills and experience***	
4.5 The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance 4.6 The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate. 4.10 Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board	All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. All Executive appointments, although internal appointments have external independent assessors on the panels and also Welsh Government representation. The Annual Governance Statement provides details on the membership of the Board and Committee and the attendance record of individuals at these meetings. The Health Board assesses its own effectiveness each year and is subject to external and internal audit programmes and assessments by regulators and inspectors and Welsh Government. Assessments generated through these mechanism are converted to action and improvement plans and are implemented during each financial year and progress monitored by appropriate Committees and the Board.

members; this may include providing board members with direct access to officials where appropriate.
4.11 An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include:
 	
• developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention
• ensuring good information flows within the board and its committees and between senior management and non-executive board members, including:
  • challenging and ensuring the quality of board papers and board information
  • ensuring board papers are received by board members according to a timetable agreed by the board
  • providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements
  • ensuring the board follows due process
  • providing assurance to the board that the department:
  • complies with government policy, as set out in the code
  • adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts)
  • acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up
• arranging induction and professional development of board members (including ministers)
	In March 2022, the Board undertook an assessment of its effectiveness, including its committee structure, and identified areas for strengthening and improvement. These included, but are not limited to:
	
	• Establishment of a Board Development Programme
	• Establishment of a Board Member Induction Programme
	• The need for dedicated time for the Board to undertake horizon scanning and discuss strategic development
	• The need for a strengthened focus on outcomes, using intelligence and analytics
	• The need for a strengthened focus on the work delivered through partnerships and joint committees
	• The development of an Organisational Accountability Framework
	• Ongoing development of risk management and assurance mapping.
	
	Independent Members of the Board have direct access to members of the executive team in order to seek further information or clarification on issues as and when they arise. Regular Board Development sessions and Board briefings are also held to ensure that Board members are kept up to date on the breadth of issues.
	
	The Board Secretary acts as an independent voice within the organisation to advise and support the Board on governance matters and its approach to openness and transparency. The Board Secretary is responsible for developing the programmes of work for the Board and Committees of the organisation. Ensuring that agenda and papers are developed and reviewed

4.14 Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties). 4.15 All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed.	prior to publication to ensure the quality or reports and maximum transparency and openness in the way in which the organisation conducts its business. Board Members complete annual Declarations of Interest and this register is available on the Health Board's website. Declarations of Interest in relation to items on the agenda are also sought at each Board and Committee meeting and are formally recorded within the minutes. Individual annual assessment of Board Executive Directors is undertaken by the Chief Executive and Independent Members by the Chair.

Chapter 5: Risk Management	
Applicable Paragraphs	**Assessment**
Principles: 5.1 The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: • ***an audit and risk assurance committee, chaired by a suitably experienced non-executive board member*** • ***an internal audit service operating to Public Sector Internal Audit Standards1*** • ***sponsor teams of the department's key ALBs*** ***5.2 The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year.***	
5.3 The board's regular agenda should include scrutinising and advising on risk management. 5.4 The key responsibilities of non-executive board members include forming an audit and risk assurance committee. 5.5 The head of internal audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs. 5.6 The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department2 and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently.	The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management. A Corporate Risk Register is maintained and reported to and considered at each Board Meeting, and by the Audit, Finance and Risk Committee. Each Committee monitors risks associated with it portfolio and provides assurance reports on these to the Board. During 2021/22 the Health Board revised its Board Assurance Framework and Risk Management Approach to enable the Board to assess its strategic risks against achievement of the objectives set out in the Annual Plan 2021/22. The revised risk management approach remains in the embedding phase throughout the organisation. Continued engagement throughout the organisation has taken place to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX).

5.7 The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams. 5.8 The board should ensure an ALB makes effective arrangements for internal audit. It is good practice to work with a group or shared internal audit provision, for example covering a department and its ALBs. In any case, the board should ensure it provides for internal audit access to its ALBs. 5.9 The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. The chair of the committee should be a non-executive board member of the board with relevant experience. There should be at least one other non-executive board member of the board on the committee; the committee may also choose to seek further non-executive membership from non-members of the board in order to ensure an appropriate level of skills and experience. At least one, but preferably more, of these committee members should have recent and relevant financial experience. 5.10 Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role. 5.11 An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook*.3 5.12 The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function.	Audit Wales undertake a programme of audits each year comprising national and locally agreed audits, including an annual structured assessment. The Audit, Finance and Risk Committee and the Chief Executive also agree an annual programme of internal audits with the NHS Shared Services Audit and Risk Service appointed Head of Internal Audit. The Chief Executive also meets separately with AW and Internal Auditors. The Head of Internal Audit and Audit Wales are invited to attend all meetings of the Audit Committee, and to observe all other Committees of the Board. The **Audit, Finance and Risk Committee** is responsible for reviewing the system of governance and assurance established within the Health Board and the arrangements for internal control, including risk management, for the organisation and, in particular, advises on the Annual Governance Statement signed by the Chief Executive. The Committee also keeps under review the risk management approach of the organisation and utilises information gathered from the work of the Board, its own work, the work of other Committees and also other activity in the organisation in order to advise the Board regarding its conclusions in relation to the effectiveness of the system of governance and control. Four Independent Members of the Board comprise the membership of the Committee. In the absence of an Independent Member (Finance) whilst recruitment is ongoing, a Special Advisor (Finance) was in place and attended the Committee until July 2021.

5.13 The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board. 5.14 The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities. 5.15 All boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.	The Board Secretary ensures that appropriate secretariat is in place to support the Board and all Committees. The Board prepares an Annual Governance Statement, which is reviewed and approved by the Audit Committee prior to submission to the Board. The Terms of Reference are reviewed annually and published on the Health Board's website.

Remuneration and Staff Report 2021/22

The Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared by NHS bodies providing information under the headings in SI 2008 No 410, made to the extent that they are relevant. The Remuneration Report contains information about senior managers remuneration. The definition of 'Senior Manager' is: "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and terms of service for Executive Directors and the Chief Executive are agreed, and kept under review by the Board's Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Directors (the latter with the advice of the Chief Executive). In 2021/22, the Remuneration and Terms of Service Committee was chaired by the Health Board's Chair, Ann Lloyd CBE, and the membership included the following Members:

- Pippa Britton, Vice Chair of the Board;
- Shelley Bosson, Chair of Audit and Assurance Committee;
- Louise Wright, Independent Member (Trade Union).

Meetings are minuted and decisions fully recorded.

Independent Member Remuneration

Remuneration for Independent Members is determined by the Welsh Government, along with the tenure of appointments.

Directors' and Independent Members' Remuneration

Details of Directors' and Independent Members' remuneration for the 2021/22 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2021/22, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Remuneration and Terms of Service Committee also reviews objectives set for Executive Directors and assesses performance against those objectives when considering recommendations in respect of annual pay uplifts. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month notice period. Conditions were set by Welsh Government as part of the NHS Reform Programme of 2009. However, for part of the year there were interim Directors in post; an Interim Chief Executive, an

Interim Director of Primary, Community Care and Mental Health and Interim Director of Finance, Procurement and VBHC. Further detail on interim appointments can be found in Attachment Two of the Annual Governance Statement.

Salary and Pension Disclosure Table: Salaries and Allowances

Remuneration Report

Salary and Pension entitlements of Senior Managers Remuneration

		2021-22					2020-21				
Name	**Title**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**
		£000	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**
Executive Directors											
Judith Paget	Chief Executive (Until 31.10.21)	215 - 220	125 - 130	0	54	175 - 180		205 - 210	0	37	245 - 250
Glyn Jones	Interim Chief Executive (From 01.11.21)	200 - 205	175 - 180	0	81	255 - 260		150 - 155	0	39	190 - 195
	Director of Finance & Performance / Deputy Chief Executive (Until 31.10.21)	155 - 160									
Robert Holcombe	Interim Director of Finance, Procurement and Value Based Healthcare (From 01.11.21)	145 - 150	60 - 65	0	72	130 - 135		0	0	0	0
Nicola Prygodzicz	Director of Planning, Performance, Digital & IT / Interim Deputy Chief Executive (From 01.11.21)	125 - 130	120 - 125	6	10	130 - 135		120 - 125	0	37	155 - 160
	Director of Planning, Digital & IT (Until 31.10.21)	115 - 120									
Rhiannon Jones	Director of Nursing		135 - 140	0	60	195 - 200		130 - 135	13	84	215 - 220
Geraint Evans	Director of Workforce and Organisational Development (Until 31.08.21)	135 - 140	55 - 60	0	0	55 - 60		130 - 135	0	0	130 - 135
Sarah Simmonds	Director of Workforce and Organisational Development (From 22.07.21)	135 - 140	90 - 95	4	104	195 - 200		0	0	0	0
Dr James Calvert	Medical Director (From 04.01.21)		185 - 190	0	290	475 - 480	180 - 185	40 - 45	0	32	75 - 80
Dr Sarah Aitken	Director of Public Health and Strategic Partnerships (From 18.01.21) / Interim Director of Primary, Community and Mental Health Services (From 06.12.21 Until 28.02.22)	125 - 130	125 - 130	0	0	125 - 130	115 - 120	155 -160	0	48	205 - 210
	Interim Medical Director (Until 17.01.21)						160 - 165				
Mererid Bowley	Interim Director of Public Health & Strategic Partnerships (From 10.04.20 Until 18.01.21)		0	0	0	0	125 - 130	115 - 120	0	0	115 - 120
Dr Paul Buss	Medical Director (Until 30.04.20)		0	0	0	0	195 - 200	15 - 20	0	0	15 - 20
Peter Carr	Director of Therapies and Health Sciences		110 - 115	126	45	165 - 170		105 - 110	77	29	140 - 145
Nick Wood	Director of Primary, Community and Mental Health (Until 05.12.21)	145 - 150	100 - 105	2	29	130 - 135		140 - 145	2	28	170 - 175
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (From 28.02.22)	135 - 140	10 - 15	0	4	15 - 20		0	0	0	0

Director of Operations

Claire Birchall	Director of Operations (Until 02.05.21)	110 - 115	10 - 15	0	0	10 - 15		110 - 115	0	28	135 - 140
Leanne Watkins	Interim Director of Operations (From 12.04.21 Until 16.03.22)	110 - 115	105 - 110	39	86	195 - 200		0	0	0	0
	Director of Operations (From 17.03.22)										

Board Secretary / Director of Corporate Governance

Richard Bevan	Board Secretary (Until 30.11.20)		0	0	0	0	105 - 110	70 - 75	0	0	70 - 75
Richard Howells	Interim Board Secretary (From 01.11.20 Until 30.11.21)	90 - 95	60 - 65	0	90	150 - 155	90 - 95	35 - 40	0	35	70 - 75
Rani Mallison	Board Secretary (From 28.11.21 Until 13.03.22)	100 - 105	35 - 40	18	9	50 - 55		0	0	0	0
	Director of Corporate Governance (From 14.03.22)										

Special Advisor to the Board

Philip Robson	Special Advisor to the Board		35 - 40	0	0	35 - 40		35 - 40	0	0	35 - 40
Chris Koehli	Special Advisor to the Board (Until 17.07.21)	35 - 40	5 - 10	0	0	5 - 10		30 - 35	0	0	30 - 35

Non-Executive Directors

Ann Lloyd CBE	Chair		65 - 70	0	0	65 - 70		65 - 70	0	0	65 - 70
Emrys Elias	Vice Chair (Until 30.09.21)	55 - 60	25 - 30	0	0	25 - 30		55 - 60	0	0	55 - 60
Pippa Britton	Interim Vice Chair (From 18.10.21)	55 - 60	30 - 35	0	0	30 - 35		15 - 20	0	0	15 - 20
	Independent Member (Community) (Until 17.10.21)	15 - 20									
Katija Dew	Independent Member (Third/Voluntary Sector)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
Prof. Helen Sweetland	Independent Member (University) (From 01.01.21)		0	0	0	0	0	0	0	0	0
Richard Clark	Independent Member (Local Authority)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
Paul Deneen	Independent Member (Community)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
Shelley Bosson	Independent Member (Community)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
David Jones	Independent Member (ICT) (Until 06.11.20)		0	0	0	0	15 - 20	5 - 10	0	0	5 - 10
Louise Wright	Independent Member (Trade Union)		0	0	0	0		0	0	0	0
Keith Sutcliffe	Associate Independent Member (Chair of Stakeholder Group)		0	0	0	0		0	0	0	0
David Street	Associate Independent Member (Social Services)		0	0	0	0		0	0	0	0
Louise Taylor	Associate Independent Member (Chair of Health Professionals Forum) (Until within 2020-21)		0	0	0	0	0	0	0	0	0

	2021-22	
	Pay	Ratio
Band of Highest paid Director's Total Remuneration £000	200 - 205	
25th percentile pay £	24,883	8.1
Median pay £	32,008	6.3
75th percentile pay £	41,837	4.8

2020-21	
Pay	Ratio
205 - 210	
23,626	8.8
30,615	6.8
39,788	5.2

The NHS and social care financial recognition scheme bonus of £735 payment to reward eligible NHS staff has not been included in the NHS Remuneration Report calculations. This bonus payment is not a contractual payment, but a one off payment to reward eligible staff for their commitment and tireless efforts in the most challenging circumstances.

The 2020-21 salary shown for Mererid Bowley is the amount recharged by Public Health Wales NHS Trust, it is not the actual salary paid.

Salary has been reported as gross pay, which is before the deduction of any salary sacrifice schemes. During 2021-22 Nicola Prygodzicz had £7k sacrificed in respect of the lease car scheme, Sarah Simmonds had £4k sacrificed in respect of the lease car scheme, Nick Wood had £3k sacrificed in respect of the lease car scheme, Leanne Watkins had £6k sacrificed in respect of the lease car scheme and £1k in respect of the cycle to work scheme and Rani Mallison had £2k sacrificed as part of the lease car scheme.
The post of Special Advisor to the Board has been disclosed as it has been deemed to have an influence over board decisions.
The amount of pension benefits for the year which contributes to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes and is based on information received from NHS BSA Pensions Agency.

