Audit Risk and Assurance Committee

Thu 08 February 2024, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. Preliminary Matters

Oral *Chair*

1.0 ARAC Agenda 08_02_24.pdf (3 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of last Meeting held on 28th November 2023

Attached *Chair*

1.4 ARAC Minutes 28_11_23 v2 - Chair Approved.pdf (10 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 Audit Risk Assurance Committee Action Log 28-11_23 - Chair Approved.pdf (3 pages)

09:30 - 09:30
0 min

2. Items For Approval/Ratification/Decision

2.1. To Endorse the change to the Risk Appetite Statement

For Approval *Director of Corporate Governance*

2.1 Risk Management Update Report.pdf (4 pages)
2.1 Appendix A ABUHB_Corporate_1132 Risk Appetite Statement Track Changes.pdf (8 pages)
2.1 Appendix B ABUHB_Corporate_0277 Risk Management Framework.pdf (52 pages)
2.1 Appendix C ABUHB_Corporate_1133 Risk Management Policy and Procedure .pdf (28 pages)

2.2. To Approve the Report on the use of Single Tender Action

For Approval *Director of Finance and Procurement*

2.2 Single Tender Action Report 11.11.2023 - 19.01.2024.pdf (3 pages)
2.2a Appendix A - Single Tender Action 11.11.2023 - 19.01.2024.pdf (1 pages)

2.3. To Receive the Report on Financial Governance, Reporting and Ratify Financial Control Procedures

Attached *Director of Finance and Procurement*

- Petty Cash FCP
- Petty Cash FCP Mental Health

2.3 Governance Report 08.02.2024-v2.pdf (8 pages)
2.3a Appendix 1 ABUHB_Finance_0251 FCP Petty Cash Final.pdf (11 pages)
2.3b Appendix 2 ABUHB_Finance_0895 FCP Petty Cash - Mental Health Final.pdf (17 pages)

09:30 - 09:30
0 min

3. Items for Discussion

3.1. To Receive the Counter Fraud Annual Report

Attached *Head of Counter Fraud*

3.1 ARAC Counter Fraud Report Q3 23-24(1) (002).pdf (6 pages)

3.2. To Receive an Update on Clinical Audit Activity 2023-24

Attached *Assistant Director Patient Quality and Safety*

Including an Update on Implementation of Ward Assurance Audits

3.2 Final Clinical Audit Plan ARA Feb 2024.pdf (21 pages)
3.2a Appendix 2 Clinical Audit Activity 2023 to Jan 2024.pdf (86 pages)

3.3. To Receive the 2023/24 Committee Programme of Business to include

Attached *Director of Corporate Governance*

Including an Update on the Development of 2024/25 Programme of Business

3.3 MASTER_ARA_Committee Work Programme 2023-24. Final.pdf (5 pages)

3.4. To Receive the Internal/External Audit Recommendations Tracker

Attached *Director of Corporate Governance*

Including Assurance Reports on Longstanding (2017-21) Audit Recommendations

3.4 Internal & External Audit Recommendations Q3 2023-24 Cover Report.pdf (7 pages)
3.4 Appendix 1 Dashboard.pdf (1 pages)
3.4 Appendix 2 2017-21 Overdue Recommendations Pre-Updates.pdf (3 pages)
3.4 Appendix 2.1 - Assurance Reports (Pre-22) Revised Timescale Requests.pdf (20 pages)
3.4 Appendix 2.2 - Assurance Reports (Pre-22) Overdue following Updates.pdf (6 pages)
3.4 Appendix 3 2022-23 Overdue Recommendations Pre Updates.pdf (4 pages)
3.4 Appendix 4 2022-23 Overdue Recommendations Post Update.pdf (1 pages)
3.4 Appendix 5 Completed Recommendations.pdf (5 pages)
3.4 Appendix 6 2022-23 Revised Timescale Requests.pdf (3 pages)
3.4 Appendix 7 Not Yet Due Recommendations.pdf (4 pages)

3.5. To Receive the Internal Audit Progress Report

Attached *Deputy Head of Internal Audit, NWSSP.*

3.5 ABUHB February 2024 Audit Committee Progress Report v2.pdf (8 pages)

3.6. To Receive Internal Audit Report

Attached *Deputy Head of Internal Audit, NWSSP*

3.6.1. Facilities - Limited Assurance

Attached

Divisional Director of Facilities will be attending for this item

3.6a ABUHB 2023.24 Facilities Internal Audit Report Final.pdf (25 pages)

3.6.2. Estates Condition - Limited Assurance

Attached

Divisional Director of Facilities will be attending for this item

3.6b ABU-SSU-2324-02 Estates Condition Final report.pdf (30 pages)

3.6.3. Data Quality - Reasonable Assurance

Attached

Executive Director of Digital will be attending for this item

3.6c ABUHB 2324-09 Data Quality Final Internal Audit Report Client v2.pdf (11 pages)

3.6.4. IT Stakeholder Engagement - Reasonable Assurance

Attached

Executive Director of Digital will be attending for this item

3.6d AB-2324-25 IT Stakeholder Engagement Final Internal Audit Report for Client.pdf (11 pages)

3.7. To Receive the External Audit Progress Report 2023-24

Attached *Performance Audit Lead, Audit Wales*

3.7 Audit Risk and Assurance Committee Update - February 2024.pdf (12 pages)

3.8. To Receive the External Audit Annual Audit Report

Attached *Performance Audit Lead, Audit Wales*

3.8 ABUHB Annual Audit Report 2023 final.pdf (22 pages)

3.9. To Receive the Audit Wales Primary Care Follow-Up Report

Attached *Performance Audit Manager, Audit Wales*

Chief Operating Officer will be attending for this item

3.9 ABUHB Primary Care Follow-up final.pdf (28 pages)

3.10. To Receive Workforce Planning Report

Attached *Performance Audit Lead, Audit Wales*

Executive Director of Workforce and OD will be attending for this item

3.10 ABUHB Workforce planning report final.pdf (32 pages)

3.11. To Receive the Final Structured Assessment Report 2023

Attached *Performance Audit Lead, Audit Wales*

3.11 ABUHB Structured Assessment 2023_final.pdf (38 pages)

3.12. To Review Standing Orders, Standing Financial Instructions, and Scheme of Delegation

Attached *Director of Corporate Governance*

3.12 SO Compliance Report ARAC Feb 2024.pdf (4 pages)
3.12a Appendix 1 SO Compliance Overview.pdf (5 pages)

3.13. To Review the adequacy of arrangements for declaring, registering, and handling interests to include:

Attached *Director of Corporate Governance*

- The full report of all declared Gifts and Hospitality

- 3.13 Declaration of Iinterest Update ARAC 8.02.24.pdf (4 pages)
- 3.13 Appendix A Band 8a and above & Consultant Register of Interest - Editable.pdf (16 pages)

3.14. To Receive the Committee Risk and Assurance Report

Attached *Director of Corporate Governance*

- 3.14 Committee Risk Report_ARAC_Feb 2024.pdf (5 pages)
- 3.14Appendix A StrategicRisk Register.pdf (4 pages)
- 3.14 Appendix B Strategic Risk Assessments 21.pdf (26 pages)

09:30 - 09:30
0 min

4. Items For Information

4.1. Stakeholder Perception Research Project Report

Attached *Director of Corporate Governance*

- 4.1 Savanta Summary of Research.pdf (6 pages)

09:30 - 09:30
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5. Other Matters

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

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting

Tuesday 16th April 2024 at 13:30

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

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Thursday 8th February at 09:30**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 28th November 2023	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Endorse the change to the Risk Appetite Statement	Attached	Director of Corporate Governance
2.2	To Approve the Report on the use of Single Tender Action	Attached	Director of Finance and Procurement
2.3	To Receive the Report on Financial Governance and Reporting To Ratify Financial Control Procedures (FCPs); • Petty Cash • Petty Cash – Mental Health	Attached	Director of Finance and Procurement
3	**ITEMS FOR DISCUSSION**		
3.1	To Receive the Counter Fraud Annual Report	Attached	Head of Counter Fraud
3.2	To Receive an Update on Clinical Audit Activity 2023-24 to include; • Update on Implementation of Ward Assurance Audits	Attached	Assistant Director Patient Quality and Safety

3.3	To Receive the 2023/24 Committee Programme of Business to include; • Update on the development of 2024/25 Programme of Business	Attached	Director of Corporate Governance
3.4	To Receive the Internal/External Audit Recommendations Tracker to include • Assurance Reports on Longstanding (2017 – 21) Audit Recommendations	Attached	Director of Corporate Governance Director of Therapies & Health Science
3.5	To Receive the Internal Audit Progress Report	Attached	Deputy Head of Internal Audit, NWSSP
3.6	To Receive Internal Audit Report Limited Assurance • 3.6.1 Facilities • 3.6.2 Estates Assurance Reasonable Assurance • 3.6.3 Data Quality • 3.6.4 IT Stakeholder Engagement	Attached	Deputy Head of Internal Audit, NWSSP Chief Operating Office Director of Digital
3.7	To Receive the External Audit Progress Report 2023-24	Attached	Performance Audit Lead, Audit Wales
3.8	To Receive the External Audit Annual Audit Report	Attached	Performance Audit Lead, Audit Wales
3.9	To Receive the Audit Wales Primary Care Follow-up Report.	Attached	Performance Audit Manager, Audit Wales Chief Operating Officer
3.10	To Receive Workforce Planning Report	Attached	Performance Audit Lead, Audit Wales Director of Workforce & OD
3.11	To Receive the Final Structured Assessment Report 2023	Attached	Performance Audit Lead, Audit Wales
3.12	To Review Standing Orders, Standing Financial Instructions, and Scheme of Delegation.	Attached	Director of Corporate Governance
3.13	To Review the adequacy of arrangements for declaring, registering, and handling interests to include: • The full report of all declared Gifts and Hospitality	Attached	Director of Corporate Governance

3.14	To Receive the Committee Risk and Assurance Report	Attached	Director of Corporate Governance
4	**ITEMS FOR INFORMATION**		
4.1	Stakeholder Perception Research Project Report	Oral	Chair
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: Tuesday 16th April 2024 at 13:30		

KEY:	
Priority 1	• Every Child has the Best Start in Life
Priority 2	• Getting it Right for Children and Young Adults
Priority 3	• Adults in Gwent Live Healthily and Age Well
Priority 4	• Older Adults are Supported to Live Well and Independently
Priority 5	• Dying Well as part of Life
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance

Motion to Exclude Members of the Public and the Press

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

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

MINUTES OF THE AUDIT, RISK AND ASSURANCE COMMITTEE ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DATE OF MEETING	Tuesday 27th November 2023
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Independent Member, Committee Chair Richard Clark– Independent Member, Committee Vice Chair Shelley Bosson - Independent Member
IN ATTENDANCE	Rani Dash- Director of Corporate Governance Lucy Windsor – Head of Corporate Risk and Assurance Rob Holcombe - Director of Finance and Procurement Paul Solloway – Director of Digital *(joined at 11:00)* James Calvert – Medical Director *(joined at 11:00)* Hannah Evans – Director of Strategy, Planning and Partnerships *(joined at 11:00)* Jennifer Winslade – Director of Nursing *(joined at 11:20)* Amanda legge – Post Payment Verification Manager, NWSSP *(left at 10:15)* Sarah Jeremiah – Post Payment Verification Location Manager, NWSSP *(left at 10:15)* Nicola Prydgodzicz – Chief Executive, ABUHB Michelle Morris – Head of Counter Fraud *(left at 10:00)* Stephen Chaney – Deputy Head of Internal Audit Nathan Couch – Audit Wales Mark Ross – Assistant Finance Director Andrew Doughton – Audit Wales Michelle Jones – Head of Board Buisness Danielle Jackson – Secretariat
OBSERVERS	Helen Sweetland – Independent Member

ARAC 2811/1	**Preliminary Matters**
ARAC 2811/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 2811/1.2	**Apologies for Absence** There were no apologies of absence noted.
ARAC 2811/1.3	**Declarations of Interest** There were no declarations of interest raised to record.
ARAC 2811/1.4	**Minutes of the previous meeting**

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	The minutes of the meeting held on the 12th September 2023 were agreed as a true and accurate record.
ARAC 2811/1.5	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions that were not yet due.
ARAC 2811/2	**Items for Approval / Ratification/ Decision**
ARAC 2811/2.1	**Ratification of the use of Single Tender Waivers.** Mark Ross (MR), Assistant Finance Director, provided the Committee with a summary on Single Tender Action Waivers for the period 01 September 2023 – 10 November 2023. The Single Tender Action (STA) schedule contained a summary of the three STA requests that had been submitted and approved. The Committee **APPROVED** the use of the Single Tender Action Waivers.
ARAC 2811/2.2	**Ratification of Financial Governance, Reporting and Control Procedures.** Mark Ross (MR), Assistant Finance Director, provided the Committee with a summary of financial governance, reporting and controls. There were three financial control procedures presented that required approval: • Cash and Bank; • Patient Travel Costs; and, • Capital Procedures and Guidance Notes. Iwan Jones (IJ), Committee Chair, asked why there was no direct reference to charitable funds in the Cash and Bank policy, even though charitable funds had its own bank account. MR confirmed that a separate policy covering charitable funds existed. MR informed the Committee that technical accounting issues had been minimal with the main update being in relation to working capital and strategic cash support, which was to support the Health Board deficit. There had been positive improvement within the NHS public sector payment policy noting there had been an improvement on previous months and the non-NHS is still comfortably above 95%.

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	The Committee **APPROVED** all three financial control procedures and noted the report for assurance.
ARAC 2811/3	**Items for Discussion**
ARAC 2811/3.1	**Receive Report of Losses and Special Payments** Mark Ross (MR), Assistant Finance Director, provided the Committee with a summary of the Losses and Special Payments report. It was noted that the largest financial values within the report related to clinical negligence and personal injury and the majority of losses were covered by the Welsh Risk Pool. The overall loss incurred for the Health Board within the reporting period was £1.2m with the provision figure standing at £208m with net impact being £5m for the Health Board. Shelly Bosson (SB), Independent Member, inquired if there were any trends emerging in relation to the increase in clinical negligence claims and whether there had been any successful claims arising from delays in treatment. MR was unable to provide a definitive response due to significant fluctuation. Rob Holcombe (RH), Director of Finance and Procurement, advised that full detail regarding Losses and Special Payments is typically provided to the Quality and Patient Safety Committee (PQSOC) via the annual report. RH agreed to review the PQSOC report and circulate any findings back to the Committee, however, if the detail could not be sourced work would be undertaken to identify trends. **ACTION: Director of Finance and Procurement.** The Committee **NOTED** the report for Assurance.
ARAC 2811/3.2	**Receive Quarterly Report on Counter Fraud Activity** Michelle Morris (MR), Head of Counter Fraud, provided the Committee with an overview of the Quarterly Counter Fraud Activity Report. It was noted that there had been an unprecedented volume of referrals received during quarter 2 (July – September). The Committee was informed of a number of financial recoveries, the majority of which were related to salary and salary sacrifice overpayments, as well as the introduction of a new overpayments platform to assist in quickly resolving overpayments issues and would be rolled out nationally over the coming weeks.

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	The Committee was informed that the Core Learning Committee had approved Counter Fraud training as mandatory training for all staff. The Chair inquired whether there were any ongoing issues with the Crown Prosecution Service (CPS) being hesitant to prosecute cases, to which MM responded that there had been positive engagement from the CPS following a change in leadership within the service. The Committee **NOTED** the contents of the report for assurance. ***Michelle Morris left the meeting.***
ARAC 2811/3.3	**Receive Mid-Year Update of Post-Payment Verification** Amanda Legge (AL), Post Payment Verification Manager, NWSSP, provided the Committee with an overview of the Mid-Year Post-Payment Verification Report. It was noted that there had been ongoing challenges with General Medical Services (GMS) throughout the year, with 11 visits completed and 7 in progress out of the 55 planned. The delay was caused by problems with the new pre-payment system, which was installed after the previous system was decommissioned. It was agreed and communicated in December 2022 that Post-Payment Verification would be suspended until April 1st, 2023, to allow issues to be resolved, which was successful. A new collaborative working scheme is due to go live on 01 April 2024 which will offer an additional check in relation to pharmacy work. The claim for additional community pharmacy payable, as requested by Welsh Government and the clinical waste self-assessment for GMS had been completed. AL informed GMS and GPS visits would be completed by the end of December 2023 which would allow a focus on GMS revisits up until the end of March 2024. The Committee **NOTED** the contents of the report for assurance. ***Ammanda Legge and Sarah Jeremiah left the meeting.***
ARAC 2811/3.4	**Receive Update on Job Planning Arrangements**

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	James Calvert (JC), Medical Director provided the Committee with an update on Job Planning Arrangements. Significant effort had been put into developing the software's framework, as well as ensuring a standardised organisational approach in pay rates and job planning. The E Job Planning Software procurement (Job Planning, E Bank, and E Rostering) was successful, and final contracts were awarded in September 2023. All software is expected to be fully implemented by the end of quarter one, in June 2024. The Committee agreed to deferring the next Job Planning Arrangements update until Q1/Q2 2024, depending on the update that could be provided to assure the Committee that the Job Planning Internal Audit recommendations were complete. **ACTION: Medical Director/Secretariat.** The Committee **NOTED** the report and **AGREED** to the next update report being deferred to May 2024.
ARAC 2811/3.5	**Review Committee Programme of Business** Rani Dash (RD), Director of Corporate Governance, provided a summary of the report and noted that at the next meeting a presentation would be provided to demonstrate movement and tracking of Committee business. The Committee was informed that an assurance mapping exercise against strategic risks and committee forward work programmes was currently underway to ensure that committees received comprehensive reports on strategic risk management that were aligned with the relevant Committee. The Committee **NOTED** the Committee Programme of Business.
ARAC 2811/3.6	**Receive Report on Audit Risk and Assurance Committee (ARAC) Self-Assessment Outcome** Rani Dash (RD), Director of Corporate Governance, provided the Committee with a summary of the ARAC Self-Assessment Outcome Report. The Committee noted that the self-assessment result was positive, and that the Committee was meeting the standards overall, but that there were some areas that needed to be strengthened, some of which would be addressed in an overarching Board Business Improvement Plan and others in specific actions to improve the Audit, Risk, and Assurance Committee's effectiveness.

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	RD addressed the clinical audit section, suggesting that the Committee agree on its role in relation to the clinical audit plan, activity, and delivery. The Committee agreed that PQSOC would be responsible for clinical audit in its entirety once the ARAC was satisfied that the delivery plan for the most recent Clinical Audit Internal Audit had been fully implemented. RD would bring back an update paper to inform the Committee of how the results of all Committee Self Assessments had informed the overall Board Business Improvement Plan as well as the Audit Committee's specific actions. The Committee **NOTED** the report for Assurance.
ARAC 2811/3.7	**Receive Assurance on Implementation of the Governance Priorities set out within the IMPT 2022-25** Rani Dash (RD), Director of Corporate Governance, provided the committee with a summary of the Governance Priorities set out in IMTP 2022-25 Plan. The Committee noted that, with the exception of one action relating to implementing a system of organisational assurance mapping, all priorities within the IMTP were green or amber; however, work was currently paused pending ongoing work to embed risk management as a priority, which would then allow a more systematic approach around assurance mapping. The Committee **NOTED** the report for Assurance.
ARAC 2811/3.8	**Receive Update on Compliance with Ministerial Directions and Welsh Health Circulars (WHCs)** Rani Dash (RD), Director of Corporate Governance, provided the Committee with a summary of compliance with Ministerial Directions and Welsh Health Circulars (WHCs). RD advised that there were seven WHCs in progress, not fully implemented and four Ministerial Directions. The Committee noted that there had been a number of WHCs and Ministerial Directions that did not include timeframes, and that work was underway with owners to establish timeframes so that progress could be effectively monitored, and future reporting improved. The Committee **NOTED** the report for Assurance.

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ARAC 2811/3.9	**Review Internal and External Audit Recommendations Tracking** Rani Dash (RD), Director of Corporate Governance, provided the Committee with a summary of the Internal and External Audit Recommendation Tracker and requested that the Committee approve the 37 recommendations that had proposed revised timescales, leaving a residual position of 36 overdue: 34 internal and 2 external recommendations. The Committee expressed concern about the 36 overdue recommendations, particularly those that had been outstanding for a long time (prior to 2022) and were deemed significant in terms of assurance and priority rating. Nicola Prygodzicz (NP), Chief Executive stated that the Executive Committee had discussed the importance of implementing and completing audit recommendations on time and agreed to discuss any outstanding recommendations with the relevant lead executives. **ACTION: Chief Executive Officer.** The Committee was not assured that the action plan to complete the recommendation relating to the Medical Equipment Devices internal audit from 2017 was progressing, so it did not approve the extended timeframe without a more detailed update on the implementation plan and progress. The Committee requested that the next report to the Committee include more detail and that the Lead Executive attend to provide the necessary assurance. **ACTION: Secretariat** The Committee **NOTED** the report and **APPROVED** 36 of 37 revised timescale requests.
ARAC 2811/3.10	**Receive Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided the Committee with a summary of the Risk Report. Shelley Bosson (SB), Independent Member, inquired whether the Board had agreed to tolerate risks at the current level, noting that they were being managed. RD responded that, that there was no agreement to tolerate risks above appetite level, and that the expectation is to manage risks down to within appetite level. RD also stated that assurance mapping was in progress to ensure that detailed reports for each risk were included in Committee Forward Work Programmes to provide assurance that the risks were effectively managed.

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	RD informed the Committee that the updated Risk Management and Assurance Framework, Policy, and Procedure would be circulated to the Committee and the wider Board within the next week for consultation in preparation for Board approval in January 2024. The deadline for comments was set for 22 December 2023. The Committee **NOTED** the report and **APPROVED** the request to virtually circulate the draft Risk Management & Assurance Framework, Policy, and Procedure for review.
ARAC 2811/3.11	**Internal Audit Progress Report** Stephen Chaney (SC), Deputy Head of Internal Audit, provided a summary of the Internal Audit Progress Report to the Committee. It was proposed that the following audits be deferred into 2024/25 with the opportunity to replace with alternative reviews: • Allegations against Staff Policy, • Job Planning, The Health and Social Care (Quality and Engagement Wales) Act. Rani Dash (RD), Director of Corporate Governance, suggested that an internal audit of Health and Safety focused on risk management be conducted as a result of the lack of assurance the Board could take from the Health and Safety Annual Report at its November meeting. The Committee agreed with the need for a Health and Safety Risk Review. The committee also discussed the possibility of a whistleblowing audit as the most recent internal audit review was undertaken a few years ago. The committee noted that Internal Audit was exploring potential replacement audits. The Committee **NOTED** the report and **APPROVED** the proposed changes to the 2023/24 Audit Plan.
ARAC 2811/3.12	**Receive Internal Audit Reports – Reasonable Assurance** Stephen Chaney (SC) - Deputy Head of Internal Audit, provided the Committee with a summary of the following three reasonable assurance reports with the support of the Lead Executive - Clinical Coding - Business Continuity Planning - Putting things Right – Advisory **Clinical Coding**

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	Paul Solloway (PS), Director of Digital, informed the Committee that work was ongoing to improve the issues highlighted within the Clinical Coding audit, specifically around structural changes to improve staff retention. Shelley Bosson (SB), Independent Member, inquired whether Robotics could be used to aid in the improvement of clinical coding. PS confirmed that Robotics were in use for clinical coding where possible and there were trials taking place on the use of Artificial intelligence within a local Health Board which were being closely followed and could potentially provide opportunities to improve the automation around clinical coding going forward. PS agreed to share an action plan/timeline to provide further assurance of the work underway to address the recommendations. **ACTION: Director of Digital.** **Business Continuity Planning** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided the Committee with an update that improvements are ongoing following on from the Business Continuity Planning Report. **Putting things Right – Advisory** Jennifer Winslade (JW), Director of Nursing, assured the Committee that work was ongoing to implement recommendations and all timescales were expected to be met. The Committee **NOTED** the reports for Assurance.
ARAC 2811/3.13	**External Audit Progress Report** Andrew Doughton (AD), Audit Wales provided the Committee with a summary of the External Audit Progress Report. Work on the Charitable Funds Accounts had commenced and would be reported to the Charitable Funds Committee once completed. The Primary Care report had been issued in draft and was currently undergoing clearance, and the Workforce Planning review was expected to be published within the week. It was noted that several publications had been published since the last Committee meeting, • The National Workforce Data Briefing, • NHS Wales Financial Data Tool, • National Report on Net Zero. The Committee **NOTED** the report for Assurance.
ARAC 2811/3.14	**Received Structured Assessment**

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	Nathan Couch (NC), Audit Wales, Provided the Committee with an overview of the Structure Assessment noting it focused on four elements; - Board transparency, effectiveness, and cohesion. - Corporate systems of assurance. - Corporate approach to planning. - Corporate approach to managing financial resources. It was noted that overall, the report was positive and highlighted progress is key areas with some opportunities for improvement identified Rani Dash (RD), Director of Corporate Governance, informed the Committee that the report would be presented as a stand-alone item to the Board in January 2024. The Committee **NOTED** the report for Assurance.
ARAC 2811/4	**Items for Information**
	No items for information.
ARAC 2811/5	**Other Matters**
ARAC 2811/5.1	**Items to be Brought to the Attention of the Board and Other Committees**
ARAC 2811/5.2	**Any Other Urgent Business** No items for any other business.
ARAC 2811/5.3	**Date of the next meeting;** • Thursday 8th February 2024 09:30-12:30

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2023	**ARAC1807/2.1** Clinical Audit Update	A completed Ward Assurance Audit to be included within the activity update scheduled for the Committee meeting in February 2024 for information.	Medical Director	08 February 2024	**06.01.2024 –** The implementation of Ward assurance audits is still in its early stages, and one has not been completed in its entirety, so there is no data to demonstrate outcomes at this time.
November 2023	**ARAC 2811/3.1** Losses and Payments Report	Circulate a briefing note to Committee Members detailing the Losses and Special Payments made by the Health Board.	Director of Finance and Procurement	TBC May 2024	**Not Yet Due.**

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
November 2023	**ARAC 2811/3.4** Job Planning Arrangements	Following full implementation of the job planning process an update report is to be received at a future meeting to provide assurance that all audit recommendations have been implemented.	Medical Director Secretariat	Schedule for Q1/Q2 2024/25.	**Not Yet Due.**
November 2023	**ARAC 2811/3.9** Review of Audit Recommendations Tracking	Review outstanding overdue audit recommendations with respective executive directors during one-to-one meetings.	Chief Executive Officer	08 February 2024	**10.01.2024:** 1:1s with respective directors have been scheduled to take place February 2024.
November 2023	**ARAC 2811/3.9** Review of Audit Recommendations Tracking	Invite the Lead Executive to the next meeting to address the Committee's concerns the Committee regarding the Medical Equipment Devices Internal Audit from 2017.	Secretariat	08 February 2024	**Completed.** The Executive Director of Therapies & Health Science will be in attendance.
November 2023	**ARAC 2811/3.12** Internal Audit Reports	Produce and share an action plan/timeline to provide further assurance of the work underway to address the recommendations in the Clinical Coding Audit.	Director of Digital	08 February 2024	**Completed.** Action plan attached. Action%20Plan%20Internal%20Clincial%

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

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

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

Agenda Item: 3.15

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update to the Risk Appetite Statement and Associated Documents
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Penderfyniad/For Decision

The purpose of this report is to present the Committee with the requested changes to the Risk Appetite Statement for endorsement.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Risk Appetite Statement, along with the associated Risk Management Framework, Policy, and Procedure, were presented to the Board for approval for use throughout the Health Board at its meeting on 24 January 2024.

The Board approved all three documents but requested an amendment to the description of the Confidence & Trust risk theme in the Risk Appetite Statement. The Board considered that the description as written, had the potential to be perceived as management of the Health Board's reputation, which could be interpreted as inconsistent with openness, honesty, and transparency.

It was agreed that the description would be amended and taken forward to the Audit, Risk & Assurance Committee on 08 February 2024 for final endorsement,

prior to publication of the Risk Management Framework (of which the Appetite Statement is a schedule).

Asesiad / Assessment

Following the Board meeting, the requested amendment to the Risk Theme 'Confidence & Trust' was implemented, with the wording amended as shown below. The Risk Appetite Statement included at **Appendix A** depicts the changes made using track changes. The amendment has also been updated in the schedule of the Risk Management Framework, included at **Appendix B.**

Confidence & Trust

All risks relating to confidence and trust in the Health Board, including risks relating to key stakeholders, communities and adapting to external challenges.

The Health Board's natural position is to not tolerate risks that breakdown or impact confidence & trust. Building on and maintaining the confidence and trust of all stakeholders, including staff is vital, so to highlight both the complexity and importance of transparency, the Health Board shall be ***cautious*** *to any risk or opportunity that may influence that confidence and/or trust.*

The amendment has been reviewed and agreed by the Chair and Chief Executive. The Committee is now asked to endorse the amendment.

The Risk Management Policy and Procedure did not require the amendment, but it is included as **Appendix C** for information.

Argymhelliad / Recommendation

- The Committee is asked to **ENDORSE** the amended description for the risk theme of Confidence & Trust.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item.Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. Effective risk management is critical to delivery of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb	**No does not meet requirements**

Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Aneurin Bevan University Health Board

Risk Appetite Statement

January 2024

Issue No: 1
Approved by: Aneurin Bevan University Health Board
Owner: Aneurin Bevan University Health Board
Issue date: 25 Jan 2024
Review by date: 25 Jan 2025
Ref No: ABUHB_Corporate_1132

CONTENTS

INTRODUCTION 3

RISK APPETITE DESCRIPTION 4

RISK APPETITE BOUNDARIES 4

RISK APPETITE THEMES 5

RISK APPETITE REVIEW 7

MONITORING AND REPORTING 7

APPENDIX A – Risk Appetite Summary Table 8

INTRODUCTION

Risk is the effect of uncertainty on Aneurin Bevan University Health Board's (the Health Board's) ability to achieve its objectives.

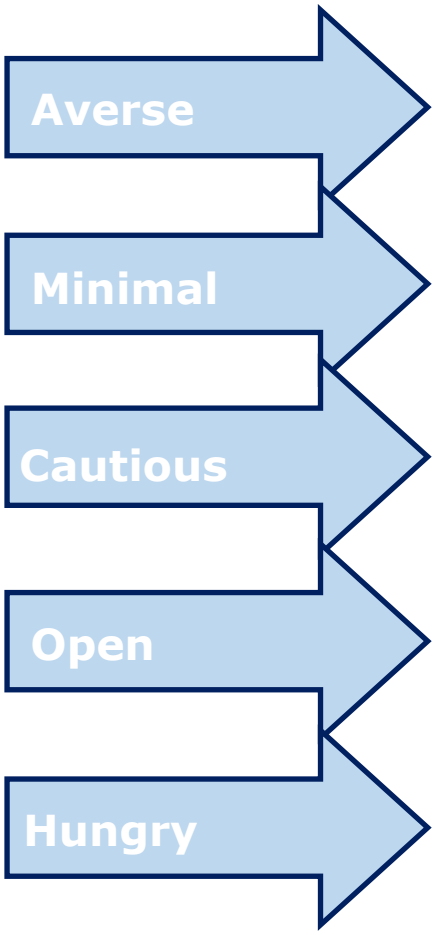
Risk itself is neither positive nor negative, but the outcome of taking risks can be to realise an opportunity or a threat. Only in extreme circumstances is the risk unforeseen. Therefore, through careful consideration and based on information available, the Health Board should be able to determine when it can take more risk and when it should not.

Risk appetite is a way of expressing the Health Board's attitude to different types of risk and the nature of the risks the Health Board is prepared to take. The Health Board's appetite for risk can vary dependent on the nature of the risk and the prevailing operating conditions or circumstances.

The Health Board's Risk Appetite Statement is not prescriptive but instead provides several underlying component parts that encourage structured thinking. The aim of the risk appetite is to enable the Health Board to reach an informed conclusion as to whether a risk can be accepted and to what extent.

RISK APPETITE DESCRIPTION

The Board has agreed the following levels of risk appetite,



Avoidance of any risk exposure

Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.

Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.

Willing to consider all potential options, subject to continued application and / or establishment of controls: recognising that there could be a high -risk exposure.

Eager to be innovative and take on a very high level of risk but only in the right circumstances.

RISK APPETITE BOUNDARIES

To enable translation of the risk appetite into Aneurin Bevan University Health Board's risk scoring methodology, the tolerance for each risk appetite has been plotted on the matrix below i.e., at what point a risk is acceptable (within tolerance) and when it is not (outside tolerance).

There may at times be risks which exceed appetite thresholds and the Health Board will therefore need to actively consider and agree to any risks managed outside tolerance in line with escalation levels.

Risk Appetite Level	Risk Appetite Threshold
Averse	**Score 5 and below**
Minimal	**Score 8 and below**
Cautious	**Score 13 and below**
Open	**Score 17 and below**
Hungry	**Score 21 and below**

RISK APPETITE THEMES

All risks should be considered in the context of the Health Board's risk appetite. To assist this a number of risk appetite themes have been developed, against which they have assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, the Health Board will be more easily able to determine how to respond and so make best use of mitigation resources.

Safety, quality and the Health Board's staff are key considerations in any risk-based decisions and so with that in mind, the following risk appetite themes and descriptions below have been determined by the Board after considering key negative and positive events that might affect the achievement of the Health Board's objectives.

People

Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of the Health Board's People Strategy which would include culture & wellbeing.

The Health Board will continue to provide and review creative opportunities to develop and grow its workforce, building the operational capability and skills needed to deliver its strategic priorities. To do this the Health Board recognises that its risk appetite will need to be **open**, exploring new innovative workforce models, innovative ways of working and recruitment while always being aligned to positive culture and promoting wellbeing.

Aneurin Bevan University Health Board Activities (Compliance & Safety)

Risks relating to all aspects of patient safety but also including safeguarding, staff & public security, in addition risks relating to compliance and/or legal implications.

Compliance, safety & security is of the upmost importance. To reflect this the Health Board has a **minimal** risk appetite when making decisions about any matter or risk that may influence compliance, legality, patient harm & safety including safeguarding.

Aneurin Bevan University Health Board Activities (Service Delivery)

Risks relating to all aspects of the Health Board's ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of the organisation's infrastructure such as IM&T and Estates, including the Health Board's ability to deliver its associated strategy.

The Health Board will have an **open** risk appetite to service delivery. This openness will be reflected in decisions that increase the likelihood of creative, innovative, and positive outcomes but also encompass wider improvements to service delivery models, including the use of IT and new technology, acknowledging that investment of resource needed to purchase equipment or deliver successful projects can be significant and must be managed appropriately.

Financial Sustainability

Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

The Health Board's risk appetite for effective financial management is **cautious** as making sure there is sound financial management whilst maximising opportunities and cost effectiveness is vital to ensure future success. While the Health Board is more receptive in its approach to risk, it shall remain vigilant to those risks that could have quality, resource, reputational and safety implications that outweigh any perceived financial benefits.