The value of pension benefits is calculated as follows:
(real increase in pension* x20) + (real increase in any lump sum) – (contributions made by member)
*excluding increases due to inflation or any increase of decrease due to a transfer of pension rights

This is not an amount which has been paid to an individual by the Health Board during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a persons salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Remuneration Report continued

Salary and Pension entitlements of Senior Managers Pension Benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Judith Paget	Chief Executive (Until 31.10.21)	2.5 - 5.0	7.5 - 10.0	110 - 115	335 - 340	0	2594	0	0
Glyn Jones	Interim Chief Executive (From 01.11.21)	5.0 - 7.5	0.0	30 - 35	0	474	389	58	0
	Director of Finance & Performance / Deputy Chief Executive (Until 31.10.21)								
Robert Holcombe	Interim Director of Finance, Procurement and Value Based Healthcare (From 01.11.21)	2.5 - 5.0	7.5 - 10.0	35 - 40	80 - 85	735	555	65	
Nicola Prygodzicz	Director of Planning, Performance, Digital & IT / Interim Deputy Chief Executive (From 01.11.21)	0.0 - 2.5	(5.0) - (2.5)	45 - 50	100 - 105	874	839	14	0
	Director of Planning, Digital & IT (Until 31.10.21)								
Rhiannon Jones	Director of Nursing	2.5 - 5.0	5.0 - 7.5	60 - 65	175 - 180	1336	1232	78	0
Sarah Simmonds	Director of Workforce and Organisational Development (From 22.07.21)	5.0 - 7.5	10.0 - 12.5	25 - 30	45 - 50	396	266	76	0
Dr James Calvert	Medical Director (From 04.01.21)	12.5 - 15.0	30.0 - 32.5	70 - 75	160 - 165	1440	1120	287	0
Peter Carr	Director of Therapies and Health Sciences	2.5 - 5.0	0.0 - 2.5	40 - 45	85 - 90	700	642	40	0
Nick Wood	Director of Primary, Community and Mental Health (Until 05.12.21)	0.0 - 2.5	0.0	30 - 35	0	453	398	21	0
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (From 28.02.22)	0.0 - 2.5	0.0 - 2.5	40 - 45	75 - 80	683	632	3	
Claire Birchall	Director of Operations (Until 02.05.21)	0.0 - 2.5	(2.5) - 0.0	35 - 40	75 - 80	691	666	0	0
Leanne Watkins	Interim Director of Operations (From 12.04.21 Until 16.03.22)	2.5 - 5.0	7.5 - 10.0	35 - 40	75 - 80	612	524	69	0
	Director of Operations (From 17.03.22)								
Richard Howells	Interim Board Secretary (From 01.11.20 Until 30.11.21)	2.5 - 5.0	7.5 - 10.0	45 - 50	130 - 135	1122	951	103	0
Rani Mallison	Board Secretary (From 28.11.21 Until 13.03.22)	0.0 - 2.5	0.0 - 2.5	15 - 20	30 - 35	256	228	4	0
	Director of Corporate Governance (From 14.03.22)								

Geraint Evans and Sarah Aitken have not contributed to the NHS Pension Scheme during 2021-22

CETV not shown for employees over retirement age

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Pensions tax annual allowance – Scheme Pays Arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government has taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

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

The Health Board has included a Scheme Pay provision of £756,155 (as notified by Welsh Government) within the Annual Accounts 2021/22.

Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. The 2021-22 financial year is the first-year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio are required.

In 2021-22, 7 (2020-21, 3) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £19k to £338k (2020-21, £18k to £228k).

The all-staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

		2021-22	2021-22	2021-22		2020-21	2020-21	2020-21
		£000	£000	£000		£000	£000	£000
Total pay and benefits		**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
	25th percentile pay ratio	200 - 205	25	8.1		205 - 210	24	8.8
	Median pay	200 - 205	32	6.3		205 - 210	31	6.8
	75th percentile pay ratio	200 - 205	42	4.8		205 - 210	40	5.2
Salary component of total pay and benefits								
	25th percentile pay ratio	200 - 205	25	8.1		205 - 210	24	8.8
	Median pay	200 - 205	32	6.3		205 - 210	31	6.8
	75th percentile pay ratio	200 - 205	42	4.8		205 - 210	40	5.2
Total pay and benefits		**Highest Paid Director**	**Employee**	**Ratio**		Highest Paid Director	Employee	Ratio
	25th percentile pay ratio	200 - 205	25	8.1		205 - 210	24	8.8
	Median pay	200 - 205	32	6.3		205 - 210	31	6.8
	75th percentile pay ratio	200 - 205	42	4.8		205 - 210	40	5.2
Salary component of total pay and benefits								
	25th percentile pay ratio	200 - 205	25	8.1		205 - 210	24	8.8
	Median pay	200 - 205	32	6.3		205 - 210	31	6.8
	75th percentile pay ratio	200 - 205	42	4.8		205 - 210	40	5.2

STAFF REPORT

Staff Profile

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total
	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,506	20	56	0	0	0	2,582
Medical and dental	886	5	87	240	0	16	1,234
Nursing, midwifery registered	3,793	1	257	0	0	0	4,051
Professional, Scientific, and technical staff	432	1	3	0	0	0	436
Additional Clinical Services	2,647	0	145	0	0	0	2,792
Allied Health Professions	789	0	15	0	0	0	804
Healthcare Scientists	224	5	14	0	0	0	243
Estates and Ancilliary	991	0	154	0	0	0	1,145
Students	4	0	0	0	0	0	4
Total	12,272	32	731	240	0	16	13,291

Change from draft figures

Staff Composition

The table above provides the breakdown of staff numbers per discipline and professional group within the Health Board.

The gender breakdown for all staff groups is provided below:

2021-22				2020-21		
	Directors	**WTE**	**%**	**Directors**	**WTE**	**%**
Female	4.78	9722.10	79.23%	5.78	9762.84	79.29%
Male	6.00	2543.12	20.77%	5.00	2549.18	20.71%
Total	**10.78**	**12,276**		**10.78**	**12,312**	

The total number of staff per discipline differs from the staff numbers table shown above due to the gender figures being based on a point in time as of 31 March 2021. The staff numbers represent the average over a 52 week period of staff in post.

Sickness Absence Data

The Health Board has monitored absence in various categories as set out in this section.

The Health Board's sickness absence rate for 2021/2022 is 6.30%, a reduction for sickness related absence from 6.47% in 2020/2021 increased from 6.15% in 2019/2020. Sickness absence started to increase in August 2021 peaking in January 2022 at 7.44% (919 wte) however it has reduced in February 2022 to 6.49%. These figures include sickness absence as a result of Covid-19 symptoms or a confirmed infection which ranged from 1.87% in April 2020 to 0.83% in February 2022.

The Covid-19 pandemic has certainly impacted on the Health Board's overall absence rates, and it has been evidenced that as the community transition rates reduce or increase, this will be replicated in our sickness absence rates. Overall sickness absence for 2021/22 has been higher than pre Pandemic sickness 2019/20 at 5.79% and 2018/19 at 5.29% which were closer to the Health Board absence target rate of 5%.

Over the past 5 years, the average working days lost per individual has increased slightly year on year. In 2020/2021 the average sickness days lost was 16 per individual employee, which increased to 17.2 days in 2021/22. The table below provides the sickness absence trend data for the Health Board over the last seven years.

Sickness Absence	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Days Lost (Short Term <28 days)	61261	53097	60406	54759	68229	60411	79761
Days Lost (Long Term >28 days)	144562	147711	153345	162684	194289	188778	203781
Total Days Lost	205823	200808	213751	217443	262518	249189	283542
Total Staff Years	902	880	937	954	1156	1093	1249
Average Working Days Lost	14.7	14.2	15.2	15.2	15.2	16	17.2
Total staff employed in period (headcou	14020	14155	14012	14334	14835	15528	15863
Total staff employed with no absnece (h	4919	5803	4848	5016	5402	6055	5710
Percentage staff with no sick	40%	41%	37%	35%	36%	39%	36%

Medical Exclusion

Medical exclusion is a term used to record those staff who have had to self-isolate for a number of reasons, for example a household member having Covid-19 symptoms, being contacted through Track, Trace and Protect, or being classified as extremely clinically vulnerable and therefore having to shield for two separate periods of time as a result of Welsh Government advice.

The table below highlights how the pandemic impacted on attendance overall, with a further 25,598 days lost due to staff having to be medically excluded which is much lower than 2020/21:

Medical Exclusion	2019/20	2020/21	2021/22
Days lost (Short term < 28 days)	6,779	36,331	18,389
Days lost (Long term >28 days)	2,439	57,707	7,208
Total days lost	9,218	94,038	25,597
Total staff years	40	412	90
Average working days lost	0.6	6	1.5
Total staff employed in period (headcount)	14,835	15,528	15,863
Total staff employed with no absence (headcount)	13,351	10,093	12,055
Percentage staff with no medical exclusion	90%	65%	76%
Percentage staff with no sick or medical exclusion	36%	33%	31%

Medical exclusion adds a further 1.5 days on average per individual employee to overall absence. Reducing the overall average absence days lost per employee from 22 days in 2020/21 to 18.8 days in 2021/22, resulting in a total of 309,139 total working days lost due to sickness absence and/or medical exclusion.

Staff Policies

Aneurin Bevan University Health Board has a range of staff policies in place, which are developed in partnership with staff and trade union colleagues. The Equality Impact Assessment policy is applied throughout the financial year;

- for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities;
- for continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- otherwise for the training, career development and promotion of disabled persons employed by the Health Board.

All staff policies include a requirement to undertake an analysis of the impact of the policy in respect of equality. In conjunction with this approach, the Sickness Absence Policy and Recruitment and Selection Policy were utilised to ensure fair consideration was given to applications for employment made by a disabled person and for supporting their continued employment.

Employee Relations Matters

Details of the number of disciplinary cases between the 1st March 2021 to the 31st March 2022 is provided below:

Disciplinary Cases	Dismissals	Appeals	Employment Tribunals
109	10	10	5

Payment to Past Directors

No payments have been made to any person who was not a director at the time the payment was made, but who had been a director of the Health Board previously.

Expenditure on Consultancy

Expenditure on Consultancy	2021-22	
Note 3.3 from the main Accounts		
Consultant	**Details**	**£000**
AKESO and Company Ltd	Health Courier Service Review	10
Andy Oswin	Brand Development Project	2
Deloitte LLP	Employment Tax	14
Ernst & Young LLP	VAT Compliance	19
Figure & Consultancy Services Ltd	Training Learning and Engagement work	60
GP Fire & security	Security infrastructure review	-4
In-Form Solutions Ltd	Commercial Advice	6
Keep on Walking Ltd	Management Support, Coaching and Wellbeing	35
Performance Matters (N.I.) LTD	Consultancy Fees Workforce and Organisation Development	4
Supportive Care UK Ltd	HR Board Rounds	23
Working Word Public Relations Ltd	Communication and Engagement Strategy	6
TOTAL		175

Tax Assurance for Off-payroll Engagements

Table 1 : For all off-Payroll engagements as of 31 March 2022, for more than £245 per day

No. of exisiting Engagements as of 31 March 2022	4
Of which, the number that have existed:	
for less than one year at time of reporting	1
for between one and two years at time of reporting	2
for between two and three years at time of reporting	
for between three and four years at time of reporting	
for four or more years at time of reporting	1

Table 2 : For all new off-Payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day

	Number
Number of new engagements between 1 April 2021 and 31 March 2022	3
Of which…	
No. assessed as caught by IR35	
No. assessed as not caught by IR35	
No. engaged directly (via contracted to department) and are on the departmental payroll	
No. of engagements reassessed for consistency/assurance purposes during the year	
No. of engagements that saw a change to IR35 status following the consistency review	

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	12

Exit Packages and Severance Payments

	2021-22	2021-22	2021-22	2021-22	2020-21
Exit packages cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures**	**Total number of exit packages**	**Number of departures where special payments have been made**	Total number of exit packages
	Whole numbers only	**Whole numbers only**	**Whole numbers only**	**Whole numbers only**	Whole numbers only
less than £10,000	**0**	**0**	**0**	**0**	0
£10,000 to £25,000	**0**	**0**	**0**	**0**	0
£25,000 to £50,000	**0**	**2**	**2**	**0**	0
£50,000 to £100,000	**0**	**1**	**1**	**0**	0
£100,000 to £150,000	**0**	**0**	**0**	**0**	0
£150,000 to £200,000	**0**	**0**	**0**	**0**	0
more than £200,000	**0**	**0**	**0**	**0**	0
Total	**0**	**3**	**3**	**0**	0

Exit packages cost band (including any special payment element)	Cost of compulsory redundancies	Cost of other departures	Total cost of exit packages	Cost of special element included in exit packages	Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	85,839	85,839	0	0
£50,000 to £100,000	0	76,771	76,771	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	162,610	162,610	0	0

Exit costs paid in year of departure	Total paid in year	Total paid in year
	2021-22	2020-21
	£	£
Exit costs paid in year	0	0
Total	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.
The Health Board has approved VERS in 2021/22.
Additional requirement as per FReM
£0 exit costs were paid in 2021-22, the year of departure (£0 - 2020-21).

Parliamentary Accountability and Audit Report

2021/22

Regularity of Expenditure

Regularity of Expenditure Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

Aneurin Bevan University Health Board ensures that the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Health Board's Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
- prepare them on a going concern basis on the presumption that the services of the Health Board will continue in operation.

Fees and charges

Where the Health Board undertakes activities that are not funded directly by the Welsh Government the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 (page 31) of the Annual Accounts 2021/22. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

The Health Board incurred costs amounting to £0.396m for the provision of the statutory audit by the Wales Audit Office.

Managing public money

This is the required Statement for Public Sector Information Holders as referenced in the Directors' Report. In line with other Welsh NHS bodies, the Health Board has adopted standing financial instructions which enforce the principles outlined in HM Treasury guidance 'Managing Public Money' which sets out the main principles for dealing with resources in the UK public sector. As a result, the Health Board should have complied with the cost allocation and charging requirements of this guidance. The

Health Board has not been made aware of any instances where this has not been done.

Remote Contingent Liabilities

This disclosure was introduced for the first time in 2015-16. It shows those contingent liabilities that are deemed to be extremely remote and have not been previously disclosed within the normal contingent liability note within the accounts. It relates to 2 medical negligence cases and 1 personal injury case in 2021/22 (2 medical negligence cases in 2020/21) and is reported in Note 21.2 to the main accounts.

Glyn Jones
Interim Chief Executive **Date: XX June 2022**

THE CERTIFICATE AND INDEPENDENT AUDITOR'S REPORT OF THE AUDITOR GENERAL FOR WALES TO THE SENEDD

REPORT OF THE AUDITOR GENERAL TO THE SENEDD

Appendix One

Glossary

A		
ABUHB – Aneurin Bevan University Health Board	A&E – Accident & Emergency	ACV – Annual Contract Value
AGP – Aerosol Generating Procedures	AVLOS – Average Length of Stay	ABCHC – Aneurin Bevan Community Health Council
AMD – Age Related Macular Degeneration		
C		
CEO – Chief Executive Officer	CHC – Community Health Council	COSO - Committee of Sponsoring Organisations of the Treadway Commission
CBE – Commander of the Most Excellent Order of the British Empire	CYP – Children and Young People	CMO – Chief Medical Officer
COTE – Care of the Elderly	CONCCO –Concern - Expression of Patient Dissatisfaction (DATIX Coding)	CAD – Care After Death
CRL – Capital Resource Limit		
CCA – Civil Contingencies Act		
D		
DATIX – concerns / incident management system	DNA - Did Not Attend	DFL – Divisional Flu Lead
E		
EASC – Emergency Ambulance Services Committee	EMS - Environmental Management System	eLGH – Enhanced Local general Hospital
EoLC - End of Life Companions	ED – Emergency Department	EHEW - Eye Health Examination Wales

ESR – Electronic Staff Record	EOL – End of Life	
F		
FReM – Financial Reporting Manual		
G		
GMS – General Medical Services	GP – General Practitioner	GS – Governance Statement
GUH – Grange University Hospital	GDPR – General Data Protection Regulations	GDP – General Dental Practitioner
GARTH – Gwent Arts in Health	GAVO – Gwent Association of Voluntary Organisations	GDAS – Gwent Drug and Alcohol Service
GURT – Age simulation suit	GWICES – Gwent Wide Integrated Community Equipment Service	
H		
HPF – Healthcare Professionals Forum	HCSW – Health Care Support Worker	HM – Her Majesty's
HCS – Health and Care Standards	HEIW -Health Education and Improvement Wales	HCC - Hepato-Cellular Carcinoma
HEIW -Health Education and Improvement Wales	HCAI – Healthcare Associated Infection	HPV - Hydrogen Peroxide Vapour
HFrEF – Heart Failure with Reduced Ejection Fraction		
I		
IT – Information Technology	IMTP – Integrated Medium Term Plan	ICF – Integrated Care Fund
ISO – International Organisation for Standardisation	ICO – Information Commissioners Office	ICT – Information Communication Technology
IPBS- Intensive Positive Behavioural support	Iceberg–a visual representation of understanding the delivery of mental health services to children	IPC – Infection Prevention and Control
IFRS - International Financial Reporting Standards		