Transformation & Partnership Working

All risks relating to the Health Board's ability to engage effectively with other organisations, including development of collaborations and partnerships, along with all risks associated with innovation, transformation, and strategic change.

The Health Board will be **open** in its risk appetite to transformation and when working with local authorities, healthcare partners and other agencies to improve the health of the population. It is acknowledged that risk exposure may exist in decisions to transform and work with others, so the Health Board shall be conscious of those risks that could have quality, reputational and safety implications for patients and/or the organisation.

Confidence & Trust

All risks relating to confidence and trust in the Health Board, including risks relating to key stakeholders, communities and adapting to external challenges.

The Health Board's natural position is to not tolerate risks that breakdown or impact confidence & trust. ~~However, b~~Building on and maintaining the confidence and trust of all stakeholders, including staff is vital, so to highlight both the complexity and importance of transparency, the Health Board shall be **cautious** to any risk or opportunity that may influence that confidence and/or trust. ~~including any short or long-term damage to the Health Board's relationships and reputation~~

RISK APPETITE REVIEW

The Health Board will review its risk appetite on an annual basis, fully recognising that this may be subject to change due to various factors both internal and external that could shape the nature and extent of the risks the Health Board is prepared to take.

The Health Board's Risk Appetite Statement will remain an integral part of its Risk Management Framework and will be embedded into the organisation's risk management system.

MONITORING AND REPORTING

The Health Board will align existing risks with risk appetite themes. In addition, the Health Board will report the volume (including an approximation of cumulative exposure/risk clusters) of risks by risk theme vs risk appetite and develop a set of Key Risk Indicators, as appropriate, to help measure/inform risk appetite.

In order that the Health Board can understand its risk exposure in connection with the risk appetite themes and ensure an effective response, reporting will be undertaken in-line with the **Risk Management Policy and Procedure**. Risk register entries will be categorised by the risk appetite theme to enable the Health Board to understand the type, nature, and volume of risk attributable to each risk appetite theme.

APPENDIX A – Risk Appetite Summary Table

RISK APPETITE	Risk Theme	Risk Appetite Level	Risk Appetite Description	Risk Appetite Thresholds
	Aneurin Bevan University Health Board Activities (Compliance & Safety)	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls	Score 8 and below
	Aneurin Bevan University Health Board Activities (Service Delivery)	Open	Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	Score 17 and below
	People	Open		
	Transformation and Partnership working	Open		
	Financial Sustainability	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls	Score 13 and below
	Confidence and Trust	Cautious		

Aneurin Bevan University Health Board

Risk Management Framework

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

Status: Issue 10 | Issue date: 25 Jan 2024
Approved by: Aneurin Bevan UHB Board | Review by date: 25 Jan 2025
Owner: Corporate Governance | Ref No: ABUHB_Corporate_0277

CONTENTS

1 INTRODUCTION 3
2 PURPOSE 3
3 PRINCIPLES 4
4 OBJECTIVES 4
5 SCOPE 6
6 RISK MANAGEMENT AND ASSURANCE ARRANGEMENTS 6
7 IMPLEMENTATION OF THE FRAMEWORK 13
8 TRAINING 14
9 SUPPORTING DOCUMENTS 14
10 MONITORING EFFECTIVENESS 14
11 REFERENCES 15

Appendix A – Risk Appetite Statement **16**
Appendix B - Risk Management Policy and Procedure **24**

1 INTRODUCTION

Aneurin Bevan University Health Board (the Health Board) is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal control. Risk management is essential, not only for providing a safe environment and improved quality of care for service users and staff, but also for the achievement of the organisation's strategic goals, corporate and clinical objectives.

The Health Board views risk management as an integral part of the overall management process, rather than as a separate arrangement, and is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Health Board's thinking and activities.

This Framework sets out the Health Board's approach to embedding a risk management culture that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and, promoting its values.

This Framework has been developed to ensure that the latest guidance, best practice and recommendations from independent reviews and assessments are considered in the systems and processes that are in place to manage risk and strengthen assurance arrangements throughout the Health Board.

2 PURPOSE

This Framework sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.

This Frameworks sets out the overarching processes that will allow the Health Board to effectively manage risk while maintaining high-risk governance and assurance standards. It explains how the Health Board's risk management activities interact with other governance and assurance arrangements to create an integrated system of internal control.

It also includes the Health Board's risk appetite statement, which articulates the levels and types of risk the Health Board is willing to accept to achieve its objectives.

3 PRINCIPLES

This Risk Management Framework is informed by a set of principles, presented below.

The Health Board:

- Recognises that, as a healthcare organisation, risk is inherent and will exist at all levels of the organisation;
- Believes that risk management is everybody's business, and its risk management and assurance arrangements apply to all directly employed staff and those engaged in work or other activities on behalf of the Health Board;
- Seeks to control risks in a proportionate and cost-effective manner such that exposures are mitigated to an acceptable level (in accordance with agreed risk appetite) or are eliminated as far as it is reasonably possible;
- Acknowledges that some risks can never be eliminated entirely;
- Seeks to mitigate and control its identified risk exposure;
- Recognises that good risk management practice facilitates the opportunities to innovate and improve;
- Encourages considered and controlled risk-taking within authorised limits in order to develop and transform its services and functions;
- Applies its risk management and assurance framework to all categories of risk;
- Will adopt and adapt instances of good practice in established risk management and assurance methodologies, but where appropriate will develop bespoke risk management arrangements where required;
- Will ensure that its risk management and assurance arrangements support transparency, accountability, and wider public interest regarding the activities of the organisation.

4 OBJECTIVES

The Health Board recognises that implementing an effective risk management framework is key to delivering its overarching strategy and developing a positive learning environment and risk-aware culture.

4.1 The objectives of risk management across the Health Board are to:

- Minimise the potential for harm to patients, staff and those who engage with the Health Board to levels that are as low as is reasonably practical;
- Protect Health Board assets;

- Enable the Health Board to anticipate, respond to, and remain resilient in changing strategic and operational circumstances;
- Ensure that risk management forms an integral part of the organisation's thinking, performance management, and business planning;
- Ensure that the Health Board achieves and sustains compliance with statutory, policy, and legal frameworks;
- Ensure that a consistent and integrated approach to risk management is embedded in the day-to-day working practices of the organisation at all levels.

4.2 To achieve these objectives the Health Board will consider risk when:

- Developing, approving, and implementing strategies, plans, and polices;
- Developing and approving business cases or investment proposals;
- Scenario planning for exceptional circumstances such as major incidents and business continuity planning;
- Planning and delivering transformation and change projects;
- Implementing cost improvement or other efficiency programmes;
- Entering into contractual relationships or other partnership agreements.

4.3 To enable the Health Board to deliver these objectives it will:

- Clearly define risk management roles, responsibilities, and reporting lines within the organisation, aligned to the organisation's Performance Management and Accountability Framework;
- Reinforce the importance of effective risk management;
- Ensure that the importance of effective risk management and assurance is reflected in the roles and responsibilities of the internal governance structure;
- Maintain timely, accurate, and comprehensive intelligence about identified risks on a single management information system (Datix) and use this to produce corporate and local risk registers and other forms of risk analysis and reporting;
- Ensure that appropriate actions and controls are in place to mitigate risks and that these are well understood by those expected to apply them;
- Ensure that gaps in control are identified and implemented in a timely manner;
- Provide training and engagement activities to strengthen risk management capacity and capability within the workforce and to

generate and sustain a good level of awareness and understanding of risk management;
- Monitor, review, and seek continuous improvement in risk management arrangements across the organisation.

5 SCOPE

This Framework applies to all Health Board employees, regardless of grade or role. This includes those with whom we contract, those who are seconded to work in the organisation, and any volunteers who work in partnership with the organisation.

Therefore, accountability and responsibility for active risk management is shared at all levels within the organisation and across our partnerships, ensuring that risk management is an integral part of the overall approach to health, partnership governance, and service delivery.

The framework overarches both clinical and non-clinical risk management and is aligned to and supports the delivery of the Health Board's:

- Quality Strategy
- Performance Management & Accountability Framework
- Regulatory Requirements
- Strategies and Strategic Plans

6 RISK MANAGEMENT AND ASSURANCE ARRANGEMENTS

Key components of the Health Board's risk management arrangements include:

- Risk Appetite
- Risk Assessment Process
- Roles and Responsibilities
- Risk Management System and tools
- Reporting and Escalation
- Governance and risk assurance

6.1 Risk Appetite

For an organisation to truly have an effective risk management system in place, it must first understand its risk appetite, which is defined as **'the amount and type of risk that an organisation is willing to seek, accept, or tolerate**.' It is an agreed level of risk that the Health Board is prepared to accept or be exposed to in pursuit of its strategic objectives.

Risk appetite is a way of expressing the Health Board's attitude to different types of risk and the nature of the risks the Health Board is prepared to take. The Health Board's appetite for risk can vary depending on the nature of the risk and the prevailing operating conditions or circumstances.

The Health Board has developed an approach to defining its risk appetite. The risk appetite is not prescriptive but instead provides several underlying component parts that encourage structured thinking. The aim of the risk appetite is to allow the Health Board to reach an informed conclusion as to whether the risk can be accepted and to what extent.

The benefits of adopting a risk appetite include:

- Supporting informed decision-making;
- Reducing uncertainty;
- Improving consistency across governance mechanisms and decision-making;
- Supporting performance improvement;
- Focusing on priority areas within an organisation;
- Informing spending review and resource prioritisation processes.

The Health Board has identified a number of risk appetite themes against which it has assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, the Health Board will be more easily able to determine how to respond and so make best use of mitigation resources.

Safety, quality, and the Health Board's staff are key considerations in any risk-based decisions. The following risk appetite themes and descriptions have been determined after considering key negative and positive events that might affect the achievement of the Health Board's objectives.

- **People:** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of the Health Board's People Strategy which would include culture & wellbeing.

- **Health Board Activities (Compliance and Safety):** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition risks relating to compliance and/or legal implications.

- **Health Board Activities (Service Delivery):** Risks related to all aspects of the Health Board's ability to deliver, manage, and improve service quality and performance along with all risks relating to the

current performance of its infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

- **Financial Sustainability:** Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

- **Transformation and Partnership Working:** All risks relating to the Health Board's ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

- **Confidence & Trust:** All risks relating to confidence and trust in the Health Board, including risks relating to key stakeholders, communities and adapting to external challenges.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk.

The Health Board's Risk Appetite Statement, which is included at **Appendix A**, sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a live document that will be regularly reviewed and modified, so that any changes to the organisation's strategy, objectives, or, its capacity to manage risk, are properly reflected.

6.2 Risk Assessment Process

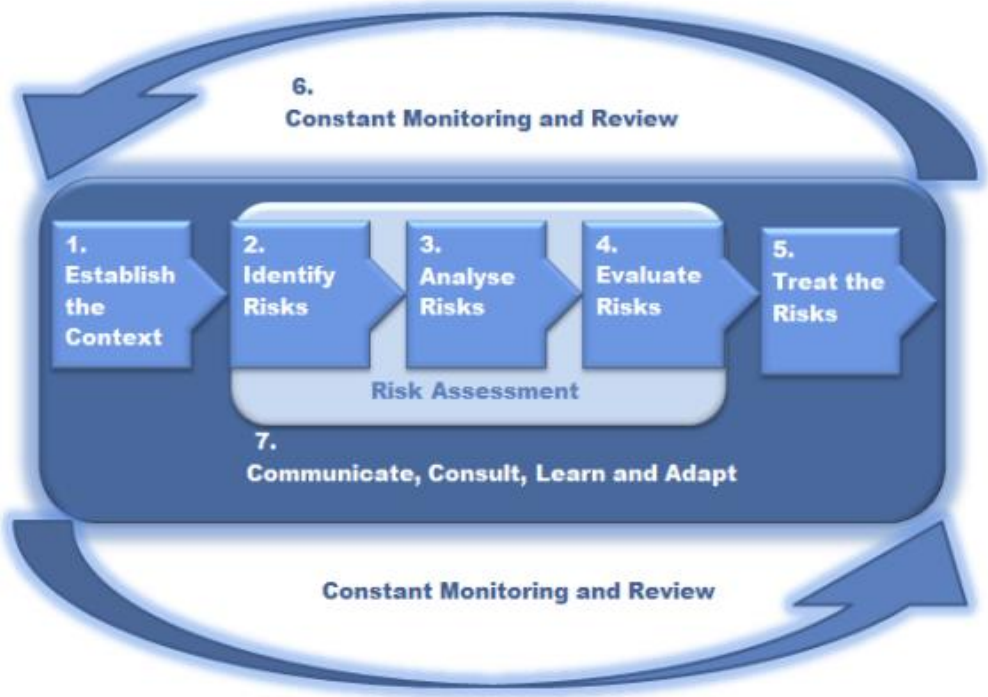
Risk Management is the systematic application of management policies, practices and procedures to the task of identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Health 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.

The process is defined in seven key steps, which are detailed within the supporting **Risk Management Policy and Procedure** (**Appendix B**).

Figure 1: The risk management process as defined in ISO 31000



6.3 Roles and Responsibilities

This Risk Management Framework applies to all Health Board employees, those with whom we contract, those who are seconded to work in the organisation and any volunteers who work in partnership with the organisation.

This framework also identifies certain designated roles with specific responsibilities to risk management and assurance. These roles are:

- The Board
- Chief Executive Officer (Health Board's Accountable Officer)
- Director of Corporate Governance
- Executive Directors
- Head of Corporate Risk and Assurance
- Risk Owner
- Risk Leads (for individual services and functions)
- All Staff

The supporting **Risk Management Policy and Procedure** (**Appendix B**) presents more information about these roles and the specific responsibilities relating to risk management.

6.4 Risk Management System

The Health Board maintains an organisation-wide information management system to support a standard approach to risk management. The system used is the risk management module of the Datix suite of applications.

Any newly identified risk must undergo a comprehensive risk assessment which must be recorded on the Health Board's risk management system, Datix. To ensure that the risk reflects the current operating environment, all risks must be monitored and updated on a regular basis.

The supporting **Risk Management Policy and Procedure** (**Appendix B**) describes further the role of Datix in effectively supporting risk management.

6.5 Risk Registers

Risk registers support day-to-day risk management and facilitate the monitoring of risk information, including changes to risk exposure and the delivery of mitigating actions.

Risk registers must be created and maintained on the Health Board's risk management framework, Datix. This includes the Strategic and Corporate Risk Registers as well as risk registers for divisions, directorates and at a local level (ward/service).

The Health Board will establish a risk register hierarchy to aid in the escalation process. This ensures that the potential risk is managed and monitored at the appropriate level. The risk register hierarchy is detailed below.

Strategic Risk Register - will hold all potential risks that has the potential to hinder achievement of one or more of the health board's strategic priorities as outlined in the Integrated Medium-Term Plan (IMTP). The Strategic Risk Register will act as the Board Assurance Framework. The term 'Board Assurance Framework' is used to refer to a document that brings together in one place all the relevant information on the risks relating to the Board's Strategic Objectives.

The Board Assurance Framework provides a structure and process that enables the Health Board to focus on the key control gaps, assurance gaps and risks that may compromise the delivery of its strategic and annual objectives. It ensures that the assurance mechanisms operating across the Health Board are fully aligned to support the Chief Executive as the Accountable Officer, and the Board, to deliver the organisation's objectives.

Corporate Risk Register – will hold all potential operational risks that require a higher level of ownership than an individual Executive Director can provide but do not directly threaten the organisation's future, these will typically span two or more directorates or require plans and resources that exceed the Division's capability or capacity to implement or any high-level operational risk that has a score of 20 or higher. There will be close alignment between the Corporate Risk Register and the Strategic Risk Register to ensure the Board is sighted on key operational risks.

Divisional Risk Register - will hold all potential operational risks that necessitate a higher level of ownership than an individual Directorate can provide. Such risks necessitate plans and resources that are beyond the Directorate's capability or capacity to implement or have a score greater than 12.

Directorate Risk Register - will hold all potential operational risks that necessitate a higher level of ownership than an individual ward/service can provide. Such risks typically necessitate plans and resources that are greater than the Directorate's capability or capacity to implement or have a score greater than 6.

Local Risk Register - will hold all potential operational risks that could impact the day-to-day running of the service. Local Risk Registers will typically have a higher number of Health and Safety risks than other risk registers given the need for local mitigation. Any risk with a score greater than 6 must be escalated to the Directorate Risk Register.

6.6 Risk Evaluation Matrix

The Health Board provides an approved methodology and supporting matrix to guide the evaluation of risks. Each risk is evaluated by calculating the likelihood and consequence of it materialising by using the NHS Wales Risk Scoring Matrix (5x5 Model) and then determining its overall risk rating of 'low',' moderate', 'high', or 'extreme'.

The Risk Scoring Matrix can be found in the **Risk Management Policy and Procedure** (**Appendix B**).

6.7 Reporting and Escalation

One of the Health Board's key management and assurance reports is the Strategic Risk Report. At each meeting respectively, the entire Strategic Risk Register will be reviewed by the:

- Board
- Audit, Risk, and Assurance Committee

At each meeting, the Board's Committees listed below will receive the Strategic Risk Report and the strategic risks delegated to it by the Board for detailed scrutiny and focus, which is outlined in in the **Risk Management Policy and Procedure** (**Appendix B**).

These will be aligned to the Committee's agenda.

- Patient Quality, Safety, and Outcomes Committee
- Finance and Performance Committee
- People and Culture Committee
- Partnerships, Population Health, and Planning Committee

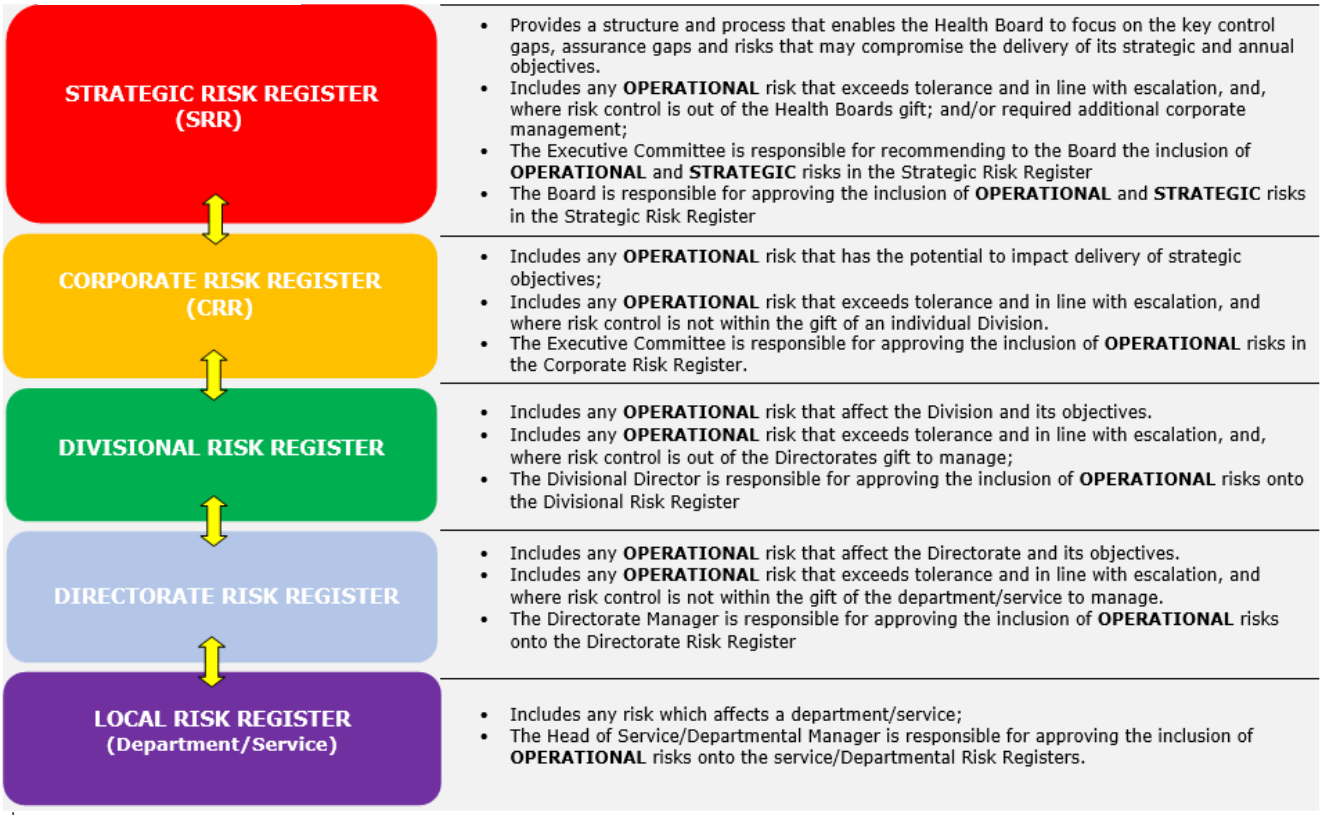
In addition, at each meeting, the Committee will receive an overview of the relevant corporate risks being managed as well as any high-level operational divisional risks that are being monitored by the Executive Committee for assurance. These will be aligned with the Committee's agenda.

In the interests of transparency and accountability and the wider public interest unless exceptional circumstances apply the Strategic Risk Report is discussed by the Board and sub-committees during the public session of its formal meeting.

The risk escalation framework is determined by the risk score or the significance of the risk to the delivery of patient safety, service delivery, or organisational objectives.

If the capability or capacity to manage a potential directorate, divisional, or corporate risk is exceeded, or if current controls are not mitigating the risk that is now present, the risk must be escalated through the appropriate governance arrangements, as presented in Figure 3, overleaf.

Figure 3



Further detail on the escalation process, is set out within the **Risk Management Policy and Procedure** (**Appendix B**).

7 IMPLEMENTATION OF THE FRAMEWORK

Led by the Director of Corporate Governance, the Corporate Governance Directorate will plan and deliver the implementation of the Risk Management Framework along with a programme of training and other developmental activities to raise awareness and understanding of risk management to strengthen the maturity, capacity, and capability for risk management across the Health Board.

Activities to support implementation of this Framework will include:

- working with teams, services, directorates and functions to develop their risk management capability and ensure risk management is dynamic and part of the everyday;
- embedding risk management in quality and governance processes at all levels of the Health Board;
- using data in a risk-focused way (what does this tell us about the service and where are these risks and vulnerability);

- ensuring risk registers interact appropriately at different levels of the Health Board to ensure risks are appropriately escalated and that there is oversight of risks as appropriate; and
- ensuring staff are aware of the options for managing a risk – whether to tolerate (accept), treat (reduce or remove), transfer (responsibility), terminate (suspend the risk situation/activity) or take the opportunity.

8 TRAINING

All new staff are required to attend an Induction Programme which includes risk management training. Additional training will be available through ESR.

Board members will receive risk management training, both individually and collectively, to enable them to discharge their responsibilities effectively. This will be delivered at a minimum through Board Member Induction, with formal training delivered to the collective Board every two years.

The Corporate Governance Directorate will deliver training, and ongoing support and advice to all staff and Board Members. This will ensure that the Health Board incorporates risk management as a core function of all programmes of work associated with the delivery of organisational objectives and will aid in the identification of risks to objectives at the outset of planning processes.

9 SUPPORTING DOCUMENTS

This Framework should be read in conjunction with the:

- Risk Management Policy and Procedure
- ABUHB Risk Appetite Statement
- Guidance Note for Risk Assessment and Management
- Guidance for Using the Risk Management System – Datix

10 MONITORING EFFECTIVENESS

Compliance with the standards set out in the Risk Management and Assurance Framework will be assessed routinely by the Audit, Risk & Assurance Committee, and by the Board.

The framework will be reviewed and updated annually or sooner if a change in obligations requires it.

The Annual Governance Statement is signed by the Chief Executive Officer and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report.

The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year. The Health Board's risk management arrangements are also subject to audit review annually.

11 REFERENCES

- International Organisation for Standardisation, ISO 3100 Standard: Risk Management Principles and Guidance, 2018
- Good Governance Institute, Risk Appetite for NHS Organisations, 2019
- NHS National Patient Safety Agency, Risk Model Matrix
- HM Treasury, Management of Risk: Principles and Concepts (The Orange Book), 2019
- HM Treasury, Management of Risk: Risk Appetite Guidance Note, 2021
- NHS Providers, Aneurin Bevan University Health Board Risk Appetite, 2023

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Aneurin Bevan University Health Board

Risk Appetite Statement

January 2024

CONTENTS

12 INTRODUCTION 18

13 RISK APPETITE DESCRIPTION 19

14 RISK APPETITE BOUNDARIES 19

15 RISK APPETITE THEMES 20

16 RISK APPETITE REVIEW 22

17 MONITORING AND REPORTING 22

18 APPENDIX 1 – Risk Appetite Summary Table 23

12 INTRODUCTION

Risk is the effect of uncertainty on Aneurin Bevan University Health Board's (the Health Board's) ability to achieve its objectives.

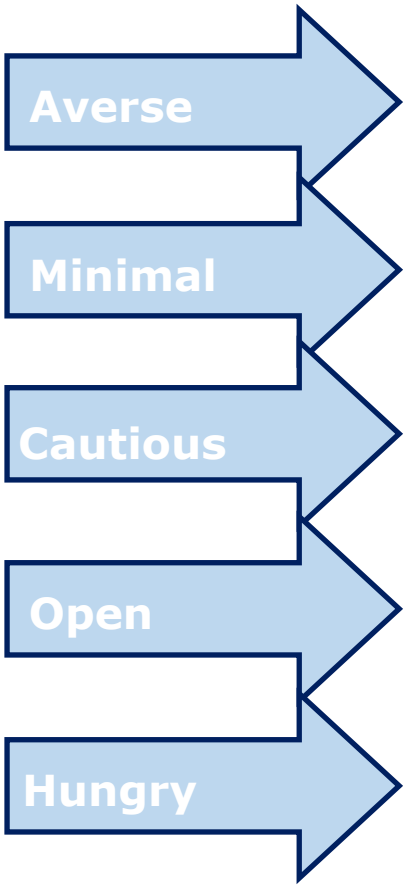
Risk itself is neither positive nor negative, but the outcome of taking risks can be to realise an opportunity or a threat. Only in extreme circumstances is the risk unforeseen. Therefore, through careful consideration and based on information available, the Health Board should be able to determine when it can take more risk and when it should not.

Risk appetite is a way of expressing the Health Board's attitude to different types of risk and the nature of the risks the Health Board is prepared to take. The Health Board's appetite for risk can vary dependent on the nature of the risk and the prevailing operating conditions or circumstances.

The Health Board's Risk Appetite Statement is not prescriptive but instead provides several underlying component parts that encourage structured thinking. The aim of the risk appetite is to enable the Health Board to reach an informed conclusion as to whether a risk can be accepted and to what extent.

13 RISK APPETITE DESCRIPTION

The Board has agreed the following levels of risk appetite.



Avoidance of any risk exposure

Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.

Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.

Willing to consider all potential options, subject to continued application and / or establishment of controls: recognising that there could be a high -risk exposure.

Eager to be innovative and take on a very high level of risk but only in the right circumstances.

14 RISK APPETITE BOUNDARIES

To enable translation of the risk appetite into Aneurin Bevan University Health Board's risk scoring methodology, the tolerance for each risk appetite has been plotted on the matrix below i.e., at what point a risk is acceptable (within tolerance) and when it is not (outside tolerance).

There may at times be risks which exceed appetite thresholds and the Health Board will therefore need to actively consider and agree to any risks managed outside tolerance in line with escalation levels.

Risk Appetite Level	Risk Appetite Threshold
Averse	**Score 5 and below**
Minimal	**Score 8 and below**
Cautious	**Score 13 and below**
Open	**Score 17 and below**
Hungry	**Score 21 and below**

15 RISK APPETITE THEMES

All risks should be considered in the context of the Health Board's risk appetite. To assist this a number of risk appetite themes have been developed, against which they have assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, the Health Board will be more easily able to determine how to respond and so make best use of mitigation resources.

Safety, quality and the Health Board's staff are key considerations in any risk-based decisions and so with that in mind, the following risk appetite themes and descriptions below have been determined by the Board after considering key negative and positive events that might affect the achievement of the Health Board's objectives.

15.1 People

Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of the Health Board's People Strategy which would include culture & wellbeing.

The Health Board will continue to provide and review creative opportunities to develop and grow its workforce, building the operational capability and skills needed to deliver its strategic priorities. To do this the Health Board recognises that its risk appetite will need to be **open**, exploring new innovative workforce models, innovative ways of working and recruitment while always being aligned to positive culture and promoting wellbeing.

15.2 Aneurin Bevan University Health Board Activities (Compliance & Safety)

Risks relating to all aspects of patient safety but also including safeguarding, staff & public security, in addition risks relating to compliance and/or legal implications.

Compliance, safety & security is of the upmost importance. To reflect this the Health Board has a **minimal** risk appetite when making decisions about any matter or risk that may influence compliance, legality, patient harm & safety including safeguarding.

Aneurin Bevan University Health Board Activities (Service Delivery)

Risks relating to all aspects of the Health Board's ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of the organisation's infrastructure such as IM&T and Estates, including the Health Board's ability to deliver its associated strategy.

The Health Board will have an **open** risk appetite to service delivery. This openness will be reflected in decisions that increase the likelihood of creative, innovative, and positive outcomes but also encompass wider improvements to service delivery models, including the use of IT and new technology, acknowledging that investment of resource needed to purchase equipment or deliver successful projects can be significant and must be managed appropriately.

Financial Sustainability

Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

The Health Board's risk appetite for effective financial management is **cautious** as making sure there is sound financial management whilst maximising opportunities and cost effectiveness is vital to ensure future success. While the Health Board is more receptive in its approach to risk, it shall remain vigilant to those risks that could have quality, resource, reputational and safety implications that outweigh any perceived financial benefits.

Transformation & Partnership Working

All risks relating to the Health Board's ability to engage effectively with other organisations, including development of collaborations and partnerships, along with all risks associated with innovation, transformation, and strategic change.

The Health Board will be **open** in its risk appetite to transformation and when working with local authorities, healthcare partners and other agencies to improve the health of the population. It is acknowledged that risk exposure may exist in decisions to transform and work with others, so the Health Board shall be conscious of those risks that could have quality, reputational and safety implications for patients and/or the organisation.

Confidence & Trust

All risks relating to confidence and trust in the Health Board, including risks relating to key stakeholders, communities and adapting to external challenges.

The Health Board's natural position is to not tolerate risks that breakdown or impact confidence & trust. Building on and maintaining the confidence and trust of all stakeholders, including staff is vital, so to highlight both the complexity and importance of transparency, the Health Board shall be **cautious** to any risk or opportunity that may influence that confidence and/or trust..

16 RISK APPETITE REVIEW

The Health Board will review its risk appetite on an annual basis, fully recognising that this may be subject to change due to various factors both internal and external that could shape the nature and extent of the risks the Health Board is prepared to take.

The Health Board's Risk Appetite Statement will remain an integral part of its Risk Management Framework and will be embedded into the organisation's risk management system.

17 MONITORING AND REPORTING

The Health Board will align existing risks with risk appetite themes. In addition, the Health Board will report the volume (including an approximation of cumulative exposure/risk clusters) of risks by risk theme vs risk appetite and develop a set of Key Risk Indicators, as appropriate, to help measure/inform risk appetite.

In order that the Health Board can understand its risk exposure in connection with the risk appetite themes and ensure an effective response, reporting will be undertaken in-line with the **Risk Management Policy and Procedure**. Risk register entries will be categorised by the risk appetite theme to enable the Health Board to understand the type, nature, and volume of risk attributable to each risk appetite theme.

18 APPENDIX 1 – Risk Appetite Summary Table

RISK APPETITE	Risk Theme	Risk Appetite Level	Risk Appetite Description	Risk Appetite Thresholds
	Aneurin Bevan University Health Board Activities (Compliance & Safety)	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls	Score 8 and below
	Aneurin Bevan University Health Board Activities (Service Delivery)	Open	Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	Score 17 and below
	People	Open		
	Transformation and Partnership working	Open		
	Financial Sustainability	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls	Score 13 and below
	Confidence and Trust	Cautious		

Aneurin Bevan University Health Board

Risk Management Policy and Procedure

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

Contents:

19 INTRODUCTION 26
20 AIMS 26
21 SCOPE 27
22 ROLES AND RESPONSIBILITIES 27
23 RISK MANAGEMENT 31
23.1 33
23.1.1 Step 1: Establish the Context 34
23.1.2 Step 2: Identify Risks 35
23.1.3 Step 3: Analyse Risks 36
23.1.4 Step 4: Evaluate the Risk 37
23.1.5 Step 5: Treat the Risk 37
23.1.6 Step 6: Communication and Consultation 38
23.1.7 Step 7: Monitoring and Review 38
24 ESCALATION PROCESS 40
25 DATIX RISK MANAGEMENT SYSTEM 42
26 SUPPORTING DOCUMENTS 42
27 TRAINING AND IMPLEMENTATION 42
28 APPENDICES 42
29 APPENDIX 1: Risk Statement Examples 43
30 APPENDIX 2: NHS Wales Risk Scoring Matrix (5x5 Model) 44
31 APPENDIX 3 Local Risk Assessment 50
32 APPENDIX 4: Risk Assessment Template Strategic/Corporate Risk 51
33 APPENDIX 5: Escalation Process 52

19 INTRODUCTION

Aneurin Bevan University Health Board (the Health Board) is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal control. Risk management is essential, not only for providing a safe environment and improved quality of care for service users and staff, but also for the achievement of the organisation's strategic goals, corporate and clinical objectives.

The Health Board views risk management as an integral part of the overall management process, rather than as a separate arrangement, and is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Health Board's thinking and activities.

This Policy sets out the Health Board's approach to embedding a risk management culture that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and promoting its values.

20 AIMS

The aim of this Risk Management Policy and Procedure is to underpin the Health Board's Risk Management Framework that ensures:

- integration of risk management into activities across the organisation as well as planning and decision-making processes;
- chances of adverse incidents, risks and complaints are minimised by effective risk identification, prioritisation, treatment, and management;
- a risk management framework is maintained, which provides assurance to the Board that strategic and operational risks are being managed;
- risk management is an integral part of Health Board's culture and encourages learning from incidents; and
- employees, reputation, finances, and business continuity are protected through the process of risk identification, assessment, control and mitigation.

This Policy should be read in the context of the Health Board's Risk Management Framework which describes the Health Board's key principles and objectives to ensure an effective risk management system is in place across the organisation.

21 SCOPE

This Risk Management Policy and Procedure applies to all Health Board employees, regardless of grade or role. This includes those with whom we contract, those who are seconded to work in the organisation, and any volunteers who work in partnership with the organisation.

Therefore, accountability and responsibility for active risk management is shared at all levels within the organisation and across our partnerships, ensuring that risk management is an integral part of the overall approach to health, partnership governance, and service delivery.