J		
JCVI – Joint Committee on Vaccination and Immunisation		
L		
LMC – Local Medical Committee	LHB – Local Health Board	LNC – Local Negotiating Committee
LES – Local Enhanced Service	LFD – Lateral Flow Device	LPS – Liberty Protection Safeguards
M		
MpMRI – multi-parametric magnetic resource imaging	MSK - Musculoskeletal	MDT – Multi Disciplinary Team
Myst – My Support team	MIU – Minor Injuries Unit	MAU – Medical Assessment Unit
MHLD – Mental Health and Learning Disabilities	MCA – Mental Capacity Act	MRSA - Methicillin Resistant Staphylococcus Aureus
MELO – Mental Health Resources Website		
N		
NCN – Neighbourhood Care Network	NHS – National Health Service	NEST - a strategic framework for the delivery of well being service for children – describing what all children need to thrive and what the systems around children also need. N- Nurture E-Empathy S – Support T – Trusted Adult.
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
OD – Organisational Development	OOH – Out of Hours	OAK - Options, Advice and Knowledge

OT – Occupational Therapy		
P		
PSB – Public Service Board	PQSOC – Patient Quality, Safety and Outcomes Committee	POCU – Post Operative Care Unit
PHW – Public Health Wales	PCR – Polymerase Chain Reaction	POCT – Point of Care Testing
PIFU - Patient Initiated Follow-ups	PROMS – Patient Reported Outcome Measures	PPE – Personal Protective Equipment
PWP - Psychological Wellbeing Practitioners	PCMHSS - Primary Care Mental Health Services	PREMS - Patient Reported Experience Measures
PoC – Proof of Concept	PLO – Patient Liaison Officer	PTR – Putting Things Right
PSOW – Public Services Ombudsman Wales	PA – Physician Associate	PADR – Personal Appraisal Development Review
PTSD – Post Traumatic Stress Disorder	PCC – Patient Centred Care	
R		
RGH – Royal Gwent Hospital	RCS – Royal College of Surgeons	RATS – Remuneration and Terms of Service Committee
RTT – Referral to Treatment	RPB – Regional Partnership Board	RIIV - Research, Improvement, Innovation and Value
RITA - Reminiscence Interactive Technology Assistance	RCP - Royal College of Physicians	RIF – Regional Integration Fund
S		
SIRO – Senior Information Risk Owner	SoS – See on Symptoms	SRG – Stakeholder Reference Group
SC2HU – Step Closer to Home Unit	SAR – Subject Access Request	SPACE - development of single point of access for children and young adults
SI – Serious Incident		
T		
TUPF – Trade Union Partnership Forum	TVA – Torfaen Voluntary Alliance	

U		
UPC - Urgent Primary Care	UDA - Units of Dental Activity	
V		
VERS – Voluntary Early Release Scheme	VBHC – Value Based Healthcare	
W		
WASPI - Wales Accord on the Sharing of Personal Information	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WPAS - Welsh Patient Administration System	WTE – Whole Time Equivalent
WHO – World Health Organisation		
Y		
YAB – Ysbyty Aneurin Bevan	YYF – Ysbyty Ystrad Fawr	

Audit, Risk & Assurance Committee

Aneurin Bevan University Health Board Final Accounts for 2021/22

Executive Summary

The accounts for 2021/22 are attached to this paper.

There have been no changes from the draft accounts that affect performance against any of the Health Board's duties reported to the Committee on the 17th May.

Audit Wales has confirmed they intend to give an unqualified opinion on the Aneurin Bevan University Health Board 2021/22 Financial Statements, except for the regularity opinion which they intend to qualify. The scheme pays issue, reported at the 17th May meeting, gives rise to a regularity opinion which is the reason that Audit Wales have confirmed the qualified opinion relating to this matter. The regularity opinion on the scheme pays issue is applicable to all NHS Wales organisations that are impacted. No materiality issues arose in relation to True and Fair view.

A number of classification type adjustments have been made during the audit and all the changes are included in the table below. None of the adjustments have any impact on the financial targets.

The Committee are asked to note that the accounts have been satisfactorily completed, and along with the ISA 260 report from Audit Wales and the Head of Internal Audit Opinion, recommend approval of the Accounts by the Board at the meeting on 14th June.

A number of questions on the draft accounts have been raised by Committee members and these are attached in appendix 2 along with explanations.

The Audit, Risk & Assurance Committee is asked to CONSIDER and REVIEW the Final Draft Annual Accounts 2021/22 and AGREE a recommendation to the Board for formal approval on 14th June 2022.	
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]**	**Audit, Risk & Assurance Committee**

Date of the Report: 08 June 2022

Papers Attached:
Appendix 1 – ABUHB 2021/22 Final Accounts
Appendix 2 – Responses to queries raised on the meeting held on 17th May.
Appendix 3 – Breakdown of Spend on Voluntary Organisation

Additional Supporting Appendices:

	Title	Reference
1.	Local Financial Returns 2021/22	ABUHB LFR101
2.	Financial Returns 2021/22	ABUHB FR3
3.	Losses and Special Payments Financial Returns 2021/22	ABUHB FR4
4.	Losses and Special Payments Financial Returns 2021/22	ABUHB FR5
5.	NHS Interparty Eliminations 2021/22	ABUHB FR6
6.	Analysis of Impairments & Reversals recognised in 2021/22	ABUHB FR7-9
7.	WGA Additional Requirements 2021/22	ABUHB FR10
8.	DoH Transfer of Assets 2021/22	ABUHB FR13
9.	Memorandum Statements 2021/22	LMS 2021-22
10.	WGA Disclosure Signage 2021/22	LMS 2 2021-22
11.	Monnow Vale Health and Social Care Unit, Memorandum Statement 2021/22	

Purpose of the Report

In respect of the Annual Report and Accounts 2021/22, this paper presents to the Audit, Risk and Assurance Committee the final draft audited version of:

- The Annual Accounts 2021/22 (Part 3)

for consideration and review prior to being submitted for formal approval at ABUHB's Board Meeting on 14th June 2022 and submitted to Welsh Government on 15th June 2022, in-line with HM Treasury Requirements.

Adjustments to the Accounts

2021/22 ANNUAL ACCOUNTS –

Adjustments Actioned from Draft to Final as identified within ISA260 report

Note No.	Issue	Impact on Financial Targets
3.3	**ADJUSTMENTS ACTIONED** Increase in Losses & Special Payments due to the transfer of the loss (£603K) from note 3.1 and elimination of transfer to creditors re provisions from 2020/21 (£5,296K) with the opposite entry adjusted re other.	None
11.1	Gross Book Value and Depreciation of Plant & Machinery Assets adjusted as part of verification exercise Gross Book Value and Depreciation of IT Equipment Assets adjusted as part of verification exercise	None
15	Scheme Pays Accrual moved from other debtors to the designated Scheme Pays line £756K.	None
18	Accruals for the COVID annual leave accrual categorised as 'Non-NHS Creditor' in the draft accounts, moved to 'Accruals' in the final accounts.	None
20	Clinical Negligence and Defence fees provision less than and more than one year were incorrectly stated in the draft accounts. Structured Settlement cases advised and added to final accounts.	None

21.1	Contingent Liability note has been amended to exclude the 2021/22 Transfer to Creditors with subsequent narrative re value and number of cases amended. Narrative re CHC contingent liability has been amended and case numbers also amended.	None
30	Expenditure with Torfaen Voluntary Alliance added. Note number and heading added	None
	REMUNERATION REPORT	
	Added column re Full Year Equivalent Salary for both 2021/22 and 2020/21.	None
	Nicola Prygodzicz – amended title to read **Interim** Deputy Chief Executive	None
	Dr Chris O'Connor – Salary bands changed from £5-10K to £10-£15K. Total bands changed from £10-£15K to £15-£20K.	
	Louise Taylor – date changed form – Nov 20 to 'left during 2020/21'	None
	Peter Carr – value of Benefits in Kind changed from £7K to £12.6K. Salary band changed from £160K-£165K to £165K-£170K	None
	PENSIONS BENEFITS	
	Nicola Prygodzicz – amended title to read **Interim** Deputy Chief Executive. Real increase in pension changed from (£2.5)-£0.0K to (£5.00) - (£2.5).	None
	Judith Paget – Real increase in pension at pension age changed from £0.0-£2.5K to £2.5-£5.0K. Cash Equivalent Transfer Value changed from £0.00 to £2.594K	None

Recommendation

The Audit, Risk & Assurance Committee is asked to CONSIDER and REVIEW the Final Draft Annual Accounts 2021/22 and AGREE a recommendation to the Board for formal approval on 14th June 2022.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	*Statutory financial reporting is a key duty for the organisation. Failure to have an unqualified audit opinion on the financial statements of the organisation would cause significant reputational damage.*
Financial Assessment	*No direct financial implications*
Quality, Safety and Patient Experience Assessment	*No direct implications.*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact.*
Health and Care Standards	*Not applicable.*
Link to Integrated Medium Term Plan/Corporate Objectives	*Having an agreed IMTP is a core statutory financial duty which is disclosed in the financial statements.*

ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1st October 2009 following the merger of Gwent Healthcare NHS Trust and the following Local Health Boards.
Blaenau Gwent Local Health Board
Caerphilly Local Health Board
Monmouthshire Local Health Board
Newport Local Health Board
Torfaen Local Health Board

The Health Board covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen with a population of approximately 600,000 people. The Health Board has an annual budget from the Welsh Government of just under £1.6 billion per year from which we plan and deliver services for the population of the Health Board area. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being Act and the Well Being of Future Generations Act.

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2021-22. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £000	2020-21 £000
Expenditure on Primary Healthcare Services	3.1	**293,748**	287,056
Expenditure on healthcare from other providers	3.2	**463,401**	417,804
Expenditure on Hospital and Community Health Services	3.3	**950,978**	951,356
		1,708,127	1,656,216
Less: Miscellaneous Income	4	**(109,638)**	(105,020)
LHB net operating costs before interest and other gains and losses		**1,598,489**	1,551,196
Investment Revenue	5	**(16)**	(17)
Other (Gains) / Losses	6	**(232)**	(43)
Finance costs	7	**562**	683
Net operating costs for the financial year		**1,598,803**	**1,551,819**

See note 2 on page 27 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 75 form part of these accounts.

Other Comprehensive Net Expenditure

	2021-22 £000	2020-21 £000
Net (gain) / loss on revaluation of property, plant and equipment	**(9,960)**	(6,695)
Net (gain) / loss on revaluation of intangibles	**0**	0
(Gain) / loss on other reserves	**0**	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	**0**	0
Net (gain)/loss on revaluation of financial assets held for sale	**0**	0
Impairment and reversals	**0**	0
Transfers between reserves	**0**	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Other comprehensive net expenditure for the year	**(9,960)**	(6,695)
Total comprehensive net expenditure for the year	**1,588,843**	1,545,124

The notes on pages 8 to 75 form part of these accounts.

Statement of Financial Position as at 31 March 2022

	Notes	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Property, plant and equipment	11	**810,479**	779,935
Intangible assets	12	**5,211**	6,595
Trade and other receivables	15	**125,697**	118,391
Other financial assets	16	**521**	554
Total non-current assets		**941,908**	905,475
Current assets			
Inventories	14	**8,726**	9,857
Trade and other receivables	15	**133,774**	95,887
Other financial assets	16	**33**	32
Cash and cash equivalents	17	**1,720**	1,821
		144,253	107,597
Non-current assets classified as "Held for Sale"	11	**0**	1,205
Total current assets		**144,253**	108,802
Total assets		**1,086,161**	1,014,277
Current liabilities			
Trade and other payables	18	**(223,290)**	(202,444)
Other financial liabilities	19	**0**	0
Provisions	20	**(63,283)**	(45,999)
Total current liabilities		**(286,573)**	(248,443)
Net current assets/ (liabilities)		**(142,320)**	(139,641)
Non-current liabilities			
Trade and other payables	18	**(3,709)**	(4,315)
Other financial liabilities	19	**0**	0
Provisions	20	**(132,424)**	(124,942)
Total non-current liabilities		**(136,133)**	(129,257)
Total assets employed		**663,455**	636,577
Financed by :			
Taxpayers' equity			
General Fund		**530,429**	512,572
Revaluation reserve		**133,026**	124,005
Total taxpayers' equity		**663,455**	636,577

The financial statements on pages 2 to 7 were approved by the Board on 14th June 2022 and signed on its behalf by:

Chief Executive and Accountable Officer …….. Date: 14 June 2022

The notes on pages 8 to 75 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2022

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2021-22			
Balance as at 31 March 2021	512,572	124,005	**636,577**
Adjustment	0	0	**0**
Balance at 1 April 2021	512,572	124,005	**636,577**
Net operating cost for the year	(1,598,803)		**(1,598,803)**
Net gain/(loss) on revaluation of property, plant and equipment	0	9,960	**9,960**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other Reserve Movement	0	0	**0**
Transfers between reserves	939	(939)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2021-22	(1,597,864)	9,021	**(1,588,843)**
Net Welsh Government funding	1,588,806		**1,588,806**
Notional Welsh Government Funding	26,915		**26,915**
Balance at 31 March 2022	530,429	133,026	**663,455**

The notes on pages 8 to 75 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2021

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2020-21			
Balance at 1 April 2020	543,040	117,974	**661,014**
Net operating cost for the year	(1,551,819)		**(1,551,819)**
Net gain/(loss) on revaluation of property, plant and equipment	0	6,695	**6,695**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other reserve movement	0	0	**0**
Transfers between reserves	664	(664)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2020-21	(1,551,155)	6,031	**(1,545,124)**
Net Welsh Government funding	1,495,498		**1,495,498**
Notional Welsh Government Funding	25,189		**25,189**
Balance at 31 March 2021	512,572	124,005	**636,577**

The notes on pages 8 to 75 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2022

	Notes	2021-22 £000	2020-21 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(1,598,803)**	(1,551,819)
Movements in Working Capital	27	**(20,952)**	52,668
Other cash flow adjustments	28	**92,791**	123,531
Provisions utilised	20	**(10,474)**	(12,352)
Net cash outflow from operating activities		**(1,537,438)**	(1,387,972)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(52,999)**	(104,378)
Proceeds from disposal of property, plant and equipment		**3,347**	927
Purchase of intangible assets		**(930)**	(2,723)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(50,582)**	(106,174)
Net cash inflow/(outflow) before financing		**(1,588,020)**	(1,494,146)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,588,806**	1,495,498
Capital receipts surrendered		**0**	0
Capital grants received		**0**	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**(887)**	(832)
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**1,587,919**	1,494,666
Net increase/(decrease) in cash and cash equivalents		**(101)**	520
Cash and cash equivalents (and bank overdrafts) at 1 April 2021		**1,821**	1,301
Cash and cash equivalents (and bank overdrafts) at 31 March 2022		**1,720**	1,821

The notes on pages 8 to 75 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2021-22 Manual for Accounts. The accounting policies contained in that manual follow the 2021-22 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, except for IFRS 16 Leases, which is deferred until 1 April 2022; to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-20 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, in Wales the additional 6.3% being funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency).

However, NHS Wales' organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Note 34 within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2017-18 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated. For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use.
- the intention to complete the intangible asset and use it.
- the ability to use the intangible asset.
- how the intangible asset will generate probable future economic benefits.
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it.
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale, within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11. Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1. The LHB as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the SoCNE.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11.2. The LHB as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Wales organisation net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the NHS Wales organisation's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2020-21 and 2019-20. The WRP is hosted by Velindre NHS Trust.