22 ROLES AND RESPONSIBILITIES

Employees in all positions are responsible for maintaining risk awareness by identifying and reporting risks to their line manager and/or directors as appropriate. All areas must conduct ongoing robust risk assessments and escalate risks through the Health Board's governance and escalation route, as outlined below in the Risk Management Process section.

Although risk management is everyone's responsibility, certain roles bear more responsibility and ownership for implementing risk management systems and processes and ensuring risks are managed effectively.

The Board is made up of Executive Directors and Independent Members that share equal responsibility for the success of the organisation, including the effective management of risk and compliance with relevant legislation. In relation to risk management the Board is responsible for:

- articulating the strategic objectives and success measures for the organisation;
- protecting the reputation of the organisation;
- providing leadership on the management of risk;
- determining the risk appetite for the organisation;
- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- considering any risks that are outside of appetite.

The Audit, Risk and Assurance Committee is responsible, on behalf of the Board, for reviewing the adequacy and effectiveness of:

- all risk and control related disclosure statements (the Annual Governance Statement), prior to endorsement by the Board;

- the effectiveness of the organisational risk management system;
- the underlying assurance processes that indicate the degree of achievement of strategic objectives and the effectiveness of the management of risks;
- reviewing risk related documents, policies, and procedures;
- reviewing on a regular basis the strategic risks, controls, and treatment plans and, in relation to those risks which are outside the risk appetite of the organisation, recommend appropriate action to the Board; and
- escalating to the Board any matters of significance which require Board attention or approval.

The Chief Executive (CEO) is the Accountable Officer of the Health Board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, financial and organisational controls, and governance.

In respect of risk management, the CEO has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate planning process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Executive Directors are accountable and responsible for ensuring that their respective areas of responsibility are implementing this Framework, and related policies/procedures. Each Director is accountable for the delivery of their particular area of responsibility, and will therefore ensure

that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

Specifically, they will:

- support the embedding of an effective risk management culture throughout the Health Board;
- communicate to their teams, the Board's strategic objectives; and ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area, which will encourage integration of risk management;
- lead the risk management process within respective areas which includes risk assessments; incident reporting; the investigation of incidents/near misses; and, the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area, and that risks are treated as required;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post, and that those key objectives are reflected in the individual performance review/staff appraisal process.

In addition, Clinical Executive Directors (Medical Director, Director of Nursing and the Director of Therapies & Health Sciences) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework and the Board's Quality Strategy.

Director of Corporate Governance is the delegated Director lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the Board Assurance Framework and Risk Management Framework. The Director of Corporate Governance will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- work closely with the Chair; Chief Executive; Chair of the Audit, Risk and Assurance Committee; and Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite, and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- work closely with the Chief Executive and Executive Directors to support the development and maintenance of Corporate and Divisional level risk registers;
- develop and oversee the effective execution of the Health Board's assurance arrangements;
- develop and implement the Health Board's Risk Management Framework; and
- produce the health board's Annual Governance Statement.

Head of Corporate Risk and Assurance is accountable to the Director of Corporate Governance, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the Health Board's assurance arrangements;
- support the management and development of the Health Board's assurance arrangements and Risk Management Framework;
- work with Divisions, Directorates, Functions and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the Strategic Risk Register and Corporate Risk Register for reporting to Board and its Committees; and
- provide training, information and advice to operational staff, teams functions on risk management and risk registers, ensuring alignment to risk management reporting and escalation arrangements.

Risk Leads and Risk Owners are the responsible point of contacts for an identified risk, who coordinates efforts to mitigate and manage the risk with various individuals who may also own parts of the risk.

These responsibilities include:

- taking responsibility for managing risk;
- ensuring that risks are assessed where they are:
    - identified within the working activities carried out within their management control;
    - identified within the environment within their control;
    - reported from the staff within their management control.
- identifying and managing risks that cut across delivery areas;
- ensuring all incidents/accidents and near misses are reported;
- monitoring mitigating actions and ensuring action owners are clear about their roles, and what they need to achieve;
- discussing risks on a regular basis with staff, and through discussions at meetings to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach; and
- ensuring risks are updated regularly and acted upon.

Line Managers are expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement this Framework and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the Health Board's approach to risk management and governance. They will support the application of this Framework and its related processes and participate in the monitoring and auditing process where required.

All Staff are responsible for ensuring that identified risks are reported to their immediate line manager so that effective controls can be considered and implemented as needed. All staff have a general responsibility for overall risk management issues and must adhere to Health Board procedures in their work.

23 RISK MANAGEMENT

The Health Board, like all organisations, faces actual and theoretical risks ranging from trivial to existential. ISO 31000, Risk Management, recommends that risk management be based on three core elements:

- a set of principles that describes the essential attributes of good risk management;
- a risk management framework that provides a structure for risk management; and
- a risk management process that prescribes a tailored, structured approach to understanding, communicating, and managing risk in practice.
- Risk management is everybody's business, and its risk management and assurance arrangements apply to all directly employed staff and those engaged in work or other activities on behalf of the Health Board;
- Seeks to control risks in a proportionate and cost-effective manner such that exposures are mitigated to an acceptable level (in accordance with agreed risk appetite) or are eliminated as far as it is reasonably possible;
- Acknowledges that some risks can never be eliminated entirely;
- Seeks to mitigate and control its identified risk exposure;
- Encourages considered and controlled risk-taking within authorised limits in order to develop and transform its services and functions;
- Applies its risk management and assurance framework to all categories of risk;
- Will adopt and adapt instances of good practice in established risk management and assurance methodologies, but where appropriate will develop bespoke risk management arrangements where required;
- Will ensure that its risk management and assurance arrangements support transparency, accountability, and wider public interest regarding the activities of the organisation.

The Health Board recognises that there are significant benefits to managing risk, these include:

- Supports achievement of Health Borad objectives;
- Avoids or mitigates the impact of failure;
- Supports cost efficiency and value for money;
- Compliance with legal and regulatory framework;
- Management of external impacts and changes; and
- Exploit opportunities encouraging innovation

The Health Board's Risk Management system is supported by the Risk Management Framework which can be found here. The Framework sets out the Health Board's approach to embedding a risk management culture

that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and, promoting its values.

Risks are linked to objectives and strategic aims, which exist at different levels:

- **Strategic risks** – risks that affect the Heath Board's ability to deliver its strategic priorities or to function as an organisation as a whole;

- **Corporate Risks** – risks that have an impact on the delivery of the Health Board's business objectives or common risks that necessitate a corporate response;

- **Divisional –** risks that have an impact on the delivery of divisional objectives or common risks that necessitate a co-ordinated response;

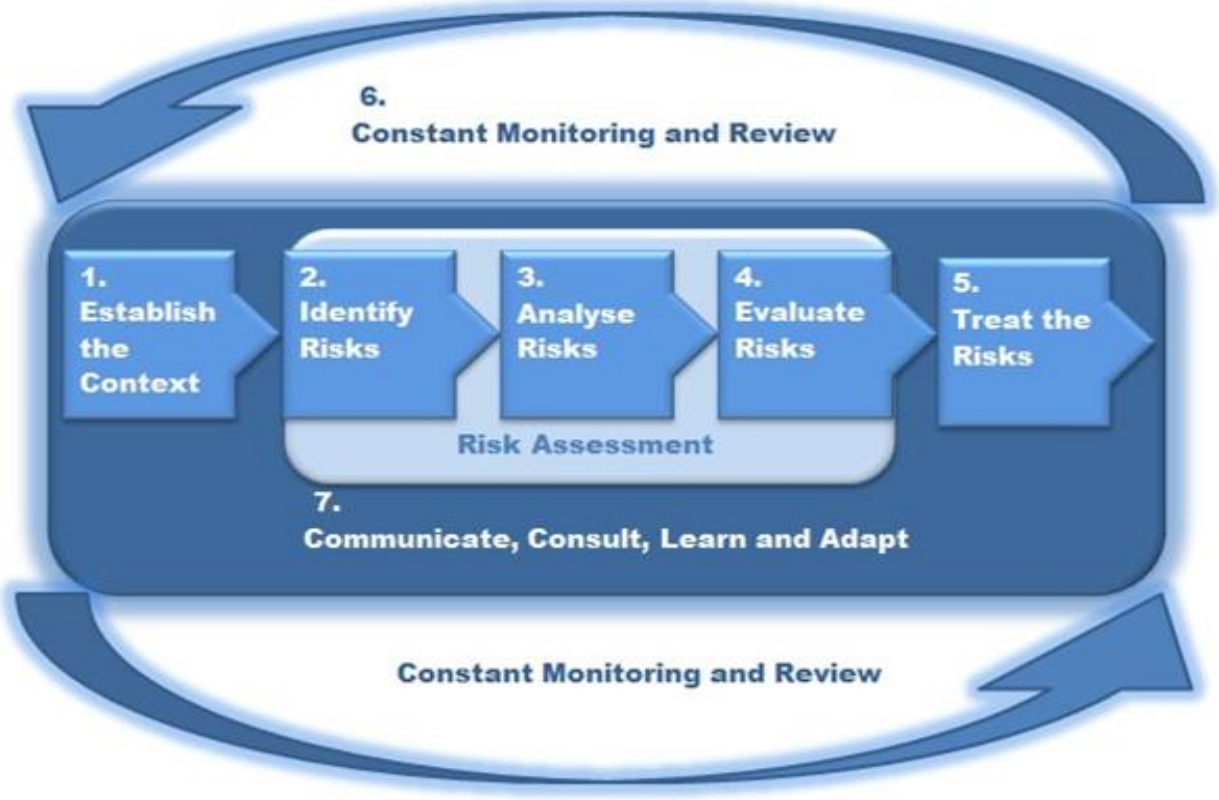
- **Directorate / Team risks** - risks that are related to the delivery of departmental operations and objectives;

- **Programmes/Projects -** risks associated with, usually, time limited activities and medium- to long-term delivery of benefits.

Strategic risk, corporate, operational, and local team risk registers should not include project risks. All projects' risks will be managed through the appropriate project boards with reporting and escalation through the change management governance process.

The risk management process is illustrated in Figure 1 and each step in the process is explained in greater detail.

Figure 1



23.1.1 Step 1: Establish the Context

Before identifying risks, first decide on the scope of the activity, including your objectives, and develop an understanding of your operating environment.

Identify your stakeholders (internal and external) to determine whether they could potentially expose the Health Board to risk, could be exposed to risk, or could assist with risk management.
There are three other elements that are important to consider when establishing the context for a risk assessment:

- **The external context** - the environment in which we operate and seek to achieve objectives including, operational, cultural, political, people, environmental, legal, regulatory, financial, technological, and economic factors.

- **The internal context** - includes factors that are relevant to the risk assessment. This is important as risk assessments will be most effective when they are linked to the objectives of the organisation or activity under assessment. Factors typically considered in the internal context include the organisation's strategic objectives, organisational capabilities, and culture.

- **The risk management context** - this defines the goals and objectives of the risks.

23.1.2 Step 2: Identify Risks

The aim of this step is to develop a comprehensive list of future events which could be uncertain but are likely to have an impact (either positively or negatively) on the achievement of the objectives - these are the risks. It is important to understand the difference between a Risk and an Issue, as these can often get confused. A useful way of remembering the difference is;

- Risks are things that **might** happen and stop us achieving objectives, or otherwise impact on the success of the Health Board.

- Issues are things that **have h**appened or are **currently** happening, that are being actively managed.

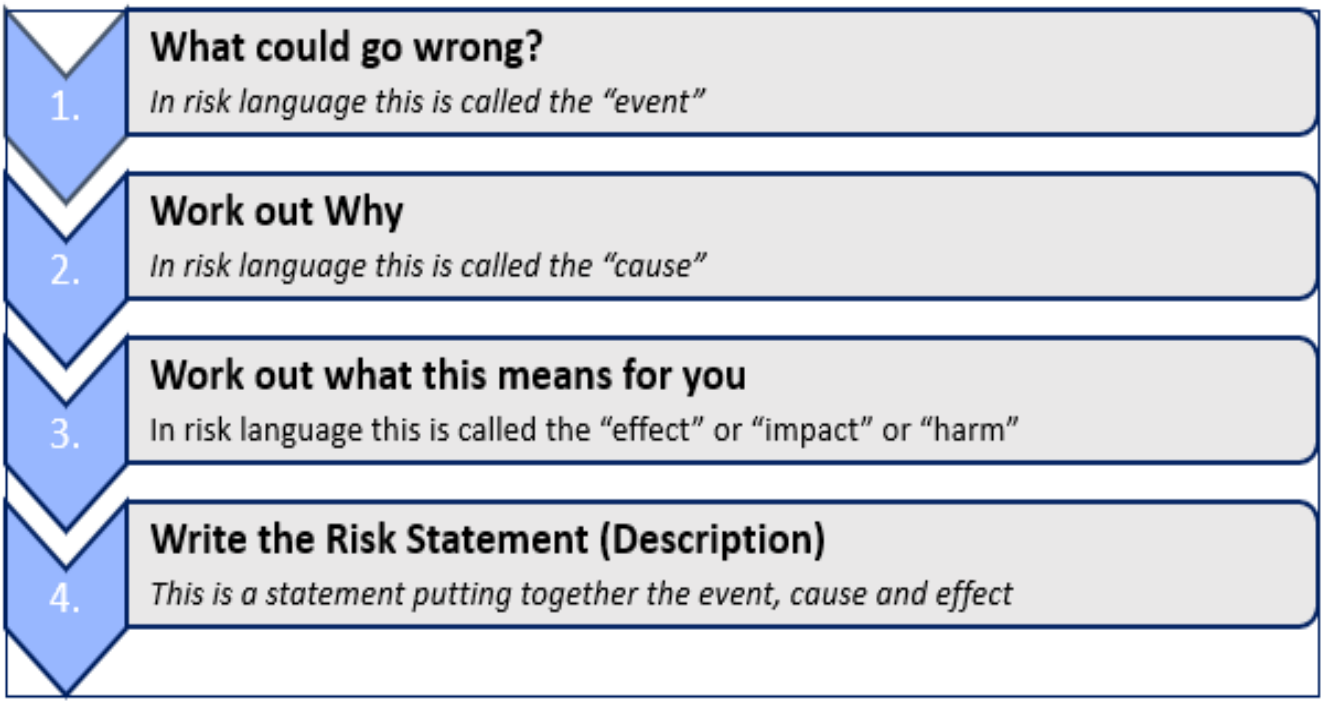
An Issue or a Risk can be determined by the temporal proximity of the event as outlined in the table below.

Temporal Proximity	Risk or Issue
Has happened or is currently happening	**Issue**
Potential to materialise in this financial year	**Risk**
Potential to materialise in the next financial year	**Risk**
Potential to materialise in the next 3-5 years	**Risk**

Common techniques for identifying risks are the use of risk categories or linking risks to each objective identified in the context setting phase. Another method is to consider threats and opportunities the Health Board faces and use these to identify relevant risks.

For each risk identified ensure that its source or cause is well understood and documented, including key elements such as the risk event, the potential cause and the potential impact should the risk be realised. A clear risk description is important to ensure corresponding actions for treatment are effective.

The steps below will guide the development of a risk description, examples of this process are included at **Appendix 1.**



23.1.3 Step 3: Analyse Risks

Risk analysis establishes the potential impact of each risk and its likelihood of occurrence. The combination of these two factors determines the severity of the risk, which may be positive or negative. Before considering how to manage a risk, you need to assess its seriousness. This is done by measuring the risk's **LIKELIHOOD** and **IMPACT**.

Although there are many ways to achieve this, a common approach is to use a matrix or 'risk heat map'. Consequence and likelihood are plotted on the two axes of the matrix, with each corresponding cell assigned a level of severity.

Risks should be measured at the following three stages.

- **INITIAL –** This will be the score when the risk is first identified – this will not change.
- **CURRENT** - This should reflect the latest level of risk each time that the risk is reviewed.
- **TARGET**- The desired level of risk that we are working to reduce the risk to, with the effective implementation of controls and mitigating actions.

The NHS 5 X 5 Risk Scoring Matrix is presented at **Appendix 2.**

23.1.4 Step 4: Evaluate the Risk

Risk evaluation determines the tolerability of each risk. Tolerability is not the same as severity. Tolerability aids in determining which risks require treatment and their order of priority. This is achieved by comparing the risk severity established in the risk analysis step to the risk criteria found in the defined likelihood and consequence criteria.

The Health Board has defined its risk appetite against six broad themes and agreed on the level at which risks within those themes are considered unacceptable; risks below this level are considered tolerable. The Risk Appetite Statement can be accessed here.

Decisions on tolerability should also consider the risk's broader context, including the risk's impact on other stakeholders.

Financial, legal, regulatory, and other considerations should be factored into treatment decisions. Considered and informed acceptance of risk supports decision making and is essential for organisational performance, including the achievement of objectives.

23.1.5 Step 5: Treat the Risk

Risk treatment is the action taken in response to the risk evaluation when additional mitigation activities are agreed upon.

Risk treatment is a cyclical process in which individual risk treatments (or combinations of treatments) are evaluated to see if they are adequate to reduce residual risk levels to a tolerable or appropriate level. If not, then new risk treatments need to be developed and assessed until a satisfactory level of residual risk is achieved.

There are four strategies to managing a risk, known as the 4T's (Treat, Tolerate, Transfer, Terminate) which consider the factors below:

- Avoiding the risk entirely by not undertaking the activity;
- Removing a source or cause of the risk;
- Sharing the risk with other parties;
- Retaining the risk by informed decision;
- Taking more risk to achieve certain objectives or opportunities;
- Changing the likelihood and/or consequence of the risk through modifying controls in place.