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the LHB has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the LHB not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budget

The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

Monmouthshire County Council - Monnow Vale Health and Social Care Unit
Funds are pooled for the provision of health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. The financial operation of the pool is governed by a pooled budget agreement between the Local Health Board and Monmouthshire County Council. The income from Monmouthshire County Council is recorded as Local Authority Income in these accounts.

Expenditure for services provided under the arrangement is recorded under the appropriate expense headings in these accounts.

The property in which the unit is housed has been provided by a Private Finance Partner; the contract with the PFI partner is for 30 years and is categorised as an on balance sheet PFI scheme with the HB recognising **72%** of the property - see Note 32 of these accounts for further details.

The five Local Authorities in Gwent - Gwent Wide Integrated Community Equipment Service
Funds are pooled for the provision of an efficient and effective GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partner localities. The pool is hosted by Torfaen County Borough Council. The Health Board makes a financial contribution to the scheme but does not account for the schemes expenditure or assets/liabilities generated by this expenditure.

The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Torfaen County Borough Council, are accounted for as expenditure within these accounts.

Monmouthshire County Council - Mardy Park Rehabilitation Centre
Funds are pooled for the provision of care to individuals who have rehabilitation needs. The LHB has entered into a pooled budget with Monmouthshire County Council. The pool is hosted by Monmouthshire County Council.

The five Local Authorities in Gwent - Gwent Frailty Programme
Funds are pooled for the purpose of establishing a consistent service across Gwent. The pool is hosted by Caerphilly County Borough Council , as lead commissioner. The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Caerphilly County Borough Council, are accounted for as expenditure within these accounts. Additional information is provided in Note 32.

The five Local Authorities in Gwent and ABUHB – A pooled Fund for Care Home Accommodation functions for Older People
Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The overarching strategic aim of this Agreement is: -
• To ensure coordinated arrangements for ensuring an integrated approach across the Partnership to the commissioning and arranging for Care Home Accommodation for Older People.
• To ensure provision of high quality, cost effective Care Home Accommodation which meets local health and social care needs, through the establishment of a pooled fund
• To develop a managed market approach to the supply of quality provision to meets the needs of Older People Care Home Accommodation.

Funds are pooled for the provision and commissioning of specified services for older people (>65 years of age) in a care home setting in Gwent. The pool has been hosted by Torfaen County Borough Council since August 2018.

The Health Board makes a financial contribution to the scheme equivalent to actual expenditure incurred in commissioning related placements in homes during the year, but in addition does incur minimal costs associated with a share of the services provided by the host organisation and these are accounted for as expenditure within these accounts.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable from the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1 April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

In line with International Accounting Standard (IAS)19, the Health Board has included in its accounts an accrual for untaken annual leave as at 31st March 2022. The impact of COVID-19 has had a significant impact on the ability of staff to take annual leave during 2021-22. The accrual is reflected in notes 3.1, 3.3 and 9.1 to the accounts.

1.24.1. Provisions

The NHS Wales organisation provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
	Contingent Liability for all other estimated expenditure.	
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of minus 0.25%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

The Health Board has provided for some £188m (£163m 2020/21) within note 20 in respect of potential clinical negligence and personal injury claims and associated defence fees. These provisions have been arrived at on the advice of NHS Wales Shared Services Partnership - Legal & Risk Services. Given the nature of such claims this figure could be subject to significant change in future periods. However, the potential financial effect of such uncertainty is mitigated by the fact that the LHB's ultimate liability in respect of individual cases is capped at £0.025m, with amounts above this excess level being reimbursed by the Welsh Risk Pool.

The Health Board has estimated a liability of 0.495m (£0.458m 2020/21) in respect of retrospective claims for Continuing Health Care funding. The estimated provision is based upon an assessment of the likelihood of claims meeting criteria for continuing health care and the actual costs incurred by individuals in care homes. The provision is based on information made available to the Health Board at the time of these accounts and could be subject to significant change as outcomes are determined. Aneurin Bevan University Local Health Board has reviewed its portfolio of outstanding claims for continuing healthcare and made an assessment of likely financial liability based on an estimated success factor, eligibility factor and expected weekly average costs of claims. The assumptions have been derived by reviewing a sample of claims.

Primary care expenditure includes estimates for areas which are paid in arrears and not finalised at the time of producing the accounts. These estimates relate to GMS Quality Assurance and Improvement Framework, GMS Enhanced Services, and pharmacy estimates, which are based on an assessment of likely final performance.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

Wihtin the Provsions Note (note 20) the amount relating to Early Retirements and Permanent Injury benefits has been discounted using the PES (2021) Post Employment Benefits Liabilities Real Rate in Exccess of CPI of -1.30%.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS Wales organisation therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the NHS Wales organisation's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.2. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.3. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Wales organisation's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.4. Assets contributed by the LHB to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHBs SoFP.

1.26.5. Other assets contributed by the LHB to the operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

Other PFI arrangements off Statement of Financial Position

Where the LHB has no control or residual interest in the assets and the balance of risks and rewards lie with the operator, the arrangement is treated as an operating lease and the costs are included in the SoCNE as incurred. The LHB has one such arrangement relating to the maintenance of the energy systems in Nevill Hall Hospitals.

Joint PFI contract

The LHB has entered into an agreement to share a facility, provided by a Private Finance Partner, with Monmouthshire County Council to match the agreement with the Private Finance Partner. The arrangement is treated as a PFI arrangement and the total obligation is included as a liability of the LHB. The contribution towards the unitary charge committed by Monmouthshire County Council is treated as a financial asset. The future contribution was measured initially at the same amount as the fair value of the share of the PFI asset and is subsequently measured as a finance lease.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 16 Leases is to be effective from 1st April 2022.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.30. Accounting standards issued that have been adopted early

During 2021-22 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the NHS Wales organisation has established that as it is the corporate trustee of the Aneurin Bevan University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Aneurin Bevan University LHB NHS Charitable Fund as a subsidiary and therefore is required to consolidate the results of the Aneurin Bevan University LHB NHS Charitable Fund within the statutory accounts of the LHB.

However, the LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties' notes.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Aneurin Bevan University LHB NHS Charitable Fund or its independence in its management of charitable funds.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is reponsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

Annual financial performance

	2019-20	2020-21	2021-22	**Total**
	£000	£000	£000	**£000**
Net operating costs for the year	1,319,803	1,551,819	1,598,803	**4,470,425**
Less general ophthalmic services expenditure and other non-cash limited expenditure	(161)	(1,423)	(58)	**(1,642)**
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	0	**0**
Total operating expenses	1,319,642	1,550,396	1,598,745	**4,468,783**
Revenue Resource Allocation	1,319,674	1,550,641	1,598,994	**4,469,309**
Under /(over) spend against Allocation	32	245	249	**526**

Aneurin Bevan University LHB has met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2019-20 to 2021-22.

The health board received £0 strategic cash only support in 2021-22.
The cash only support is provided to assist the health board with payments to staff and suppliers, there is no requirement to repay this strategic cash assistance.

2.2 Capital Resource Performance

	2019-20	2020-21	2021-22	**Total**
	£000	£000	£000	**£000**
Gross capital expenditure	133,286	112,376	52,167	**297,829**
Add: Losses on disposal of donated assets	7	0	0	**7**
Less NBV of property, plant and equipment and intangible assets disposed	(555)	(884)	(3,115)	**(4,554)**
Less capital grants received	(93)	(333)	(22)	**(448)**
Less donations received	(300)	(201)	(166)	**(667)**
Charge against Capital Resource Allocation	132,345	110,958	48,864	**292,167**
Capital Resource Allocation	132,373	110,971	48,914	**292,258**
(Over) / Underspend against Capital Resource Allocation	28	13	50	**91**

Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2019-20 to 2021-22.

2.3 Duty to prepare a 3 year integrated plan

Due to the pandemic, the process for the 2020/21 - 2022/23 integrated plan was paused in spring 2020, temporary planning arrangement were implemented

As a result the extant planning duty for 2021-22 remains the requirement to submit and have approved a 2019-22 integrated plan, as set out in the NHS Wales Planning Framework 2019-22. The last 3 year plan signed off was 2019/20 - 2021/22.

The Aneurin Bevan University Health Board submitted a 2019-22 integrated plan in accordance with the planning framework.

The Minister for Health and Social Services extant approval

Status	**Approved**
Date	27/03/2019

The LHB **has** therefore met its statutory duty to have an approved financial plan.

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2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2021-22	2020-21
Total number of non-NHS bills paid	**322,710**	245,667
Total number of non-NHS bills paid within target	**306,680**	236,594
Percentage of non-NHS bills paid within target	95.0%	96.3%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited	Non-cash limited	2021-22 Total	2020-21 Total
	£000	£000	£000	£000
General Medical Services	112,524		**112,524**	108,993
Pharmaceutical Services	32,225	(7,143)	**25,082**	27,109
General Dental Services	38,030		**38,030**	33,079
General Ophthalmic Services	2,142	7,201	**9,343**	8,734
Other Primary Health Care expenditure	2,487		**2,487**	2,289
Prescribed drugs and appliances	106,282		**106,282**	106,852
Total	**293,690**	**58**	**293,748**	287,056

Note 3.1 - Expenditure on Primary Healthcare Services
The General Medical Services expenditure includes £12,860k (2020/21 £13,743k) in relation to staff salaries, the General Dental Services expenditure includes £1,732k (2020/21 £1,719k) in relation to staff salaries, the Prescribed Drugs & Appliance expenditure includes £334k (2020/21 £313k) in relation to staff salaries, and the General Ophthalmic Services includes £10k (2020/21 £0) in relation to staff salaries.

3.2 Expenditure on healthcare from other providers

	2021-22	2020-21
	£000	£000
Goods and services from other NHS Wales Health Boards	**62,504**	58,322
Goods and services from other NHS Wales Trusts	**45,812**	36,487
Goods and services from Welsh Special Health Authorities	**0**	0
Goods and services from other non Welsh NHS bodies	**9,321**	8,469
Goods and services from WHSSC / EASC	**177,035**	161,384
Local Authorities	**50,403**	43,934
Voluntary organisations	**18,825**	14,833
NHS Funded Nursing Care	**9,157**	8,660
Continuing Care	**83,675**	81,347
Private providers	**6,535**	4,228
Specific projects funded by the Welsh Government	**0**	0
Other	**134**	140
Total	**463,401**	417,804

Local Authorities expenditure relates to the following bodies:	**£'000**	£'000
Blaenau Gwenty County Borough Council	**5,048**	**4,442**
Caerphilly County Borough Council	**19,080**	**17,785**
Monmouthshire County Council	**5,531**	**4,932**
Newport City Council	**12,204**	**8,039**
Torfaen County Borough Council	**8,460**	**8,626**
Gloucestershire County Council	**21**	**87**
Cardiff City Council	**0**	**21**
Vale of Glamorgan Council	**58**	**0**
Pembrokeshire County Council	**0**	**2**
Swindon Borough Council	**1**	**0**
	50,403	43,934

3.3 Expenditure on Hospital and Community Health Services

	2021-22 £000	2020-21 £000
Directors' costs	2,243	2,346
Operational Staff costs	695,903	664,559
Single lead employer Staff Trainee Cost	16,109	5,067
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	116,736	100,158
Supplies and services - general	21,699	23,734
Consultancy Services	175	168
Establishment	8,101	8,670
Transport	2,257	2,429
Premises	42,463	36,870
External Contractors	0	0
Depreciation	41,158	32,654
Amortisation	2,517	1,574
Fixed asset impairments and reversals (Property, plant & equipment)	(12,619)	62,133
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	209
Audit fees	396	373
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	2,831	1,886
Research and Development	0	0
Other operating expenses	11,009	8,526
Total	**950,978**	951,356

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	2021-22 £000	2020-21 £000
Clinical negligence;		
Secondary care	39,857	10,844
Primary care	84	0
Redress Secondary Care	185	5
Redress Primary Care	0	0
Personal injury	1,441	86
All other losses and special payments	665	30
Defence legal fees and other administrative costs	1,259	1,731
Gross increase/(decrease) in provision for future payments	**43,491**	**12,696**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	(65)	(95)
Less: income received/due from Welsh Risk Pool	(40,595)	(10,715)
Total	**2,831**	1,886

	2021-22 £	2020-21 £
Permanent injury included within personal injury £:	208,625	34,156

The Health Board spent £2.2m (£2.2m 2020/21) on Research and Development. The majority of this spend relates to staff £2.1m (£1.9m 2020/21) which along with the non-staff spend is reflected under the various headings within note 3.3.

Note 3.4 includes £510,040 (£548,056 2020/21) relating to Redress cases which represents 66 (75 2020/21) cases where payments were made in year totalling £383,813 (£236,694 2020/21) including defence fees. An additional provision has been created for a further 20 (36 2020/21) cases where an offer has been made or causation and breach have been proven with estimated costs of £126,227 (£311,362 2020/21).

Note 3.3 includes a credit relating to reversals of impairment of fixed assets. This is primarily as a result of the 2021-22 indices provided by the District Valuation Office with land rates and building rates rising by two and five percentage points respectively. The detailed figures can be found in Note 13.

4. Miscellaneous Income

	2021-22 £000	2020-21 £000
Local Health Boards	21,743	21,348
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	9,772	8,905
NHS Wales trusts	9,626	10,172
Welsh Special Health Authorities	12,313	10,130
Foundation Trusts	9	4
Other NHS England bodies	1,441	1,211
Other NHS Bodies	36	16
Local authorities	20,520	18,260
Welsh Government	8,060	7,252
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	0	0
Dental fee income	3,463	1,865
Private patient income	(3)	16
Overseas patients (non-reciprocal)	16	63
Injury Costs Recovery (ICR) Scheme	986	886
Other income from activities	822	972
Patient transport services	0	0
Education, training and research	4,088	3,689
Charitable and other contributions to expenditure	930	1,243
Receipt of NWSSP Covid centrally purchased assets	0	7,057
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	166	201
Receipt of Government granted assets	22	389
Non-patient care income generation schemes	112	69
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	0	0
Contingent rental income from finance leases	0	0
Rental income from operating leases	0	0
Other income:		
Provision of laundry, pathology, payroll services	73	72
Accommodation and catering charges	2,194	1,736
Mortuary fees	285	331
Staff payments for use of cars	682	758
Business Unit	0	1,887
Scheme Pays Reimbursement Notional	756	0
Other	11,526	6,488
Total	**109,638**	105,020

Other income Includes;		
Salary Scarifice Schemes & Fleet Vehicles	3,193	2,129
VAT recoveries re Business Activities and Contracted Out Services	2,011	1,060
Integrated Care Fund	2,164	0
Other	4,158	3,299
	0	0
	0	0
Total	**11,526**	6,488

Injury Cost Recovery (ICR) Scheme income

	2021-22 %	2020-21 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.76	22.43

5. Investment Revenue

	2021-22	2020-21
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	16	17
Total	16	17

6. Other gains and losses

	2021-22	2020-21
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	237	43
Gain/(loss) on disposal of intangible assets	(32)	0
Gain/(loss) on disposal of assets held for sale	27	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	232	43

7. Finance costs

	2021-22	2020-21
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	2	0
Interest on obligations under PFI contracts		
main finance cost	269	381
contingent finance cost	387	375
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	658	756
Provisions unwinding of discount	(96)	(73)
Other finance costs	0	0
Total	562	683

8. Operating leases

LHB as lessee

As at 31st March 2022 the LHB had 34 operating leases agreements in place for the leases of premises, 664 arrangement in respect of equipment and 285 in respect of vehicles, with 2 premises, 107 equipment and 165 vehicle leases having expired in year.

Payments recognised as an expense	**2021-22**	2020-21
	£000	£000
Minimum lease payments	**6,245**	6,070
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**6,245**	6,070

Total future minimum lease payments		
Payable	**£000**	£000
Not later than one year	**4,358**	4,725
Between one and five years	**10,468**	9,110
After 5 years	**8,847**	9,355
Total	**23,673**	23,190

LHB as lessor

Rental revenue	**£000**	£000
Rent	**196**	190
Contingent rents	**0**	0
Total revenue rental	**196**	190

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**192**	176
Between one and five years	**739**	704
After 5 years	**844**	1,085
Total	**1,775**	1,965

LHB as Lessee
The LHB has the following leases, none of which is subject to any contingency:
- Leases on properties which are at fixed rentals subject to periodic review. The significant Leases expire at dates between November 2022 and November 2043 except for one lease which does not expire until March 2064
- Leases of medical and other equipment, IT equipment and photocopiers, at fixed rentals, generally for between three and seven years and
- Vehicle leases at fixed rentals generally for a period of three to five years

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2020-21
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	514,949	1,857	54,360	12,876	0	2,957	586,999	558,183
Social security costs	53,196	0	0	1,490	0	0	54,686	48,393
Employer contributions to NHS Pension Scheme	86,605	0	0	1,743	0	0	88,348	82,769
Other pension costs	123	0	0	0	0	0	123	332
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	654,873	1,857	54,360	16,109	0	2,957	730,156	689,677

Charged to capital	964	1,930
Charged to revenue	729,192	687,747
	730,156	689,677
Net movement in accrued employee benefits (untaken staff leave total accrual included in note above)	97	245
The 2021-22 net movement in accrued employee benefits footnote above includes Covid 19 Net movement in accrued employee benefits	2,474	17,129

The staff under the 'Other' heading relate to Agency Medical Staff who are paid via a direct engagement scheme which commenced in January 2020.

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2020-21
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,506	20	56	0	0	0	2,582	2,390
Medical and dental	886	5	87	240	0	16	1,234	1,179
Nursing, midwifery registered	3,793	1	257	0	0	0	4,051	3,825
Professional, Scientific, and technical staff	432	1	3	0	0	0	436	456
Additional Clinical Services	2,647	0	145	0	0	0	2,792	2,582
Allied Health Professions	789	0	15	0	0	0	804	774
Healthcare Scientists	224	5	14	0	0	0	243	237
Estates and Ancilliary	991	0	154	0	0	0	1,145	1,217
Students	4	0	0	0	0	0	4	1
Total	12,272	32	731	240	0	16	13,291	12,661

9.3. Retirements due to ill-health

	2021-22	2020-21
Number	2	12
Estimated additional pension costs £	74,988	473,647

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

9.4 Employee benefits

The LHB does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2021-22 Number of compulsory redundancies	2021-22 Number of other departures	2021-22 Total number of exit packages	2021-22 Number of departures where special payments have been made	2020-21 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	2	2	0	0
£50,000 to £100,000	0	1	1	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	3	3	0	0

Exit packages cost band (including any special payment element)	2021-22 Cost of compulsory redundancies	2021-22 Cost of other departures	2021-22 Total cost of exit packages	2021-22 Cost of special element included in exit packages	2020-21 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	85,839	85,839	0	0
£50,000 to £100,000	0	76,771	76,771	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	162,610	162,610	0	0

Exit costs paid in year of departure	Total paid in year 2021-22	Total paid in year 2020-21
	£	£
Exit costs paid in year	0	0
Total	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Health Board has approved VERS in 2021/22.

Additional requirement as per FReM
£0 exit costs were paid in 2021-22, the year of departure (£0 - 2020-21).

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. The 2021-22 financial year is the first year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio are required.

	2021-22	**2021-22**	**2021-22**	2020-21	2020-21	2020-21
	£000	**£000**	**£000**	£000	£000	£000
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**200 - 205**	**25**	**8.1**	205 - 210	24	8.8
Median pay	**200 - 205**	**32**	**6.3**	205 - 210	31	6.8
75th percentile pay ratio	**200 - 205**	**42**	**4.8**	205 - 210	40	5.2
Salary component of total pay and benefits						
25th percentile pay ratio	**200 - 205**	**25**	**8.1**	205 - 210	24	8.8
Median pay	**200 - 205**	**32**	**6.3**	205 - 210	31	6.8
75th percentile pay ratio	**200 - 205**	**42**	**4.8**	205 - 210	40	5.2

	Highest Paid			Highest Paid		
Total pay and benefits	**Director**	**Employee**	**Ratio**	Director	Employee	Ratio
25th percentile pay ratio	**200 - 205**	**25**	**8.1**	205 - 210	24	8.8
Median pay	**200 - 205**	**32**	**6.3**	205 - 210	31	6.8
75th percentile pay ratio	**200 - 205**	**42**	**4.8**	205 - 210	40	5.2
Salary component of total pay and benefits						
25th percentile pay ratio	**200 - 205**	**25**	**8.1**	205 - 210	24	8.8
Median pay	**200 - 205**	**32**	**6.3**	205 - 210	31	6.8
75th percentile pay ratio	**200 - 205**	**42**	**4.8**	205 - 210	40	5.2

In 2021-22, 7 (2020-21, 3) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £19k to £338k (2020-21, £18k to £228k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

There has been a reduction in the pay ratio which attributable to a reduction in the chief exectuive / highest paid director salary and a coinciding increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	**2020-21**	2019-20
	to	to
	2021-22	2020-21
% Change from previous financial year in respect of Chief Executive	**%**	**%**
Salary and allowances	**(2)**	2
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**(2)**	2
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**5**	3
Performance pay and bonuses	**0**	0

The NHS and social care financial recognition scheme bonus of £735 payment to reward eligible NHS staff has not been included in the NHS Remuneration Report calculations. This bonus payment is not a contractual payment, but a one off payment to reward eligible staff for their commitment and tireless efforts in the most challenging circumstances.

9.7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,000 for the 2021-2022 tax year (2020-2021 £6,240 and £50,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2021-22	**2021-22**	2020-21	2020-21
NHS	**Number**	**£000**	Number	£000
Total bills paid	**4,776**	**342,787**	5,719	302,038
Total bills paid within target	**4,154**	**328,582**	4,858	295,559
Percentage of bills paid within target	**87.0%**	**95.9%**	84.9%	97.9%
Non-NHS				
Total bills paid	**322,710**	**632,798**	245,667	596,364
Total bills paid within target	**306,680**	**603,323**	236,594	569,515
Percentage of bills paid within target	**95.0%**	**95.3%**	96.3%	95.5%
Total				
Total bills paid	**327,486**	**975,585**	251,386	898,402
Total bills paid within target	**310,834**	**931,905**	241,452	865,074
Percentage of bills paid within target	**94.9%**	**95.5%**	96.0%	96.3%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2021-22	2020-21
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**77**	1,466
Total	**77**	**1,466**

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2021	76,903	643,590	2,783	23,260	124,444	548	36,112	4,867	912,507
Indexation	1,486	9,910	67	0	0	0	0	0	11,463
Additions									
- purchased	0	9,173	115	17,912	15,831	0	7,286	497	50,814
- donated	0	0	0	0	152	0	14	0	166
- government granted	0	0	0	0	22	0	0	0	22
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	17,726	0	(17,798)	0	0	72	0	0
Revaluations	0	(668)	0	0	0	0	0	0	(668)
Reversal of impairments	67	20,451	65	0	0	0	0	0	20,583
Impairments	0	(8,503)	0	(171)	0	0	0	0	(8,674)
Reclassified as held for sale	0	0	0	0	(91)	0	0	0	(91)
Disposals	0	0	0	0	(10,060)	(2)	(3,699)	(1,180)	(14,941)
At 31 March 2022	78,456	691,679	3,030	23,203	130,298	546	39,785	4,184	971,181
Depreciation at 1 April 2021	0	51,563	314	0	62,413	439	16,061	1,782	132,572
Indexation	0	1,508	8	0	0	0	0	0	1,516
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	(681)	0	0	0	0	0	0	(681)
Reversal of impairments	0	684	6	0	0	0	0	0	690
Impairments	0	(1,400)	0	0	0	0	0	0	(1,400)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(8,355)	(2)	(3,616)	(1,180)	(13,153)
Provided during the year	0	22,503	87	0	11,984	33	6,084	467	41,158
At 31 March 2022	0	74,177	415	0	66,042	470	18,529	1,069	160,702
Net book value at 1 April 2021	76,903	592,027	2,469	23,260	62,031	109	20,051	3,085	779,935
Net book value at 31 March 2022	78,456	617,502	2,615	23,203	64,256	76	21,256	3,115	810,479
Net book value at 31 March 2022 comprises :									
Purchased	75,349	615,715	2,615	23,203	63,317	76	21,228	3,095	804,598
Donated	3,107	1,655	0	0	645	0	28	20	5,455
Government Granted	0	132	0	0	294	0	0	0	426
At 31 March 2022	78,456	617,502	2,615	23,203	64,256	76	21,256	3,115	810,479
Asset financing :									
Owned	78,456	610,791	2,615	23,203	64,000	76	20,752	3,115	803,008
Held on finance lease	0	0	0	0	0	0	504	0	504
On-SoFP PFI contracts	0	6,711	0	0	256	0	0	0	6,967
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2022	78,456	617,502	2,615	23,203	64,256	76	21,256	3,115	810,479

The net book value of land, buildings and dwellings at 31 March 2022 comprises :

	£000
Freehold	691,251
Long Leasehold	7,179
Short Leasehold	143
	698,573

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	**Total £000**
Cost or valuation at 1 April 2020	78,457	378,550	2,687	296,279	88,798	548	27,676	3,269	**876,264**
Indexation	(1,489)	5,349	40	0	0	0	0	0	**3,900**
Additions									
- purchased	0	7,715	18	47,429	40,469	0	10,587	2,019	**108,237**
- donated	0	8	0	0	193	0	0	0	**201**
- government granted	0	0	0	0	333	0	0	0	**333**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	319,613	0	(319,613)	0	0	0	0	**0**
Revaluations	0	(2,819)	0	0	0	0	0	0	**(2,819)**
Reversal of impairments	0	5,677	38	0	0	0	0	0	**5,715**
Impairments	(65)	(70,503)	0	0	(374)	0	0	0	**(70,942)**
Reclassified as held for sale	0	0	0	0	(493)	0	0	0	**(493)**
Disposals	0	0	0	(835)	(4,482)	0	(2,151)	(421)	**(7,889)**
At 31 March 2021	76,903	643,590	2,783	23,260	124,444	548	36,112	4,867	**912,507**
Depreciation at 1 April 2020	0	40,327	227	1,792	58,071	407	13,157	1,859	**115,840**
Indexation	0	760	4	0	0	0	0	0	**764**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	1,792	0	(1,792)	0	0	0	0	**0**
Revaluations	0	(6,378)	0	0	0	0	0	0	**(6,378)**
Reversal of impairments	0	414	3	0	0	0	0	0	**417**
Impairments	0	(3,325)	0	0	(186)	0	0	0	**(3,511)**
Reclassified as held for sale	0	0	0	0	(210)	0	0	0	**(210)**
Disposals	0	1	0	0	(4,452)	0	(2,132)	(421)	**(7,004)**
Provided during the year	0	17,972	80	0	9,190	32	5,036	344	**32,654**
At 31 March 2021	0	51,563	314	0	62,413	439	16,061	1,782	**132,572**
Net book value at 1 April 2020	78,457	338,223	2,460	294,487	30,727	141	14,519	1,410	**760,424**
Net book value at 31 March 2021	76,903	592,027	2,469	23,260	62,031	109	20,051	3,085	**779,935**
Net book value at 31 March 2021 comprises :									
Purchased	73,857	590,186	2,469	23,260	61,020	109	20,030	3,057	**773,988**
Donated	3,046	1,709	0	0	685	0	21	28	**5,489**
Government Granted	0	132	0	0	326	0	0	0	**458**
At 31 March 2021	76,903	592,027	2,469	23,260	62,031	109	20,051	3,085	**779,935**
Asset financing :									
Owned	76,903	584,103	2,469	23,260	61,492	109	20,051	3,085	**771,472**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	7,924	0	0	539	0	0	0	**8,463**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2021	76,903	592,027	2,469	23,260	62,031	109	20,051	3,085	**779,935**

The net book value of land, buildings and dwellings at 31 March 2021 comprises :

	£000
Freehold	**663,123**
Long Leasehold	**8,276**
Short Leasehold	**0**
	671,399

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:

i) Donated Assets
Assets totalling £166K during the year were purchased via Charitable Funds donations and contributions from Sparkle. Government Granted equipment assets totalling £22K were received from the Department of Health in relation to the Covid-19 response.

ii) Valuations
The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

In 2021-22 indexation has been applied to the land and buildings based on indices received from the Valuation Office Agency and as agreed in the Technical Update Note 007 issued by Welsh Government on 31st March 2022. No indexation has been applied to equipment.

In addition, in 2021-22 there have been separate revaluations for four assets under construction coming into use. The most significant of these is the opening of the Hospital Sterilisation and Disinfection Unit (HSDU) at Grange University Hospital, with the others relating to the Lift Replacement Programme in the Royal Gwent and Nevill Hall Hospitals. Refurbishment of Ward 3/3 at NHH and the Rebound Facility at Serennu Childrens Centre.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5 - 15 years.

iv) Compensation
There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
The Health Board is required to assess whether it owns any surplus assets which have no sale restrictions and plans for future use to comply with IFRS 13. No such assets were identified in 2021-22, therefore no write downs were applicable.

vi) The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period
There were three Assets Held for Sale as at 1st April 2021, with on additional equipment asset (RGH Cardiac Catheter Lab 1 imaging system) reclassified as Held for Sale during the financial year. All four assets (Cath Labs 1 and , and properties Leechpool and Homelands/Penhow) were sold during 2021-22.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2021	337	782	86	0	0	**1,205**
Plus assets classified as held for sale in the year	0	0	91	0	0	**91**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	(337)	(782)	(177)	0	0	**(1,296)**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2022	0	0	0	0	0	**0**
Balance brought forward 1 April 2020	337	794	0	0	0	**1,131**
Plus assets classified as held for sale in the year	0	0	283	0	0	**283**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	(12)	(197)	0	0	**(209)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2021	337	782	86	0	0	**1,205**

12. Intangible non-current assets

2021-22

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure-internally generated	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	**2,443**	**0**	**7,161**	**0**	**0**	**9,604**
Revaluation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Additions- purchased	59	0	1,106	0	0	1,165
Additions- internally generated	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Disposals	(664)	0	(732)	0	0	(1,396)
Gross cost at 31 March 2022	**1,838**	**0**	**7,535**	**0**	**0**	**9,373**
Amortisation at 1 April 2021	**970**	**0**	**2,039**	**0**	**0**	**3,009**
Revaluation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Impairment	0	0	0	0	0	0
Provided during the year	408	0	2,109	0	0	2,517
Reclassified as held for sale	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Disposals	(664)	0	(700)	0	0	(1,364)
Amortisation at 31 March 2022	**714**	**0**	**3,448**	**0**	**0**	**4,162**
Net book value at 1 April 2021	**1,473**	**0**	**5,122**	**0**	**0**	**6,595**
Net book value at 31 March 2022	**1,124**	**0**	**4,087**	**0**	**0**	**5,211**
At 31 March 2022						
Purchased	1,124	0	4,087	0	0	5,211
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0
Total at 31 March 2022	**1,124**	**0**	**4,087**	**0**	**0**	**5,211**

12. Intangible non-current assets
2020-21

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure-internally generated	**Total**
	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2020	1,514	0	6,001	0	0	**7,515**
Revaluation	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Additions- purchased	1,146	0	2,459	0	0	**3,605**
Additions- internally generated	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	**0**
Disposals	(217)	0	(1,299)	0	0	**(1,516)**
Gross cost at 31 March 2021	**2,443**	**0**	**7,161**	**0**	**0**	**9,604**
Amortisation at 1 April 2020	943	0	2,009	0	0	**2,952**
Revaluation	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	**0**
Provided during the year	245	0	1,329	0	0	**1,574**
Reclassified as held for sale	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	**0**
Disposals	(218)	0	(1,299)	0	0	**(1,517)**
Amortisation at 31 March 2021	**970**	**0**	**2,039**	**0**	**0**	**3,009**
Net book value at 1 April 2020	**571**	**0**	**3,992**	**0**	**0**	**4,563**
Net book value at 31 March 2021	**1,473**	**0**	**5,122**	**0**	**0**	**6,595**
At 31 March 2021						
Purchased	1,468	0	5,122	0	0	**6,590**
Donated	5	0	0	0	0	**5**
Government Granted	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	**0**
Total at 31 March 2021	**1,473**	**0**	**5,122**	**0**	**0**	**6,595**

Additional Disclosures re Intangible Assets

i) On initial recognition intangible non-current assets are measured at cost. Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent asset basis), indexed for relevant price increases, as a proxy for fair value.

ii) The useful economic life of Intangible non-current assets are assigned on an individual asset basis using either a standard life of 5 years or the period covered by the licence.

iii) All fully depreciated assets still in use are being carried at nil net book value.

iv) These assets have not been subject to indexation or revaluation during the year.