Selecting the most appropriate treatment requires balancing the cost and effort of implementation against the benefits derived from additional risk mitigation. In some cases, further treatment may be unachievable or

unaffordable and the residual risk may need to be accepted and communicated.

Consideration should be given to how external stakeholders can provide support when developing treatment options or if treatments can be implemented collaboratively.

Risk treatments are commonly documented in a risk treatment plan. These generally include:

- reasons for treatment selection, including expected benefits and potential concerns;
- accountabilities for approving the plan and its implementation;
- resource requirements;
- reporting, assurance, and monitoring requirements; and
- priorities, timing, and schedules.

23.1.6 Step 6: Communication and Consultation

Communication and consultation are essential attributes of good risk management.

Risk management cannot be done in isolation and is fundamentally communicative and consultative and is a requirement within each element of the risk management process.

Formal risk reporting is only one form of risk communication. Good risk communication generally includes the following attributes:

- encourages stakeholder engagement and accountability;
- maximises the information obtained to reduce uncertainty;
- meets the reporting and assurance needs of stakeholders;
- ensures that relevant expertise is drawn upon to inform each step of the process;
- informs other stakeholder processes such as corporate planning and resource allocation.

23.1.7 Step 7: Monitoring and Review

Risks change over time and hence risk management will be most effective where it is dynamic and evolving.

Monitoring and review are integral to successful risk management, it is important to articulate who is responsible for conducting monitoring and review activities.

Key objectives of risk monitoring and review include:

- detecting changes in the internal and external environment, including evolving objectives and strategies;
- identifying new or emerging risks;
- ensuring the continued effectiveness and relevance of controls and the implementation of treatment programs;
- obtaining further information to improve the understanding and management of already identified risks; and
- analysing and learning lessons from events, including near-misses, successes, and failures

Monitoring and review can be periodic or in response to trigger events or changing circumstances.

The table below serves as a guide for conducting periodic risk assessments based on the risk level (severity). The frequency of the review process, however, should be proportional to the rate at which the organisation and its operating environment change.

Risk Score	Risk Level	Review Risk Assessment
1 - 3	Low	12 months
4 - 8	Moderate	6 months
8 - 12	High	3 months
15 - 25	Extreme	1 month

NB: Depending on the Likelihood and Impact, a score of 8 can indicate a 'moderate' or 'high' risk. For a moderate score of 8, the Likelihood would be 2 (Unlikely) x Impact 4 (Major). For it to be 'High,' the Likelihood would be 4 (Likely) x Impact 2 (Minor).

The results and observations from monitoring and review are most useful when well documented and shared. The Health Board Risk Management System, Datix, should be used to record, manage, monitor and review all risks. The information recorded on Datix feeds into the organisation-wide risk register, giving a holistic view of risks across the entire organisation and can be used to identify themes and ensure the risk is managed and monitored at the most appropriate level.

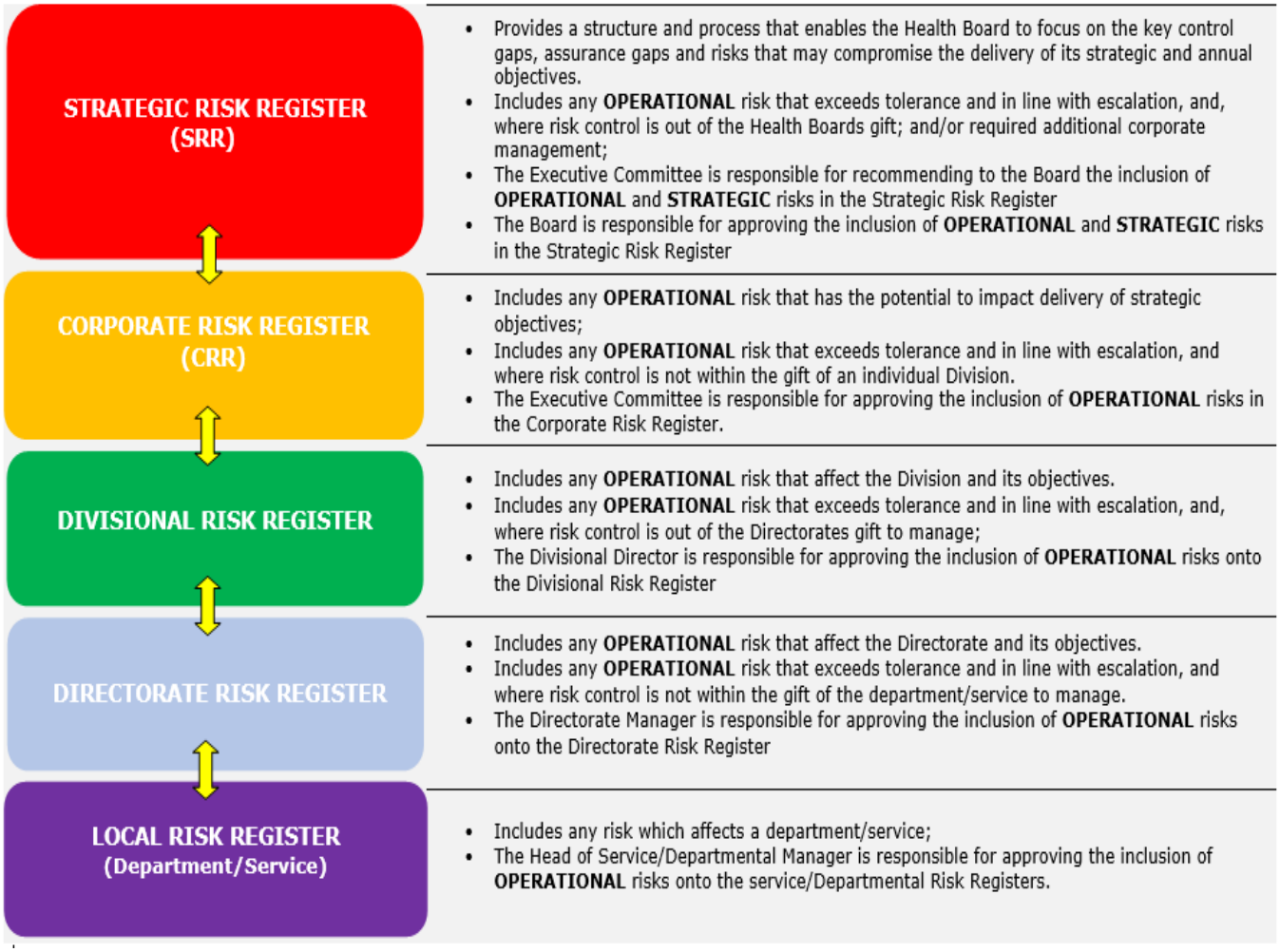
They should be included in formal risk reports, be recorded, and published internally and externally as appropriate.

Risk monitoring should be included as a standing agenda item in assurance meetings for regular discussion and review of risk information. This discussion might identify that the impact of some risks, or the actions required to mitigate them, are such that the risk needs to be escalated to a higher management level.

24 ESCALATION PROCESS

The Health Board uses hierarchical risk registers to ensure that risks are managed, escalated, and reported at the appropriate organisational level. The risk escalation framework is determined by the risk score or the significance of the risk to the delivery of patient safety, service delivery, safeguarding assets, or organisational objectives.

If the capability or capacity to manage a potential directorate, divisional, or corporate risk is exceeded, or if current controls are not mitigating the risk materialising, the risk must be escalated using Datix and communicated to the appropriate person, as illustrated below, and explained in detail in the next section.



Trigger Points for Escalation

Strategic Risk Register holds all risks which present a direct threat to the Board's strategic priorities as outlined in the Integrated Medium-Term Plan (IMTP). Furthermore, any risks identified on the Corporate Risk Register that are deemed significant or have the potential to have a strategic impact will be escalated and monitored through the Strategic Risk Register.

Corporate Risk Register holds all potential operational risks that require a higher level of ownership than an individual Executive Director can provide but do not directly threaten the organisation's future, these will typically span two or more directorates or require plans and resources that exceed the Division's capability or capacity to implement or have a score greater than 20.

Divisional Risk Register holds all potential operational risks that necessitate a higher level of ownership than an individual Directorate can provide. Such risks necessitate plans and resources that are beyond the Directorate's capability or capacity to implement or have a score greater than 12.

Directorate Risk Register holds all potential operational risks that necessitate a higher level of ownership than an individual ward/service can provide. Such risks typically necessitate plans and resources that are greater than the Directorate's capability or capacity to implement or have a score greater than 6.

Local Risk Register holds all potential operational risks that could impact the day-to-day running of the service. Local Risk Registers will typically have a higher number of Health and Safety risks than other risk registers. Any risk with a score greater than 6 must be escalated to the Directorate Risk Register.

Risks that are proposed for escalation to the Corporate or Strategic Risk Registers are subject to a more thorough risk assessment. The Executive Team and Board require assurance that the controls and additional controls will mitigate the risk to a tolerable level, as well as evidence of the assurance in place at an operational, organisational, and independent level.

Risk Assessment Templates are included in **Appendices 3 and 4** for Divisional, Directorate, and Local risks, as well as Corporate and Strategic risks. **Appendix 5** illustrates a flow chart of the escalation process.

25 DATIX RISK MANAGEMENT SYSTEM

Risks must be recorded on the Health Board's Risk Management System, Datix. The DatixWeb Risk Module Training Guide is a step-by-step guide to recording and managing risks on Datix and can be accessed here.

26 SUPPORTING DOCUMENTS

This document should be read in conjunction with the:

- Risk Management Framework
- Risk Appetite Statement
- DatixWeb Risk Module Training Guide

27 TRAINING AND IMPLEMENTATION

All new staff are required to attend an Induction Programme which includes risk management training. Additional training will be available through ESR.

Board members will receive risk management training, both individually and collectively, to enable them to discharge their responsibilities effectively. This will be delivered at a minimum through Board Member Induction, with formal training delivered to the collective Board every two years.

The Corporate Governance Directorate will deliver training, and ongoing support and advice to all staff and Board Members. This will ensure that the Health Board incorporates risk management as a core function of all programmes of work associated with the delivery of organisational objectives and will aid in the identification of risks to objectives at the outset of planning processes.

AUDIT AND REVIEW

This document will be reviewed annually in line with the Risk Management Framework and will be subject to regular auditing to ensure that risk management practices are effectively embedded across the Health Board

28 APPENDICES

- Appendix 1 - Risk Statement Examples
- Appendix 2 – NHS Wales Risk Scoring Matrix (5x5 Model)
- Appendix 3 - Risk Assessment Template Divisional / Directorate / Local Risk Assessment
- Appendix 4 - Risk Assessment Template Strategic/Corporate Risk
- Appendix 5 - Escalation Process

29 APPENDIX 1: Risk Statement Examples

1. What could go wrong?	2. What could be the cause of this?	3. What would be the effect/impact?	4. Risk Statement (Description)
Poor quality care provided to patients	• High staff sickness rate • Inability to recruit sufficient staff. • Inability to release staff for statutory and mandatory training	• Adverse harm to patients • Loss of public confidence in services • Breach of Staffing Levels Act	There is a risk that safe staffing levels are not maintained, compromising patient safety and care.
Staff could fall over storage boxes	• Medical records stored in boxes unsafely in office accommodation	• Staff absence due to injury • Breach of Health & Safety at Work Legislation • Litigation Claims for Injury	There is a risk that the unsafe storage of medical records could cause potential harm to staff and loss to the organisation.
Unable to update electronic patient records	• System downtime • Internet access • IT failure	• Adverse harm to patients • Compliance with record-keeping standards • Litigation claims • Reputational damage	There is a risk that patient records will not be updated with critical information should access to web-based/electronic recording systems be compromised.

30 APPENDIX 2: NHS Wales Risk Scoring Matrix (5x5 Model)

X-Axis = Likelihood/Frequency of the risk occurring.

Y-Axis = the level of risk **Consequence/Impact**

Color-coding is crucial for a 5×5 risk assessment matrix to represent the combination level of probability and consequence of the identified risks.

Each risk box represents the rating of a risk that is calculated based on its levels of likelihood and impact using a numeric value.

Calculating Risks Using the 5×5 Risk Matrix

The first step is to assign a numeric value from 1 to 5, 1 being the lowest, for each of the categories under Likelihood and Consequence. Then, use the formula of multiplying the value of the Likelihood by the value of the Consequence to determine the Risk Level.

Likelihood x Consequence = Risk Level

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely (61-90%)	4 (Moderate)	8 (High)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible (41-60%)	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely (11-40%)	2 (Low)	4 (Moderate)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare (1-10%)	1 (Low)	2 (Low)	3 (Low)	4 (Moderate)	5 (Moderate)

The 5 risk rating levels under Likelihood/Frequency are as follows:

	Likelihood/frequency score (severity levels) and examples of descriptors				
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency **How often might it/does it happen.**	This will probably never happen/recur. (e.g., 1 – 10%)	Do not expect it to happen/recur but it is possible it may do so. (e.g.,11 – 40%)	Might happen or recur occasionally. (e.g.,41 – 60%)	Will probably happen/recur but it is not a persisting issue. (e.g.,61 – 90%)	Will undoubtedly happen/recur, possibly frequently. (e.g.,91 -100%)

The 5 risk rating levels under Consequence/Impact are as follows:

	Severity/Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public **(Physical or Psychological harm)**	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring. minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term. incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects	Incident leading to death. Multiple permanent injuries or irreversible health effects An event which impacts on many patients

Quality **Complaints** **Audit**	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (Stage 1) Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources **Organisational Development** **Staffing** **Competence**	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training

			Poor staff attendance for mandatory/key training	Very low staff morale No staff attending mandatory/ key training.	/key training on an ongoing basis.
Statutory duty **Inspections**	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating Severely critical report
Adverse publicity / **Reputation**	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days Service well below reasonable public expectation. MP concerned. (Questions in the House) Total loss of public confidence
Business objectives / **Projects**	Insignificant cost increase/ schedule slippage	<5 per cent over project budget	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project/ budget

		Schedule slippage		Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Fraud	Unlikely to result in material loss or reputational damage. Little or no loss to the organisation, material loss less than £500	Material loss or reputational damage likely to be minimal. Some risk to the organisation which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint	Could result in material loss or reputational damage. Moderate risk to the organisation which may result in reduction of service. Material loss of up to £10000. Reputational damage across NHS with a high potential for complaint or a low risk of litigation	Could result in high material loss or reputational damage. May result in temporary loss of service or material loss of up to £50000. Reputational damage widespread and outside of NHS with a likelihood of litigation)	Could result in significant material loss or reputational damage. High risk which may result in prolonged loss of service or material loss of over £50000. Nationwide media coverage causes reputational damage which is likely to lead to criminal prosecution or external investigation)
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

The table below outlines the time frame for implementation of actions based on risk score and level.

Risk Score	Overall Risk	Timeframe
1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit.
4 - 8	Moderate	Actions implemented as soon as possible but no later than a year.
8 - 12	High	Actions implemented as soon as possible but no later than six months.
15 - 25	Extreme	Requires urgent action. The Health Board is made aware, and it implements immediate corrective action. However, where likelihood is rare or unlikely then potential decision needed on tolerance and action timescales.

NB: Depending on the Likelihood and Impact, a score of 8 can indicate a 'moderate' or 'high' risk. For a moderate score of 8, the Likelihood would be 2 (Unlikely) x Impact 4 (Major). For it to be 'High,' the Likelihood would be 4 (Likely) x Impact 2 (Minor).

31 / Local Risk Assessment

RISK ID:				
Description				
Threat				
Impact				
Risk Handler		Risk Exposure	Current Level	Target
Monitoring Forum		Likelihood		
Initial Date of Assessment		Impact		
Last Reviewed		Risk rating		

Notes for completion:
When a potential risk threatens the achievement of objectives or is deemed a high-level operational risk, it should be escalated through the hierarchical structure and a request to the Lead Executive Director for consideration by the Executive Committee for inclusion on the Corporate Risk Register (CRR).

The **Threshold** for escalation to the:

- Directorate Risk Register is set at **8 and above**,
- Divisional Risk Register **12 and above**,
- Corporate Risk Register **20 and above.**

The timeframe for actions to be implemented must be aligned to the risk score/level.