13 . Impairments

	2021-22 Property, plant & equipment £000	2021-22 Intangible assets £000	2020-21 Property, plant & equipment £000	2020-21 Intangible assets £000
Impairments arising from :				
Loss or damage from normal operations	0	0	0	0
Abandonment in the course of construction	171	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0
Unforeseen obsolescence	0	0	0	0
Changes in market price	0	0	0	0
Others (specify)	7,103	0	69,129	0
Reversal of Impairments	(19,893)	0	(5,298)	0
Total of all impairments	(12,619)	0	63,831	0
Analysis of impairments charged to reserves in year :				
Charged to the Statement of Comprehensive Net Expenditure	(12,619)	0	62,342	0
Charged to Revaluation Reserve	0	0	1,489	0
	(12,619)	0	63,831	0

2021-22	Impairment amount	Reason for impairment	Nature of Asset	Valuation basis	Charge to SoCNE	Charge to reserve
	£000				£000	£000
Abandonment in the course of construction						
Assets abandoned in the course of construction	171	Historic AUC written off	AUC	Existing Use	171	0
Other Impairments						
Grange University Hospital HSDU Facility	6,500	Assets Valued on Coming Into Use	Operational	Existing Use	6,500	0
Ward 3/3 NHH	477	Assets Valued on Coming Into Use	Operational	Existing Use	477	0
RGH / NHH Main Lifts	126	Assets Valued on Coming Into Use	Operational	Existing Use	126	0
Total Impairment	7,274				7,274	0
Reversal of Impairments						
	£000				£000	£000
Grange University Hospital	(11,462)				(11,462)	0
Ysbyty Ystrad Fawr	(5,843)				(5,843)	0
Ysbyty Aneurin Bevan	(1,570)				(1,570)	0
Serennu Childrens Centre	(352)	Indexation - reversal of impairment in previous years	Operational Assets	Indexation	(352)	0
St Cadocs	(215)				(215)	0
Royal Gwent	(69)				(69)	0
Llanfrechfa Grange	(67)				(67)	0
Neville Hall	(47)				(47)	0
Various Community Sites	(24)				(24)	0
Serennu Childrens Centre	(244)	Assets Valued on Coming Into Use	Operational	Existing Use	(244)	0
Total Reversal of Impairments	(19,893)				(19,893)	0
Net credit to SoCNE	(12,619)				(12,619)	0

14.1 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	**2,905**	3,117
Consumables	**5,561**	6,563
Energy	**260**	177
Work in progress	**0**	0
Other	**0**	0
Total	**8,726**	9,857
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2022	31 March 2021
	£000	£000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

15. Trade and other Receivables

Current	31 March 2022 £000	31 March 2021 £000
Welsh Government	6,903	7,017
WHSSC / EASC	3,038	441
Welsh Health Boards	1,552	1,672
Welsh NHS Trusts	6,114	3,500
Welsh Special Health Authorities	455	111
Non - Welsh Trusts	178	208
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	756	0
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	84,862	63,083
NHS Wales Primary Sector FLS Reimbursement	2	0
NHS Wales Redress	475	488
Other	0	0
Local Authorities	8,159	4,273
Capital debtors - Tangible	0	0
Capital debtors - Intangible	0	0
Other debtors	15,653	11,399
Provision for irrecoverable debts	(1,870)	(1,951)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	7,497	5,646
Other accrued income	0	0
Sub total	**133,774**	95,887
Non-current		
Welsh Government	0	0
WHSSC / EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	0	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	124,435	117,181
NHS Wales Primary Sector FLS Reimbursement	57	0
NHS Wales Redress	0	0
Other	0	0
Local Authorities	0	0
Capital debtors - Tangible	0	0
Capital debtors - Intangible	0	0
Other debtors	1,205	1,210
Provision for irrecoverable debts	0	0
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	0	0
Other accrued income	0	0
Sub total	**125,697**	118,391
Total	**259,471**	214,278

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2022 £000	31 March 2021 £000
By up to three months	**1,365**	1,264
By three to six months	**409**	194
By more than six months	**1,289**	1,257
	3,063	2,715

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	**(1,951)**	(2,070)
Transfer to other NHS Wales body	**0**	0
Amount written off during the year	**17**	24
Amount recovered during the year	**0**	0
(Increase) / decrease in receivables impaired	**62**	89
Bad debts recovered during year	**2**	6
Balance at 31 March	**(1,870)**	(1,951)

In determining whether a debt is impaired consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

Receivables VAT

Trade receivables	**2,674**	2,625
Other	**314**	458
Total	**2,988**	3,083

16. Other Financial Assets

	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**33**	32	**521**	554
Derivatives	**0**	0	**0**	0
Other (Specify)				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**33**	**32**	**521**	**554**

17. Cash and cash equivalents

	2021-22	2020-21
	£000	£000
Balance at 1 April	**1,821**	1,301
Net change in cash and cash equivalent balances	**(101)**	520
Balance at 31 March	**1,720**	1,821
Made up of:		
Cash held at GBS	**1,698**	1,797
Commercial banks	**0**	0
Cash in hand	**22**	24
Cash and cash equivalents as in Statement of Financial Position	**1,720**	1,821
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**1,720**	1,821

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities - increase of £496k
PFI liabilities - reduction of £1,016k

The movement relates to cash, no comparative information is required by IAS 7 in 2021-22.

18. Trade and other payables

Current	**31 March 2022**	31 March 2021
	£000	£000
Welsh Government	**75**	66
WHSSC / EASC	**4,487**	2,370
Welsh Health Boards	**2,646**	2,569
Welsh NHS Trusts	**4,338**	3,935
Welsh Special Health Authorities	**216**	0
Other NHS	**3,725**	4,335
Taxation and social security payable / refunds	**5,694**	5,170
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**70,123**	59,115
Local Authorities	**15,293**	16,562
Capital payables- Tangible	**9,701**	11,886
Capital payables- Intangible	**1,117**	882
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Obligations under finance leases, HP contracts	**50**	0
Imputed finance lease element of on SoFP PFI contracts	**947**	911
Pensions: staff	**9,683**	9,001
Non NHS Accruals	**103,786**	97,401
Deferred Income:		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**(8,591)**	(11,759)
Sub Total	**223,290**	202,444
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**0**	0
Local Authorities	**0**	0
Capital payables- Tangible	**0**	0
Capital payables- Intangible	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Obligations under finance leases, HP contracts	**446**	0
Imputed finance lease element of on SoFP PFI contracts	**3,263**	4,315
Pensions: staff	**0**	0
Non NHS Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**3,709**	4,315
Total	**226,999**	206,759

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The Capital Payables - Tangible figure includes balances that have been agreed with other NHS Wales bodies, as part of the Agreement of Balances process.

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	**31 March 2022 £000**	31 March 2021 £000
Between one and two years	**1,086**	997
Between two and five years	**1,045**	1,854
In five years or more	**1,578**	1,464
Sub-total	**3,709**	4,315

19. Other financial liabilities

	Current		**Non-current**	
Financial liabilities	**31 March 2022 £000**	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2021	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2022
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	40,393	(7,745)	(9,204)	26,472	25,378	(6,325)	(12,164)	0	56,805
Primary care	0	0	0	0	84	(43)	0	0	41
Redress Secondary care	312	0	0	0	252	(371)	(67)	0	126
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	117	0	(195)	0	1,261	(555)	(29)	0	599
All other losses and special payments	0	0	0	0	665	(665)	0	0	0
Defence legal fees and other administration	1,857	0	0	672	1,870	(1,271)	(889)		2,239
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	412			317	333	(404)	(210)	(53)	395
2019-20 Scheme Pays - Reimbursement	0			0	11	0	0	0	11
Restructuring	0			0	0	0	0	0	0
Other	2,908		0	0	1,273	(275)	(839)		3,067
Total	45,999	(7,745)	(9,399)	27,461	31,127	(9,909)	(14,198)	(53)	63,283
Non Current									
Clinical negligence:-									
Secondary care	116,068	0	(185)	(26,472)	49,738	(140)	(15,350)	0	123,659
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,353	0	0	0	209	(256)	0	(44)	3,262
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	1,525	0	0	(672)	303	(89)	(25)		1,042
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	3,628			(317)	0	0	0	0	3,311
2019-20 Scheme Pays - Reimbursement	0			0	745	0	0	0	745
Restructuring	0			0	0	0	0	0	0
Other	368		0	0	151	(80)	(34)		405
Total	124,942	0	(185)	(27,461)	51,146	(565)	(15,409)	(44)	132,424
TOTAL									
Clinical negligence:-									
Secondary care	156,461	(7,745)	(9,389)	0	75,116	(6,465)	(27,514)	0	180,464
Primary care	0	0	0	0	84	(43)	0	0	41
Redress Secondary care	312	0	0	0	252	(371)	(67)	0	126
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,470	0	(195)	0	1,470	(811)	(29)	(44)	3,861
All other losses and special payments	0	0	0	0	665	(665)	0	0	0
Defence legal fees and other administration	3,382	0	0	0	2,173	(1,360)	(914)		3,281
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	4,040			0	333	(404)	(210)	(53)	3,706
2019-20 Scheme Pays - Reimbursement	0			0	756	0	0	0	756
Restructuring	0			0	0	0	0	0	0
Other	3,276		0	0	1,424	(355)	(873)		3,472
Total	170,941	(7,745)	(9,584)	0	82,273	(10,474)	(29,607)	(97)	195,707

Expected timing of cash flows:

	In year to 31 March 2023	Between 1 April 2023 31 March 2027	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	56,805	123,659	0	180,464
Primary care	41	0	0	41
Redress Secondary care	126	0	0	126
Redress Primary care	0	0	0	0
Personal injury	599	1,284	1,978	3,861
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	2,239	1,042	0	3,281
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	395	3,311	0	3,706
2019-20 Scheme Pays - Reimbursement	11	14	731	756
Restructuring	0	0	0	0
Other	3,067	405	0	3,472
Total	63,283	129,715	2,709	195,707

The expected timing of cash flows are based on best available information; but they could change on the basis of individual c ase changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2022/23 it will receive £57,649,915 and in 2023/24 and beyond £124,434,996 from the Welsh Risk Pool in respect of clinical negligence and personal in jury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £494,632. The estimation method used to calculate the provision for 2021/22 is consistent with the methodology used in 2020/21. In the continuing absence of detailed assessment information th e Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual cla imant provision would be established.

Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and a provision for potential pension costs know as 'final pay control'.

The total Health Board provision also includes an amount of £126,227 which relates to 20 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

Provision (Continued)

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

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

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

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

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

The Health Board have incldued a Scheme Pay provsion of £756,155 (as notified by Welsh Government) within these accounts.

20. Provisions (continued)

	At 1 April 2020	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2021
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	14,314	0	(1,178)	35,737	7,723	(8,735)	(7,468)	0	**40,393**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	524	0	0	0	237	(218)	(231)	0	**312**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	497	0	0	(169)	165	(263)	(113)	0	**117**
All other losses and special payments	0	0	0	0	30	(30)	0	0	**0**
Defence legal fees and other administration	1,155	0	0	660	1,653	(1,032)	(579)		**1,857**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	440			90	438	(410)	(107)	(39)	**412**
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	1,442		0	0	1,719	(52)	(201)		**2,908**
Total	**18,372**	**0**	**(1,178)**	**36,318**	**11,965**	**(10,740)**	**(8,699)**	**(39)**	**45,999**
Non Current									
Clinical negligence:-									
Secondary care	146,409	0	(4,118)	(35,737)	11,811	(1,074)	(1,223)	0	**116,068**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,443	0	0	169	223	(259)	(189)	(34)	**3,353**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	1,686	0	0	(660)	681	(158)	(24)		**1,525**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	3,718			(90)	0	0	0	0	**3,628**
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	203		0	0	327	(121)	(41)		**368**
Total	**155,459**	**0**	**(4,118)**	**(36,318)**	**13,042**	**(1,612)**	**(1,477)**	**(34)**	**124,942**
TOTAL									
Clinical negligence:-									
Secondary care	160,723	0	(5,296)	0	19,534	(9,809)	(8,691)	0	**156,461**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	524	0	0	0	237	(218)	(231)	0	**312**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,940	0	0	0	388	(522)	(302)	(34)	**3,470**
All other losses and special payments	0	0	0	0	30	(30)	0	0	**0**
Defence legal fees and other administration	2,841	0	0	0	2,334	(1,190)	(603)		**3,382**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	4,158			0	438	(410)	(107)	(39)	**4,040**
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	1,645		0	0	2,046	(173)	(242)		**3,276**
Total	**173,831**	**0**	**(5,296)**	**0**	**25,007**	**(12,352)**	**(10,176)**	**(73)**	**170,941**

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2021/22 it will receive £40,616,280 and in 2022/23 and beyond £117,181,426 from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £458,086. The estimation method used to calculate the provision for 2020/21 is consistent with the methodology used in 2019/20. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.
Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and a provision for potential pension costs know as 'final pay control'.
The total Health Board provision also includes an amount of £311,362 which relates to 36 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2021-22 £'000**	2020-21 £'000
Legal claims for alleged medical or employer negligence:-		
Secondary care	**408,594**	420,315
Primary care	**181**	45
Redress Secondary care	**62**	146
Redress Primary care	**0**	0
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**5,453**	5,719
Continuing Health Care costs	**718**	1,364
Other	**0**	0
Total value of disputed claims	**415,008**	427,589
Amounts (recovered) in the event of claims being successful	**(410,445)**	(422,167)
Net contingent liability	**4,563**	5,422

ABUHB – Contingent Liability Note
Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them. The value of legal claims has decreased by £12m from the value of legal claims in 2020/21, while the number of claims has decreased from 273 in 2020/21 to 272 in 2021/22.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Continuing Healthcare Cost uncertainties
The Health Board continues to make good progress in reviewing the outstanding claims for reimbursement of retrospective care payments (IRPs) during 2021/22. As a consequence there has been a movement in the level of provision and uncertainty including in these Accounts.

Note 20 sets out the £0.495m provision made for probable continuing care costs relating to 52 outstanding claims received by 31st March 2022. This compares with the 2020/21 provision of £0.458m and 57 outstanding phase 1 to 7 claims.