Score	Overall Risk	Timeframe for implementing Actions
1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit
4 - 8	Moderate	Actions implemented as soon as possible but no later than a year
8 - 12	High	Actions implemented as soon as possible but no later than six months
15 - 25	Extreme	Requires urgent action

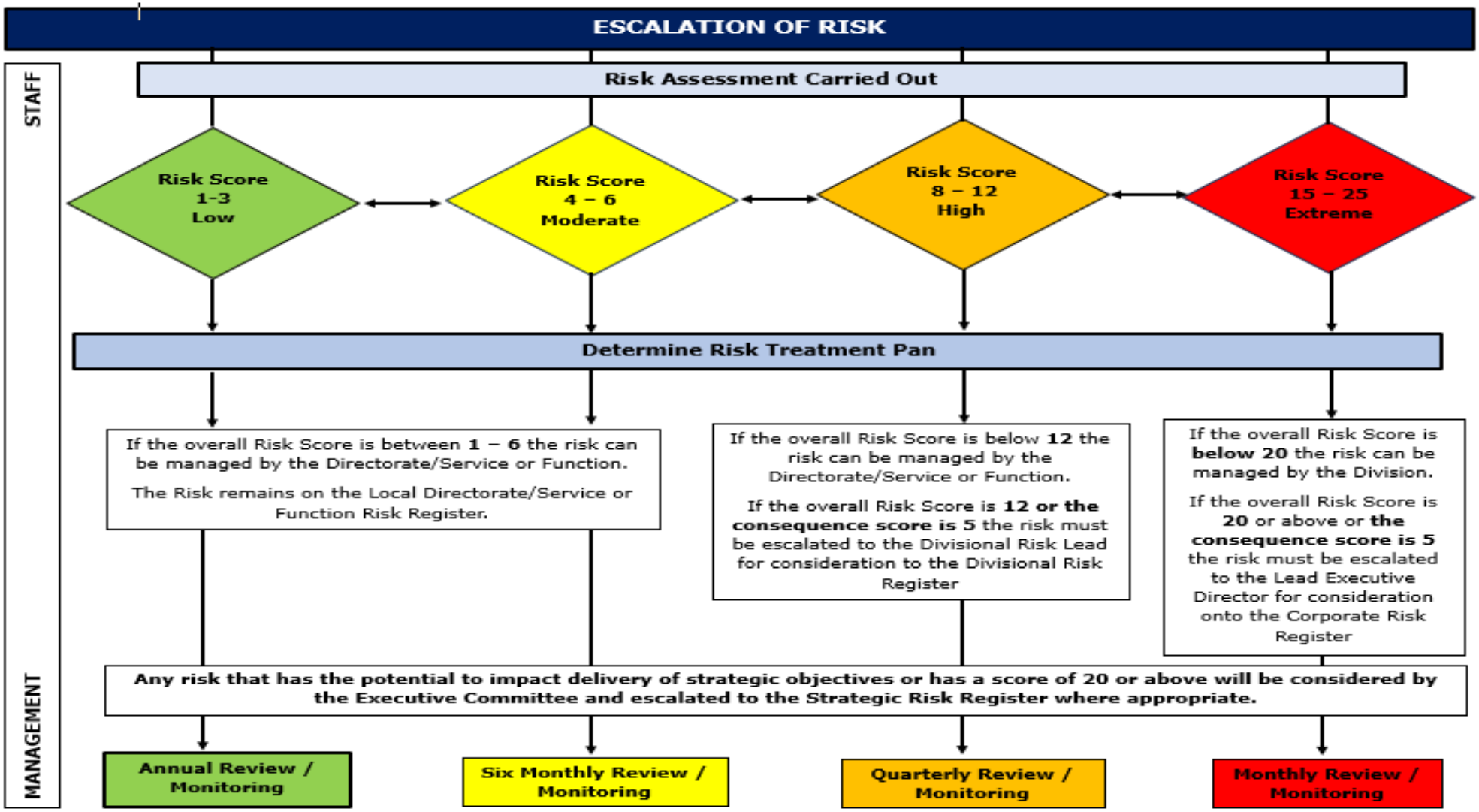
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Gaps Control** *(Are further controls possible to reduce risk exposure to target level)*	**Timeframe to Implement further enhancement of controls**	**Progress against Actions to Improve Control** *(What has been implemented)*

32 APPENDIX 4: Risk Assessment Template Strategic/Corporate Risk

Risk ID:	STRATEGIC/CORPROATE RISK				
Description					
Strategic Threat					**Risk Appetite Level – Use RA Statement to complete.**
Impact					**Risk Appetite Threshold - Use RA Statement to complete.** **SUMMARY** The current risk level is **within/outside** of target level but **within/outside** appetite threshold. The target level to be achieved is **within/outside** the set appetite threshold.
Lead Director		Risk Exposure	Current Level	Target Level	RUN CHART TO BE ADDED HERE
Monitoring Committee		Likelihood			
Initial Date of Assessment		Impact			
Last Reviewed		Risk rating			

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
		Level 1 Operational *(Implemented by the department that performs daily operation activities)*	**Gaps in Assurance**	**Positive** **Reasonable** **Negative** **Assurance**
		Level 2 Organisational *(Executed by risk management and compliance functions.)*	**Action to Address Gaps in Assurance**	
		Level 3 Independent *(Internal and external independent bodies.)*		

33 APPENDIX 5: Escalation Process



Aneurin Bevan University Health Board

Risk Management Policy and Procedure

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

Status: Issue 1 | Issue date:25 Jan 2024
Approved by: Aneurin Bevan University Health Board | Review by date: 25 Jan 2025
Owner: Corporate Governance Directorate | Ref No: ABUHB_Corporate_1133

Contents:

INTRODUCTION 3
AIMS 3
SCOPE 4
ROLES AND RESPONSIBILITIES 4
RISK MANAGEMENT 9
Principles of Risk Management 9
Benefits of Risk Management 10
Risk Management Framework 10
Risk Management Process 11
Step 1: Establish the Context 11
Step 2: Identify Risks 12
Step 3: Analyse Risks 13
Step 4: Evaluate the Risk 14
Step 5: Treat the Risk 14
Step 6: Communication and Consultation 15
Step 7: Monitoring and Review 15
ESCALATION PROCESS 17
DATIX RISK MANAGEMENT SYSTEM 18
SUPPORTING DOCUMENTS 19
TRAINING AND IMPLEMENTATION 19
APPENDICES 19
APPENDIX 1: Risk Statement Examples 20
APPENDIX 2: NHS Wales Risk Scoring Matrix (5x5 Model) 21
APPENDIX 3: Risk Assessment Template Divisional / Directorate / Local Risk Assessment 26
APPENDIX 4: Risk Assessment Template Strategic/Corporate Risk 27
APPENDIX 5: Escalation Process 28

INTRODUCTION

Aneurin Bevan University Health Board (the Health Board) is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal control. Risk management is essential, not only for providing a safe environment and improved quality of care for service users and staff, but also for the achievement of the organisation's strategic goals, corporate and clinical objectives.

The Health Board views risk management as an integral part of the overall management process, rather than as a separate arrangement, and is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Health Board's thinking and activities.

This Policy sets out the Health Board's approach to embedding a risk management culture that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and promoting its values.

AIMS

The aim of this Risk Management Policy and Procedure is to underpin the Health Board's Risk Management Framework that ensures:

- integration of risk management into activities across the organisation as well as planning and decision-making processes;
- chances of adverse incidents, risks and complaints are minimised by effective risk identification, prioritisation, treatment, and management;
- a risk management framework is maintained, which provides assurance to the Board that strategic and operational risks are being managed;
- risk management is an integral part of Health Board's culture and encourages learning from incidents; and
- employees, reputation, finances, and business continuity are protected through the process of risk identification, assessment, control and mitigation.

This Policy should be read in the context of the Health Board's Risk Management Framework which describes the Health Board's key principles and objectives to ensure an effective risk management system is in place across the organisation.

SCOPE

This Risk Management Policy and Procedure applies to all Health Board employees, regardless of grade or role. This includes those with whom we contract, those who are seconded to work in the organisation, and any volunteers who work in partnership with the organisation.

Therefore, accountability and responsibility for active risk management is shared at all levels within the organisation and across our partnerships, ensuring that risk management is an integral part of the overall approach to health, partnership governance, and service delivery.

ROLES AND RESPONSIBILITIES

Employees in all positions are responsible for maintaining risk awareness by identifying and reporting risks to their line manager and/or directors as appropriate. All areas must conduct ongoing robust risk assessments and escalate risks through the Health Board's governance and escalation route, as outlined below in the Risk Management Process section.

Although risk management is everyone's responsibility, certain roles bear more responsibility and ownership for implementing risk management systems and processes and ensuring risks are managed effectively.

The Board is made up of Executive Directors and Independent Members that share equal responsibility for the success of the organisation, including the effective management of risk and compliance with relevant legislation. In relation to risk management the Board is responsible for:

- articulating the strategic objectives and success measures for the organisation;
- protecting the reputation of the organisation;
- providing leadership on the management of risk;
- determining the risk appetite for the organisation;
- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- considering any risks that are outside of appetite.

The Audit, Risk and Assurance Committee is responsible, on behalf of the Board, for reviewing the adequacy and effectiveness of:

- all risk and control related disclosure statements (the Annual Governance Statement), prior to endorsement by the Board;

- the effectiveness of the organisational risk management system;
- the underlying assurance processes that indicate the degree of achievement of strategic objectives and the effectiveness of the management of risks;
- reviewing risk related documents, policies, and procedures;
- reviewing on a regular basis the strategic risks, controls, and treatment plans and, in relation to those risks which are outside the risk appetite of the organisation, recommend appropriate action to the Board; and
- escalating to the Board any matters of significance which require Board attention or approval.

The Chief Executive (CEO) is the Accountable Officer of the Health Board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements, and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and, governance.

In respect of risk management, the CEO has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate planning process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Executive Directors are accountable and responsible for ensuring that their respective areas of responsibility are implementing this Framework, and related policies/procedures. Each Director is accountable for the delivery of their area of responsibility, and will therefore ensure that the

systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

Specifically, they will:

- support the embedding of an effective risk management culture throughout the Health Board;
- communicate to their teams, the Board's strategic objectives; and, ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area, which will encourage integration of risk management;
- lead the risk management process within respective areas which includes: risk assessments; incident reporting; the investigation of incidents/near misses; and, the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area, and that risks are treated as required;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post, and that those key objectives are reflected in the individual performance review/staff appraisal process.

In addition, Clinical Executive Directors (Medical Director, Director of Nursing and the Director of Therapies & Health Science) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework and the Board's Quality Strategy.

Director of Corporate Governance is the delegated Director lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the Board Assurance Framework and Risk Management Framework. The Director of Corporate Governance will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- work closely with the Chair; Chief Executive; Chair of the Audit, Risk and Assurance Committee; and Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- work closely with the Chief Executive and Executive Directors to support the development and maintenance of Corporate and Divisional level risk registers;
- develop and oversee the effective execution of the Health Board's assurance arrangements;
- develop and implement the Health Board's Risk Management Framework; and
- produce the health board's Annual Governance Statement.

Head of Corporate Risk and Assurance is accountable to the Director of Corporate Governance, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the Health Board's assurance arrangements;
- support the management and development of the Health Board's assurance arrangements and Risk Management Framework;
- work with Divisions, Directorates, Functions and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the Strategic Risk Register and Corporate Risk Register for reporting to Board and its Committees; and
- provide training, information and advice to operational staff, teams functions on risk management and risk registers, ensuring alignment to risk management reporting and escalation arrangements.

Risk Leads and Risk Owners are the responsible point of contacts for an identified risk, who coordinates efforts to mitigate and manage the risk with various individuals who may also own parts of the risk.

These responsibilities include:

- taking responsibility for managing risk;
- ensuring that risks are assessed where they are:
    - identified within the working activities carried out within their management control;
    - identified within the environment within their control;
    - reported from the staff within their management control.
- identifying and managing risks that cut across delivery areas;
- ensuring all incidents/accidents and near misses are reported;
- monitoring mitigating actions and ensuring action owners are clear about their roles, and what they need to achieve;
- discussing risks on a regular basis with staff, and through discussions at meetings to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach; and
- ensuring risks are updated regularly and acted upon.

Line Managers are expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement this Framework and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the Health Board's approach to risk management and governance. They will support the application of this Framework and its related processes, and participate in the monitoring and auditing process where required.

All Staff are responsible for ensuring that identified risks are reported to their immediate line manager so that effective controls can be considered and implemented as needed. All staff have a general responsibility for overall risk management issues and must adhere to Health Board procedures in their work.

RISK MANAGEMENT

The Health Board, like all organisations, faces actual and theoretical risks ranging from trivial to existential. ISO 31000, Risk Management, recommends that risk management be based on three core elements:

- a set of principles that describes the essential attributes of good risk management;
- a risk management framework that provides a structure for risk management; and
- a risk management process that prescribes a tailored, structured approach to understanding, communicating, and managing risk in practice.

Principles of Risk Management

- Recognises that risk is inherent and will exist at all levels of the organisation;
- Risk management is everybody's business, and its risk management and assurance arrangements apply to all directly employed staff and those engaged in work or other activities on behalf of the Health Board;
- Seeks to control risks in a proportionate and cost-effective manner such that exposures are mitigated to an acceptable level (in accordance with agreed risk appetite) or are eliminated as far as it is reasonably possible;
- Acknowledges that some risks can never be eliminated entirely;
- Seeks to mitigate and control its identified risk exposure;
- Encourages considered and controlled risk-taking within authorised limits in order to develop and transform its services and functions;
- Applies its risk management and assurance framework to all categories of risk;
- Will adopt and adapt instances of good practice in established risk management and assurance methodologies, but where appropriate will develop bespoke risk management arrangements where required;
- Will ensure that its risk management and assurance arrangements support transparency, accountability, and wider public interest regarding the activities of the organisation.

Benefits of Risk Management

The Health Board recognises that there are significant benefits to managing risk, these include:

- Supports achievement of Health Borad objectives;
- Avoids or mitigates the impact of failure;
- Supports cost efficiency and value for money;
- Compliance with legal and regulatory framework;
- Management of external impacts and changes; and
- Exploit opportunities encouraging innovation

Risk Management Framework

The Health Board's Risk Management system is supported by the Risk Management Framework which can be found here. The Framework sets out the Health Board's approach to embedding a risk management culture that underpins and supports the business of the Health Board; delivering and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and, promoting its values.

Risks are linked to objectives and strategic aims, which exist at different levels:

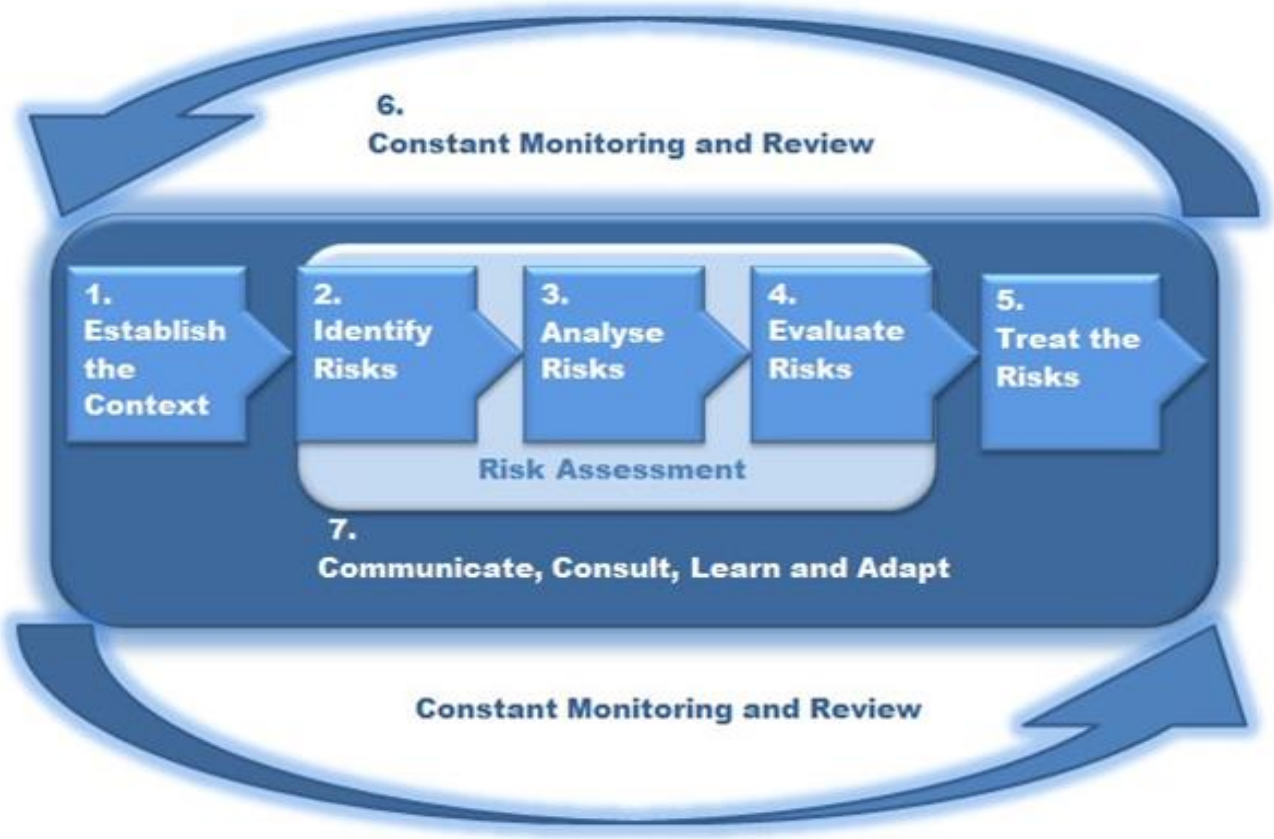
- **Strategic risks** – risks that affect the Heath Board's ability to deliver its strategic priorities or to function as an organisation as a whole;
- **Corporate Risks** – risks that have an impact on the delivery of the Health Board's business objectives or common risks that necessitate a corporate response;
- **Divisional –** risks that have an impact on the delivery of divisional objectives or common risks that necessitate a co-ordinated response;
- **Directorate / Team risks** - risks that are related to the delivery of departmental operations and objectives;
- **Programmes/Projects -** risks associated with, usually, time limited activities and medium- to long-term delivery of benefits.

Strategic risk, corporate, operational and local team risk registers should not include project risks. All projects' risks will be managed through the appropriate project boards with reporting and escalation through the change management governance process.

Risk Management Process

The risk management process is illustrated in Figure 1. This is then broken down into individual steps and explained in greater detail.

Figure 1



Step 1: Establish the Context

Before identifying risks, first decide on the scope of the activity, including your objectives, and develop an understanding of your operating environment.

Identify your stakeholders (internal and external) to determine whether they could potentially expose the Health Board to risk, could be exposed to risk, or could assist with risk management.