Note 21.1 also sets out the £0.718m contingent liability for possible additional continuing care costs relating to those claims if they are all settled and in full, comparing favourably with the £1.364m reported for 2020/21. Following a review during 2016/17, and further review in 2018/19 and 2019/20 the position in relation to dormant claims remains unchanged. Following on-going review in 21/22 a further 8 dormant claims were closed in 21/22.

There are still 7 new (Phase 7) claims, which have been received whereby the assessment process remains incomplete, as we are still awaiting full details to support the claims. One such claim was received in 20/21 and we continue to work with the Claimant's representative to obtain supporting information to allow for this claim to be assessed. The assessment process is highly complex and involves multi-disciplinary teams and for those reasons can take many months. At this stage, the HB does not have enough information to make a judgement on the likely success or otherwise of these claims, however, they may result in additional costs to the HB, which cannot be quantified at this time.

21.2 Remote Contingent liabilities

	2021-22 £000	2020-21 £000
Guarantees	0	0
Indemnities	8,827	14,159
Letters of Comfort	0	0
Total	**8,827**	**14,159**

21.3 Contingent assets

	2021-22 £000	2020-21 £000
Please give details	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March	2021-22 £000	2020-21 £000
Property, plant and equipment	11,282	10,090
Intangible assets	0	0
Total	**11,282**	10,090

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2022	
	Number	£
Clinical negligence	125	12,174,776
Personal injury	44	810,923
All other losses and special payments	136	78,302
Total	305	13,064,001

Analysis of cases in excess of £300,000

	Case Type		In year claims in excess of £300,000		Cumulative claims in excess o £300,000	
			Number	£	Number	£
Cases in excess of £300,000:						
	PI	04RVFPI0038	27,428			465,817
	MN	09RVFMN0033				1,918,000
	MN	10RVFMN0058				459,900
	MN	12RVFMN0069	1,250,000			1,250,000
	MN	14RVFMN0061				1,871,500
	MN	14RVFMN0084	732,288			752,288
	MN	14RVFMN0114	2,432,571			3,741,563
	MN	14RVFMN0118				2,152,500
	MN	14RVFMN0252	1,430,995			1,685,995
	MN	16RVFMN0131				300,781
	MN	16RVFMN0139				745,000
	MN	16RVFMN0187				416,000
	MN	16RVFMN0202				433,500
	MN	16RVFMN0206				495,000
	MN	16RVFMN0216	225,000			1,220,000
	MN	16RVFMN0242				632,000
	MN	17RVFMN0034	30,000			1,130,000
	MN	17RVFMN0070				311,000
	MN	17RVFMN0182	1,690,000			1,740,000
	MN	18RVFMN0110	25,000			365,000
	PI	18RVFPI0022	60,124			370,011
	MN	19RVFMN0146	450,000			485,000
	MN	20RVFMN0044	85,000			335,000
	MN	20RVFMN0129				350,000
Sub-total			**24**	**8,438,406**	**0**	**23,625,855**
All other cases			281	4,625,595	0	11,547,546
Total cases			**305**	**13,064,001**	**0**	**35,173,401**

24. Finance leases

24.1 Finance leases obligations (as lessee)

The Local Health Board has one finance lease receivable as a lessee.

Amounts payable under finance leases:

Land	**31 March 2022 £000**	31 March 2021 £000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.1 Finance leases obligations (as lessee) continued

Amounts payable under finance leases:

Buildings	**31 March 2022**	31 March 2021
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

Other	**31 March 2022**	31 March 2021
Minimum lease payments	**£000**	£000
Within one year	**54**	0
Between one and five years	**217**	0
After five years	**248**	0
Less finance charges allocated to future periods	**(23)**	0
Minimum lease payments	**496**	0
Included in:		
Current borrowings	**50**	0
Non-current borrowings	**446**	0
	496	0
Present value of minimum lease payments		
Within one year	**50**	0
Between one and five years	**204**	0
After five years	**242**	0
Present value of minimum lease payments	**496**	0
Included in:		
Current borrowings	**50**	0
Non-current borrowings	**446**	0
	496	0

24.2 Finance leases obligations (as lessor) continued

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under finance leases:

	31 March 2022	31 March 2021
Gross Investment in leases	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The UHB has one PFI Scheme off-statement of financial position. The scheme relates to the provision of replacement heating and lighting systems within Neville Hall hospital. The scheme has not resulted in guarantees, commitments or other rights and obligations upon the UHB. The scheme commenced in 2000 for a period of 25 years. The payments are made quarterly in advance with prepayments at year end for the period beyond 31 March 2022 included in debtors.

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2022	31 March 2021
	£000	£000
Total payments due within one year	**887**	861
Total payments due between 1 and 5 years	**2,412**	3,200
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**3,299**	4,061
Total estimated capital value of off-SoFP PFI contracts	**3,300**	3,300

25.2 PFI schemes on-Statement of Financial Position

Chepstow Community Hospital - a new community hospital including the provision of ancillary support services. This scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from February 2000. The obligation for the scheme is £1,563k.

Capital value of scheme included in Fixed Assets Note 11	**£000**
	3,263
Contract start date:	Feb-00
Contract end date:	Feb-25

Monnow Vale Health and Social Care Facility - a new health and social care facility. This scheme commenced in 2006 with unitary charge payments being made for a period of 30 years from 2006. The obligation for the scheme is £1,946k.

	£000
Capital value of scheme included in Fixed Assets Note 11	**3,121**
Contract start date:	Mar-04
Contract end date:	Mar-36

Nevill Hall Hospital Day Surgery - a purpose built day unit including the provision of medical equipment for the unit. The PFI partner has responsibility for maintaining the building and replacing the equipment used with the unit. The scheme commenced in 1998 wit h unitary

	£000
Capital value of scheme included in Fixed Assets Note 11	**583**
	Sep-99
	Sep-24

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element 31 March 2022	**On SoFP PFI Imputed interest 31 March 2022**	**On SoFP PFI Service charges 31 March 2022**
	£000	**£000**	**£000**
Total payments due within one year	**947**	**239**	**2,670**
Total payments due between 1 and 5 years	**1,928**	**338**	**6,987**
Total payments due thereafter	**1,335**	**194**	**6,317**
Total future payments in relation to PFI contracts	**4,210**	**771**	**15,974**

	On SoFP PFI Capital element 31 March 2021	On SoFP PFI Imputed interest 31 March 2021	On SoFP PFI Service charges 31 March 2021
	£000	£000	£000
Total payments due within one year	911	318	2,400
Total payments due between 1 and 5 years	2,850	550	8,557
Total payments due thereafter	1,465	234	6,421
Total future payments in relation to PFI contracts	5,226	1,102	17,378

	31/03/2022
	£000
Total present value of obligations for on-SoFP PFI contracts	**20,955**

25.3 Charges to expenditure	2021-22	2020-21
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	2,006	1,987
Total expense for Off Statement of Financial Position PFI contracts	869	1,109
The total charged in the year to expenditure in respect of PFI contracts	2,875	3,096

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	2,495	2,321
Later than five years	591	553
Total	3,086	2,874

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	3	1
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

25.5 The LHB has no Public Private Partnerships

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The LHB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The LHB has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the LHB in undertaking its activities.

Currency risk

The LHB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. The LHB therefore has low exposure to currency rate fluctuations.

Interest rate risk

LHBs are not permitted to borrow. The LHB therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the LHB's funding derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

The LHB is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The LHB is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2021-22 £000	2020-21 £000
(Increase)/decrease in inventories	**1,131**	(371)
(Increase)/decrease in trade and other receivables - non-current	**(7,273)**	30,553
(Increase)/decrease in trade and other receivables - current	**(37,888)**	(37,327)
Increase/(decrease) in trade and other payables - non-current	**(606)**	(911)
Increase/(decrease) in trade and other payables - current	**20,846**	57,520
Total	**(23,790)**	49,464
Adjustment for accrual movements in fixed assets - creditors	**1,950**	(4,688)
Adjustment for accrual movements in fixed assets - debtors	**0**	(53)
Other adjustments	**888**	7,945
	(20,952)	52,668

28. Other cash flow adjustments

	2021-22 £000	2020-21 £000
Depreciation	**41,158**	32,654
Amortisation	**2,517**	1,574
(Gains)/Loss on Disposal	**(232)**	(43)
Impairments and reversals	**(12,619)**	62,342
Release of PFI deferred credits	**0**	0
NWSSP Covid assets issued debited to expenditure but non-cash	**0**	(7,057)
Covid assets received credited to revenue but non-cash	**0**	0
Donated assets received credited to revenue but non-cash	**(166)**	(201)
Government Grant assets received credited to revenue but non-cash	**(22)**	(389)
Non-cash movements in provisions	**35,240**	9,462
Other movements	**26,915**	25,189
Total	**92,791**	123,531

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 14th June 2022; pre the date the financial statements were certified by the Auditor General for Wales.

30. Related Party Transactions

The Welsh Government is regarded as a related party. During the year the LHB have had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely

	2021-22		As at 31st March 2022	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Welsh Government	145	12,330	75	6,903
Betsi Cadwaladr University Health Board	945	87	358	12
Cardiff & Vale University Health Board	36,443	1,949	1,424	271
Cwm Taf University Health Board	23,911	1,684	415	69
Hywel Dda University Health Board	993	316	59	2
Powys Teaching Health Board	506	16,831	36	999
Swansea Bay University Health Board	3,863	895	395	199
Velindre NHS Trust	63,809	8,749	3,542	5,118
Welsh Ambulance Services NHS Trust	13,756	348	496	78
Public Health Wales NHS Trust	1,624	4,705	312	918
Welsh Health Specialised Services Committee	177,048	9,772	4,487	3,038
Health Education and Improvement Wales (HEIW)	22	11,267	22	224
Digital Health and Care Wales (DHCW)	5,208	1,091	194	231

In addition the LHB has had significant number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions are with the following:-

Government Body	2021-22		As at 31st March 2022	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Blaenau Gwent County Borough Council	6,584	2,027	1,462	908
Caerphilly County Borough Council	20,178	12,041	7,178	5,282
Monmouthshire County Council	8,381	2,303	2,615	1,189
Newport City Council	14,013	2,073	2,993	634
Torfaen County Borough Council	11,348	1,651	1,022	165

The LHB has also had significant material transactions with the following:

Aneurin Bevan Local Health Board Charitable Fund	24	930	5	175

A number of the LHB's Board members have interests in related parties as follows:

Member	Related Organisation	Relationship with Related Party	2021-22		As at 31st March 2022	
			Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Glyn Jones	Citizens Advice Bureau (Caerphilly & Blaenau Gwent)	Voluntary Treasurer and Board Trustee	265	0	16	0
	Guys & St Thomas NHS Foundation Trust	Son is Cardiac Physiologist	1	2	0	2
	Welsh Ambulance Trust	Sister is Project Manager	13,756	348	496	78
	Digital Health Care Wales	Niece has an Administrative Support Role	5,208	1,091	194	231
Robert Holcombe	JW Bowkett (Electrical Installation) Ltd	Son is an Employee of the Company	2,370	0	120	0
Dr James Calvert	Royal College of Physicians	Clinical Lead of National Asthma Audit	11	9	0	2
Philip Robson	Hospice of Valleys	Trustee	569	0	158	0
Chris Koehli	Pobl Group Limited	Non Executive Director	1,046	0	523	0
	Carers Trust Wales	Chair	91	3	91	0
Emrys Elias	Mind UK	Director Trustee	156	0	27	0
	Mind Cymru Pwyllgor	Chair of Governance Committee				
	Velindre NHS Trust	Spouse is Employee (Seconded to Health Inspectorate Wales)	63,809	8,749	3,542	5,118
	Welsh Health Specialised Services Committee	Vice Chair until 31st May 2021	177,048	9,772	4,487	3,038
Katija Dew	Newport Live	Trustee	180	10	81	3
Prof Helen Sweetland	Cardiff University	Employed	773	232	261	84
Richard Clark	Torfaen Voluntary Alliance	Company Secretary and Trustee	216	0	0	0
	Torfaen County Borough Council	County Borough Councillor, Deputy Leader and Elected Member	11,348	1,651	1,022	165
	Shared Resource Services Limited	Director	1	0	0	0
David Street	Caerphilly County Borough Council	Corporate Director, Social Services and Housing	20,178	12,041	7,178	5,282

31. Third Party assets

The LHB held £25,994.53 cash at bank and in hand at 31 March 2022 (31st March 2021, £31,205.63) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £0 at 31st March 2022 (31st March 2021, £0). This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

In addition the LHB had located on its premises a significant quantity of consignment stock. This stock remains the property of the supplier until it is used. The value of consignment stock at 31 March 2022 amounted to £3.6m (£2.0m as at 31st March 2021).

32. Pooled budgets

The Health Board has five pooled budgets. The specific accounting treatment of each pooled budget is covered within Accounting Policies note 1.22.

Monnow Vale Health and Social Care Unit
The Health Board has entered into a pooled budget with Monmouthshire County Council. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 to provide health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs and a memorandum note to the accounts provides details of the joint income and expenditure. The asset value of property, plant & equipment is £4,445K which is split 72% Aneurin Bevan Health Board and 28% Monmouthshire County Council. The costs incurred under the pooled budget is declared in the memorandum trading account.

Gwent Wide Integrated Community Equipment Service
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of an effective integrated GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the joint equipment store in the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is £1,069K for 2021/22 (£903K in 2020/21).

Mardy Park Rehabilitation Centre
The Health Board has entered into a pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are pooled under Section 33 of the NHS (Wales) Act 2006 to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council and the LHBs contribution is £220K for 2021/22 (£207K in 2020/21).

Gwent Frailty Programme
The Health Board has entered into a pooled budget with 5 Local Authorities in the Gwent area, namely Blaenau Gwent , Caerphilly, Monmouthshire, Newport and Torfaen County councils, for the provision of a Gwent wide integrated health and social care Frailty service, for service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the purpose of establishing a consistent service for the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is £9,294K for 2021/22 (£9,730K in 2020/21).

Continuing Healthcare - Older People in Care Homes
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision and commissioning of certain specialised services for older people (>65 years of age) in a care home setting in Gwent. Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.
The pool was established in August 2018 and is hosted by Torfaen County Borough Council. Under the arrangement, the Health Board makes a financial contribution equivalent to related expenditure in commissioning related placements in homes during the year. The LHB's contribution is £31,410K for 2021/22 (£31,117K in 2020/21).

Pooled Budget memorandum account for the period 1st April 2021 - 31st March 2022

Monnow Vale

	Cash	Own Contribution	Grants	Total
	£	£	£	£
Funding				
Aneurin Bevan Health Board	0	2,521,164	0	2,521,164
Monmouthshire County Council	361,508	792,474	0	1,153,982
Total Funding	**361,508**	**3,313,638**	**0**	**3,675,146**

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

Whilst the organisation is structured into divisions, the performance management and the allocation of resources flow from the Board of Aneurin Bevan University Health Board.

There are no hosted services within the health board. Divisions do not manage capital programmes, have any autonomy in relation to balance sheets or produce discrete accounts.

For the purposes of IFRS 8 it is therefore deemed that there is no requirement to report any operating segments.

34. Other Information

34.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2021 to 31 March 2022. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2021 and February 2022 alongside Health Board/Trust/SHA data for March 2022.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2021-22
Statement of Comprehensive Net Expenditure for the year ended 31 March 2022	**£000**
Expenditure on Primary Healthcare Services	**581**
Expenditure on Hospital and Community Health Services	**26,334**
Statement of Changes in Taxpayers' Equity For the year ended 31 March 2022	
Net operating cost for the year	**26,915**
Notional Welsh Government Funding	**26,915**
Statement of Cash Flows for year ended 31 March 2022	
Net operating cost for the financial year	**26,915**
Other cash flow adjustments	**26,915**
2.1 Revenue Resource Performance	
Revenue Resource Allocation	**26,915**
3. Analysis of gross operating costs	
3.1 Expenditure on Primary Healthcare Services	
General Medical Services	**581**
3.3 Expenditure on Hospital and Community Health Services	
Directors' costs	**93**
Staff costs	**26,241**
9.1 Employee costs	
Permanent Staff	
Employer contributions to NHS Pension Scheme	**26,915**
Charged to capital	**0**
Charged to revenue	**26,915**
18. Trade and other payables	
Current	
Pensions: staff	**0**
28. Other cash flow adjustments	
Other movements	**26,915**

34. Other Information

34.2 Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to NHS Wales bodies:

	2021-22 £000	2020-21 £000
Capital		
Capital Funding Field Hospitals		9300
Capital Funding Equipment & Works	7919	8961
Capital Funding other (Specify)	0	0
Welsh Government Covid 19 Capital Funding	**7,919**	**18,261**

			As previously reported in 2020-21
Revenue			
Sustainability Funding			56,400
C-19 Pay Costs Q1 (Future Quarters covered by SF)			8,527
Field Hospital (Set Up Costs, Decommissioning & Consequential losses)			0
Bonus Payment			14,663
Independent Health Sector			2,127
Stability Funding	103,562	81,717	
Covid Recovery	24,863	0	
Cleaning Standards	2,105	0	
PPE (including All Wales Equipment via NWSSP)	5,517	8,950	
Testing / TTP- Testing & Sampling - Pay & Non Pay	9,036	0	
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	13,548	7,487	
Extended Flu Vaccination / Vaccination - Extended Flu Programme	1,364	894	
Mass Covid-19 Vaccination / Vaccination - COVID-19	10,490	4,911	
Annual Leave Accrual - Increase due to Covid	1,968	20,295	
Urgent & Emergency Care	1,515	4,441	
Private Providers Adult Care / Support for Adult Social Care Providers	3,125	6,205	
Hospices	0	0	
Other Mental Health / Mental Health	114	1,079	
Other Primary Care	1,222	2,083	
Social Care	1,846		
Other	412	4,495	
Welsh Government Covid 19 Revenue Funding	**180,687**	**142,557**	

Other Category includes - STI (New WBS to be set up)

34. Other Information

34.3 Changes to accounting standards not yet effective - IFRS 16 Impact

IFRS 16 Leases supersedes IAS 17 Leases and is effective in the public sector from 1 April 2022. IFRS 16 provides a single lessee accounting model and requires a lessee to recognise right-of-use assets and liabilities for leases with a term more than 12 months unless the underlying value is of low value. The FReM makes two public sector adaptions

- The definition of a contract is expanded to include intra UK government agreements that are not legally enforceable;
- The definition of a contract is expanded to included agreements that have nil consideration.

IFRS 16 gives a narrower definition of a lease that IAS 17 and IFRIC 4 by requiring that assets and liabilities will be recognised initially at the discounted value of minimum lease payments After initial recognition, right of use assets will be depreciated on a straight line basis and interest recognised on the liabilities. Except where modified for revaluation where material, the cost model will be applied to assets other than peppercorn leases which will be measured on a depreciated replacement cost basis. The right of use asset in a peppercorn lease is accounted for similarly to a donated asset.

As required by the FReM IFRS 16 will be implemented using the accumulated catch up method.

When making the comparison to IAS17 in the note below, this is the comparison for those leases which are going to be recognised under IFRS16 that are transitioning as at 1st April 2022.

The right of use assets and leasing obligation have been calculated and indicated that the total discounted value of right of use assets and liabilities under IFRS 16 is lower than the value of minimum lease commitments under IAS 17. In the ROU asset note we have assumed the extension option on the managed service contracts which have been excluded in the leases note. The impact of implementation is an

- increase/decrease in expenditure £25k;
- increase/decrease in assets and liabilities of £27,548k.

These figures are calculated before intercompany eliminations are made, these will have a material impact on the figures.

Right of Use (RoU) Assets Impact

		Property	Non Property	Total
		£000	£000	£000
Statement of financial Position				
RoU Asset Recognition				
+	Transitioning Adjust	18132	5015	**23147**
+	As at 1 April 2022	18132	5015	**23147**
+	Renewal / New RoU Assets 2022-23	3813	588	**4401**
-	Less (Depreciation)	-3541	-1175	**-4716**
+	As at 31 March	18404	4428	**22832**

RoU Asset Liability		Property	Non Property	Total
		£000	£000	£000
-	Transitioning Adjust	-18132	-5015	**-23147**
-	As at 1 April 2022	-18132	-5015	**-23147**
-	Renewal / New RoU Liability 2022-23	-3813	-588	**-4401**
+	Working Capital	3546	1255	**4801**
-	Interest	-181	-49	**-230**
-	As at 31 March	-18580	-4397	**-22977**

Charges	Property	Non Property	Total
Expenditure	£000	£000	£000
RoU Asset depreciation [1]	3541	1175	**4716**
Interest on obligations under RoU Asset leases [2]	181	49	**230**
	3722	1224	**4946**

The new ROU assets for 2022/23 are estimated, there may be additional leases identified/changes

LHB

1 Expenditure on Hospital and Community Health Services
2 Finance Costs

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

Appendix 2

Draft Annual Accounts - Queries raised in the Audit Finance and Risk Committee on 17.05.2022.

Remuneration Report

As in previous years we have included the special advisors to the Board given the role that they undertake.

Audit Wales have confirmed that they are more comfortable with them remaining on the remuneration report as a potential over-disclosure rather than a potential under disclosure if we were to exclude them.

Note 9.6 – Fair Pay disclosure – Remuneration relationship

A query was raised with regard to the below remuneration rage and in particular the £338K

*Remuneration for all staff ranged from **£19k to £338k** (2020-21, £18k to £228k).*

This is correct with the £338K relating to a consultant.

Clinical Negligence Costs

Given that the Audit of the 2021/22 is still ongoing information will be requested form the other Welsh Health Bodies in relation to the level of provision held once the final accounts have been submitted. This will then be circulated to the Audit, Finance and Risk Committee members.

Voluntary Organisations 2021/22 Expenditure

See Appendix 3

Briefing re Quinquennial Revaluation Exercise and Annual Indexation

Within NHS Wales, Land and Building assets are subject to a formal revaluation exercise every five years. The latest exercise was undertaken as at 1 April 2017 and the next exercise will commence on 1 April 2022.

This quinquennial valuation exercise is supplemented by annual indexation to maintain assets at current cost values without the expense of frequent revaluation exercises. Indexation is another form of revaluation and

although identified separately in asset registers and the annual account formats it is treated in accounting terms in the same way as an increase or decrease to the asset base. Indices are provided by the District Valuer and are based on data available from the Building Cost Information Service (BCIS) and the Valuation Office Property Market Report for Land and Property.

Assets under construction are not indexed annually. Instead, once a project is complete, a formal valuation is obtained for those schemes costing more than £500k. This ensures the new assets are captured at the correct value for the annual accounts.

Voluntary Organisations **Appendix 3**

Analysis of Expenditure in note 3.2 to the 2021/22 Annual Accounts

Supplier	£p
MELIN HOMES LTD	4,778,799.00
ST DAVIDS FOUNDATION (ST DAVIDS HOSPICE CARE LTD)	1,604,655.80
UNITED WELSH HOUSING ASSOCIATION LTD (USW)	1,151,935.27
SOCIAL ABILITY LTD	899,997.90
AGE CYMRU	894,432.40
GROWING SPACE	693,511.72
FIRST CHOICE	634,658.00
ACTION FOR CHILDREN	540,772.70
POBL	523,158.87
BRITISH RED CROSS SOCIETY	514,951.63
ADFERIAD RECOVERY TA HAFAL	491,889.01
THE CARE COLLECTIVE DE CYMRU LTD	484,328.30
CARERS TRUST SOUTH EAST WALES LTD	430,573.68
PLATFFORM FOR CHANGE	420,528.47
ACTION FOR CHILDREN SERVICES LTD	415,062.60
HOSPICE OF THE VALLEY	399,372.78
GWENT ASSOCIATION OF VOLUNTARY ORGANISATIONS	386,480.01
ALZHEIMERS SOCIETY	383,168.96
CRUSE BEREAVEMENT CARE	373,839.00
BRIDGES COMMUNITY CENTRE	366,868.01
ADVOCACY SUPPORT IN CYMRU LTD	353,242.84
MY DEMENTIA IMPROVEMENT NETWORK	349,998.86
NEWPORT CAB TA CITIZENS ADVICE BUREAU	191,761.06
ADFERIAD RECOVERY TA HAFAL	190,973.71
LINC-CYMRU HOUSING ASSOCIATION LTD	166,480.00
BLAENAU GWENT CARE & REPAIR	158,373.00
TORFAEN VOLUNTARY ALLIANCE	147,097.82
ALZHEIMERS SOCIETY	143,880.96
MIND	119,590.00
DEWIS CENTRE FOR INDEPENDENT LIVING	101,501.37
TORFAEN MIND	81,767.20
ADFERIAD RECOVERY TA HAFAL	64,053.31
VALLEYS STEPS	59,794.51
HUG BY LAUGH LTD	58,200.00
KALEIDOSCOPE	53,896.60
VOLUNTEERING MATTERS	52,485.36
CEREBRAL PALSY CYMRU	50,435.00
OXFORD BROOKES UNIVERSITY	48,348.00
LIGHTFOOT SOLUTIONS UK LTD	47,544.00
SPARKLE (SOUTH WALES) LTD	45,000.00
LLAMAU LTD	41,168.50
BRIDGES COMMUNITY CENTRE	40,000.00
WG CRUSE	37,500.00
SIGHT CYMRU	37,337.35
LIFE SCIENCES HUB	36,000.00
2 WISH UPON A STAR	35,721.28
AGE CONCERN GWENT	27,299.55

NEW PATHWAYS		25,500.00
GWENT WILDLIFE TRUST LTD		25,000.00
CAMPBELL TICKELL LTD		24,800.00
HEADWAY CARDIFF		23,770.50
THE CONSULTATION INSTITUTE		22,500.00
4 MINDS LTD		22,100.00
LIVE MUSIC NOW		20,450.00
SEREN GROUP LTD		19,186.00
MARTIN HOPKINS PARTNERSHIP LTD		19,173.00
BREAKING FREE ONLINE LTD		18,000.00
TERRENCE HIGGINS TRUST		16,613.00
THE STROKE ASSOCIATION		16,176.59
WELLMIND HEALTH LTD		15,000.00
AGE CONNECT TORFAEN		13,289.80
GWENT MENTAL HEALTH AND LEARNING DISABILITIES ALLIANCE		12,125.00
WELSH REFUGEE COUNCIL		11,550.00
YALLA DEV LTD		10,679.04
NPP CYMRU NETWORK PSYCHOSEXUAL PARTNERSHIP		10,500.00
CAERPHILLY CARE FOR CARERS - EMERGENCY PRESSURES		8,509.44
RIGHT FROM THE START PARENTING PROGRAMME		6,599.00
GWENT ASSOCIATION OF VOLUNTARY ORGANISATIONS		6,246.01
GWALIA CARE & SUPPORT		5,248.00
INTERNATIONAL MENTAL HEALTH COLLABORATING NETWORK		5,000.00
SENSE		5,000.00
CITIZENS ADVICE		4,346.37
ST JOHN CYMRU-WALES		4,094.91
ST GWLADYS CHURCH HALL		3,772.00
BRC & AGE CYMRU GWENT		3,026.53
CRUSE BEREAVEMENT CARE		2,520.00
PRICE ALICE HOSPITAL		2,200.00
HOSPICE OF THE VALLEY		2,000.00
NEWPORT CITY HOMES HOUSING ASSOCIATION LTD		1,673.59
DIVERSE CYMRU		1,647.28
BRON AFON COMMUNITY HOUSING LTD		1,395.36
ST JOHN CYMRU-WALES		1,200.02
GOLF UNION OF WALES - TA WALES GOLF		1,080.00
ACTION FOR ELDERS TRUST		642.00
BRITISH RED CROSS SOCIETY		620.00
KINGS FUND		180.00
VENTURE WALES		104.04
CAERPHILLY CARE FOR CARERS	-	1,063.82
CARE & REPAIR CYMRU LTD	-	1,864.41
CAERPHILLY CARE & REPAIR	-	4,540.00
GMS	-	13,500.00
DIGITAL COMMUNITIES WALES	-	35,000.00
ICF	-	38,669.00
DCP 3rd Sector	-	105,760.00
HAFAL	-	108,674.28
OTHER	-	188,167.28
REGIONAL TRAINING PROGRAMME	-	200,000.00
Total		18,824,713.08

Auditor General for Wales
Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

14 June 2022

Representations regarding the 2021-22 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Health Board for the year ended 31 March 2022 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- Preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and

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  - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Health Board will continue in operation.
- Ensuring the regularity of any expenditure and other transactions incurred.
- The design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Health Board and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole. A summary of these items is set out below:

- An increase of £11.047 million in the value of land and buildings in respect of indexation, as at 31 March 2022;
- An increase in depreciation of £101,000 for 2021-22 to be charged to the Statement of Comprehensive net Expenditure;
- A reversal of past impairments of £7.577 million for 2021-22 to be credited to the Statement of Comprehensive net Expenditure; and
- An increase in the revaluation reserve of £3.470 million, as at 31 March 2022.

We have chosen not to amend these misstatements as the Health Board has applied the 2021-22 indexation rates issued by the District Valuation Office in August 2021. On 22nd March 2022, the District Valuation Office issued revised rates for the 2021-22 year. In line with all other Welsh health bodies and in compliance with instructions from Welsh Government under Technical Update 7, the Health Board has not applied the latest rate in their calculation of indexation within the financial statements.

Representations by Aneurin Bevan University Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Health Board on 14 June 2022.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:
Glyn Jones
Interim Chief Executive and Accountable Officer
14 June 2022

Signed by:
Ann Lloyd CBE
Chair
14 June 2022

Name of Committee:	Audit, Risk and Assurance Committee
Chair of Committee:	Shelley Bosson, Independent Member
Reporting Period:	Annual Report and Accounts 2021/22 – June 2022

Purpose

The purpose of this paper is to provide the Board with a recommendation from the Audit, Risk and Assurance Committee regarding the approval of ABUHB's Annual Report and Accounts for 2021/22.

Summary

The Audit, Risk and Assurance (ARA) Committee confirms that, in accordance with its Terms of Reference, it met on 13th June 2022 to consider:

1. ABUHB's Draft Annual Report and Accounts 2021/22, which includes:
    - The Performance Report;
    - The Annual Accountability Report; and
    - The Financial Statements
2. The Audit of Accounts Report (2021/22) of External Audit (Audit Wales); and
3. ABUHB's Letter of Representation for 2021/22.

Summary of discussion to be included following meeting of the Committee on 13th June 2022

Recommendation

The Audit, Risk and Assurance Committee confirms that it is not aware of any other matters that should be drawn to the Board's attention which are not included in the reports presented to the Board in respect of the Annual Report and Accounts 2021/22.

Therefore, the Audit, Risk and Assurance Committee RECOMMENDS to the Board that it:

- RECEIVES the Audit of Accounts Report (2021/22) of External Audit (Audit Wales)
- APPROVES the Annual Report and Accounts 2021/22, which includes:
    1. The Performance Report;
    2. The Annual Accountability Report; and
    3. The Financial Statements
- APPROVES the Letter of Representation; and
- AUTHORISES the Chair, Chief Executive Officer and Director of Finance, Procurement and VBH, to sign these documents where required.