There are three other elements that are important to consider when establishing the context for a risk assessment:

- **The external context** - the environment in which we operate and seek to achieve objectives including, operational, cultural, political, people, environmental, legal, regulatory, financial, technological, and economic factors.

- **The internal context** - includes factors that are relevant to the risk assessment. This is important as risk assessments will be most effective when they are linked to the objectives of the organisation or activity under assessment. Factors typically considered in the internal context include the organisation's strategic objectives, organisational capabilities, and culture.

- **The risk management context** - this defines the goals and objectives of the risks.

Step 2: Identify Risks

The aim of this step is to develop a comprehensive list of future events which could be uncertain but are likely to have an impact (either positively or negatively) on the achievement of the objectives - these are the risks.

It is important to understand the difference between a Risk and an Issue, as these can often get confused. A useful way of remembering the difference is;

- Risks are things that **might** happen and stop us achieving objectives, or otherwise impact on the success of the Health Board.

- Issues are things that **have h**appened or are **currently** happening, that are being actively managed.

An Issue or a Risk can be determined by the temporal proximity of the event as outlined in the table below.

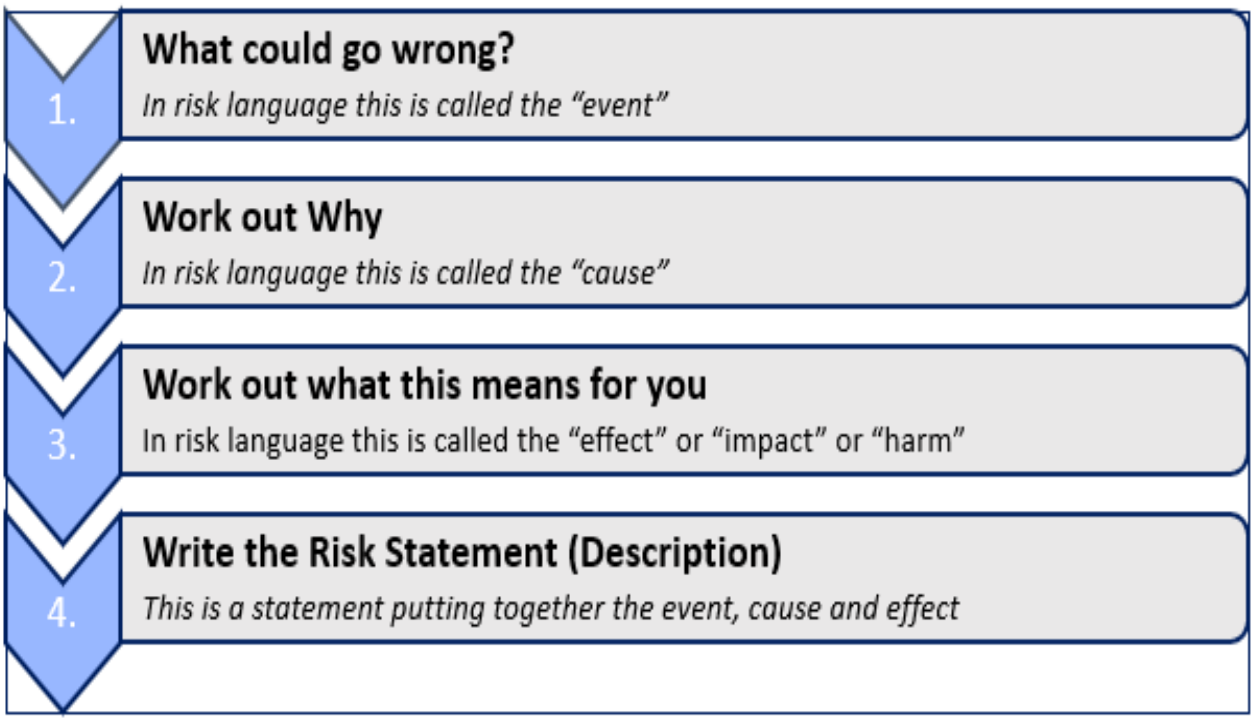
Temporal Proximity	Risk or Issue
Has happened or is currently happening	**Issue**
Potential to materialise in this financial year	**Risk**
Potential to materialise in the next financial year	**Risk**
Potential to materialise in the next 3-5 years	**Risk**

Common techniques for identifying risks are the use of risk categories or linking risks to each objective identified in the context setting phase. Another method is to consider threats and opportunities the Health Board faces and use these to identify relevant risks.

For each risk identified ensure that its source or cause is well understood and documented, including key elements such as the risk event, the potential cause and the potential impact should the risk be realised. A clear

risk description is important to ensure corresponding actions for treatment are effective.

The steps below will guide the development of a risk description, examples of this process are included at **Appendix 1.**



Step 3: Analyse Risks

Risk analysis establishes the potential impact of each risk and its likelihood of occurrence. The combination of these two factors determines the severity of the risk, which may be positive or negative.

Before considering how to manage a risk, you need to assess its seriousness. This is done by measuring the risk's **LIKELIHOOD** and **IMPACT**.

Although there are many ways to achieve this, a common approach is to use a matrix or 'risk heat map'. Consequence and likelihood are plotted on the two axes of the matrix, with each corresponding cell assigned a level of severity.

Risks should be measured at the following three stages.

- **INITIAL –** This will be the score when the risk is first identified – this will not change.
- **CURRENT** - This should reflect the latest level of risk each time that the risk is reviewed.

- **TARGET**- The desired level of risk that we are working to reduce the risk to, with the effective implementation of controls and mitigating actions.

The NHS 5 X 5 Risk Scoring Matrix is presented at **Appendix 2.**

Step 4: Evaluate the Risk

Risk evaluation determines the tolerability of each risk. Tolerability is not the same as severity. Tolerability aids in determining which risks require treatment and their order of priority. This is achieved by comparing the risk severity established in the risk analysis step to the risk criteria found in the defined likelihood and consequence criteria.

The Health Board has defined its risk appetite against six broad themes and agreed on the level at which risks within those themes are considered unacceptable; risks below this level are considered tolerable. The Risk Appetite Statement can be accessed here.

Decisions on tolerability should also consider the risk's broader context, including the risk's impact on other stakeholders.

Financial, legal, regulatory, and other considerations should be factored into treatment decisions. Considered and informed acceptance of risk supports decision making and is essential for organisational performance, including the achievement of objectives.

Step 5: Treat the Risk

Risk treatment is the action taken in response to the risk evaluation when additional mitigation activities are agreed upon.

Risk treatment is a cyclical process in which individual risk treatments (or combinations of treatments) are evaluated to see if they are adequate to reduce residual risk levels to a tolerable or appropriate level. If not, then new risk treatments need to be developed and assessed until a satisfactory level of residual risk is achieved.

There are four strategies to managing a risk, known as the 4T's (Treat, Tolerate, Transfer, Terminate) which consider the factors below:

- Avoiding the risk entirely by not undertaking the activity;
- Removing a source or cause of the risk;
- Sharing the risk with other parties;
- Retaining the risk by informed decision;
- Taking more risk to achieve certain objectives or opportunities;
- Changing the likelihood and/or consequence of the risk through modifying controls in place.

Selecting the most appropriate treatment requires balancing the cost and effort of implementation against the benefits derived from additional risk mitigation. In some cases, further treatment may be unachievable or unaffordable and the residual risk may need to be accepted and communicated.

Consideration should be given to how external stakeholders can provide support when developing treatment options or if treatments can be implemented collaboratively.

Risk treatments are commonly documented in a risk treatment plan. These generally include:

- reasons for treatment selection, including expected benefits and potential concerns;
- accountabilities for approving the plan and its implementation;
- resource requirements;
- reporting, assurance, and monitoring requirements; and
- priorities, timing, and schedules.

Step 6: Communication and Consultation

Communication and consultation are essential attributes of good risk management.

Risk management cannot be done in isolation and is fundamentally communicative and consultative and is a requirement within each element of the risk management process.

Formal risk reporting is only one form of risk communication. Good risk communication generally includes the following attributes:

- encourages stakeholder engagement and accountability;
- maximises the information obtained to reduce uncertainty;
- meets the reporting and assurance needs of stakeholders;
- ensures that relevant expertise is drawn upon to inform each step of the process;
- informs other stakeholder processes such as corporate planning and resource allocation.

Step 7: Monitoring and Review

Risks change over time and hence risk management will be most effective where it is dynamic and evolving.

Monitoring and review are integral to successful risk management, it is important to articulate who is responsible for conducting monitoring and review activities.

Key objectives of risk monitoring and review include:

- detecting changes in the internal and external environment, including evolving objectives and strategies;
- identifying new or emerging risks;
- ensuring the continued effectiveness and relevance of controls and the implementation of treatment programs;
- obtaining further information to improve the understanding and management of already identified risks; and
- analysing and learning lessons from events, including near-misses, successes, and failures

Monitoring and review can be periodic or in response to trigger events or changing circumstances.

The table below serves as a guide for conducting periodic risk assessments based on the risk level (severity). The frequency of the review process, however, should be proportional to the rate at which the organisation and its operating environment change.

Risk Score	Risk Level	Review Risk Assessment
1 - 3	Low	12 months
4 - 8	Moderate	6 months
8 - 12	High	3 months
15 - 25	Extreme	1 month

NB: Depending on the Likelihood and Impact, a score of 8 can indicate a 'moderate' or 'high' risk. For a moderate score of 8, the Likelihood would be 2 (Unlikely) x Impact 4 (Major). For it to be 'High,' the Likelihood would be 4 (Likely) x Impact 2 (Minor).

The results and observations from monitoring and review are most useful when well documented and shared. The Health Board Risk Management System, Datix, should be used to record, manage, monitor and review all risks. The information recorded on Datix feeds into the organisation-wide risk register, giving a holistic view of risks across the entire organisation and can be used to identify themes and ensure the risk is managed and monitored at the most appropriate level.

They should be included in formal risk reports, be recorded, and published internally and externally as appropriate.

Risk monitoring should be included as a standing agenda item in assurance meetings for regular discussion and review of risk information. This discussion might identify that the impact of some risks, or the actions

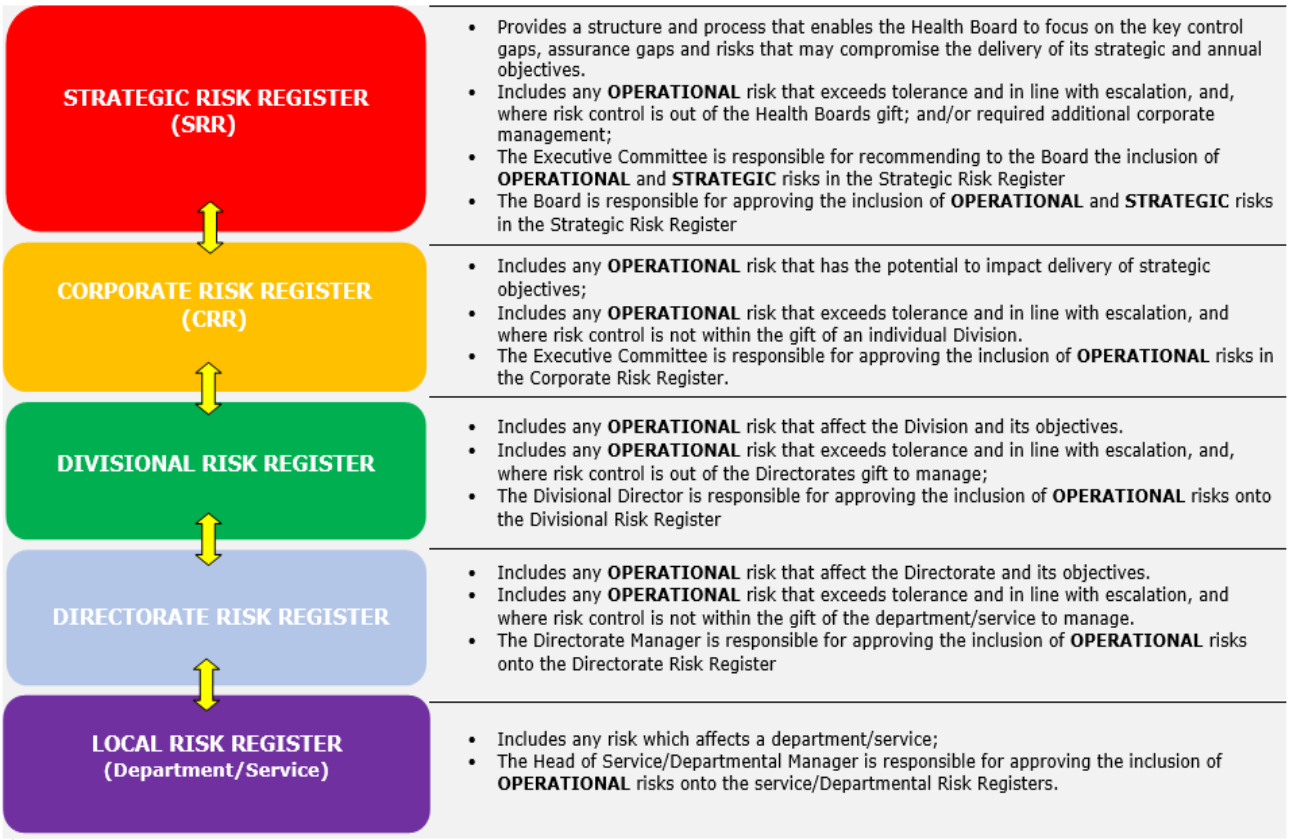
required to mitigate them, are such that the risk needs to be escalated to a higher management level.

ESCALATION PROCESS

The Health Board uses hierarchical risk registers to ensure that risks are managed, escalated, and reported at the appropriate organisational level.

The risk escalation framework is determined by the risk score or the significance of the risk to the delivery of patient safety, service delivery, safeguarding assets, or organisational objectives.

If the capability or capacity to manage a potential directorate, divisional, or corporate risk is exceeded, or if current controls are not mitigating the risk materialising, the risk must be escalated using Datix and communicated to the appropriate person, as illustrated below, and explained in detail in the next section.



Trigger Points for Escalation

Strategic Risk Register holds all risks which present a direct threat to the Board's strategic priorities as outlined in the Integrated Medium-Term Plan (IMTP). Furthermore, any risks identified on the Corporate Risk Register that are deemed significant or have the potential to have a

strategic impact will be escalated and monitored through the Strategic Risk Register.

Corporate Risk Register holds all potential operational risks that require a higher level of ownership than an individual Executive Director can provide but do not directly threaten the organisation's future, these will typically span two or more directorates or require plans and resources that exceed the Division's capability or capacity to implement or have a score greater than 20.

Divisional Risk Register holds all potential operational risks that necessitate a higher level of ownership than an individual Directorate can provide. Such risks necessitate plans and resources that are beyond the Directorate's capability or capacity to implement or have a score greater than 12.

Directorate Risk Register holds all potential operational risks that necessitate a higher level of ownership than an individual ward/service can provide. Such risks typically necessitate plans and resources that are greater than the Directorate's capability or capacity to implement or have a score greater than 6.

Local Risk Register holds all potential operational risks that could impact the day-to-day running of the service. Local Risk Registers will typically have a higher number of Health and Safety risks than other risk registers. Any risk with a score greater than 6 must be escalated to the Directorate Risk Register.

Risks that are proposed for escalation to the Corporate or Strategic Risk Registers are subject to a more thorough risk assessment. The Executive Team and Board require assurance that the controls and additional controls will mitigate the risk to a tolerable level, as well as evidence of the assurance in place at an operational, organisational, and independent level.

Risk Assessment Templates are included in **Appendices 3 and 4** for Divisional, Directorate, and Local risks, as well as Corporate and Strategic risks. **Appendix 5** illustrates a flow chart of the escalation process.

DATIX RISK MANAGEMENT SYSTEM

Risks must be recorded on the Health Board's Risk Management System, Datix. The DatixWeb Risk Module Training Guide is a step-by-step guide to recording and managing risks on Datix and can be accessed here.

SUPPORTING DOCUMENTS

This document should be read in conjunction with the:

- Risk Management Framework
- Risk Appetite Statement
- DatixWeb Risk Module Training Guide

TRAINING AND IMPLEMENTATION

All new staff are required to attend an Induction Programme which includes risk management training. Additional training will be available through ESR.

Board members will receive risk management training, both individually and collectively, to enable them to discharge their responsibilities effectively. This will be delivered at a minimum through Board Member Induction, with formal training delivered to the collective Board every two years.

The Corporate Governance Directorate will deliver training, and ongoing support and advice to all staff and Board Members. This will ensure that the Health Board incorporates risk management as a core function of all programmes of work associated with the delivery of organisational objectives and will aid in the identification of risks to objectives at the outset of planning processes.

AUDIT AND REVIEW

This document will be reviewed annually in line with the Risk Management Framework and will be subject to regular auditing to ensure that risk management practices are effectively embedded across the Health Board.

APPENDICES

- Appendix 1 - Risk Statement Examples
- Appendix 2 – NHS Wales Risk Scoring Matrix (5x5 Model)
- Appendix 3 - Risk Assessment Template Divisional / Directorate / Local Risk Assessment
- Appendix 4 - Risk Assessment Template Strategic/Corporate Risk
- Appendix 5 - Escalation Process

APPENDIX 1: Risk Statement Examples

1. What could go wrong?	2. What could be the cause of this?	3. What would be the effect/impact?	4. Risk Statement (Description)
Poor quality care provided to patients	• High staff sickness rate • Inability to recruit sufficient staff. • Inability to release staff for statutory and mandatory training	• Adverse harm to patients • Loss of public confidence in services • Breach of Staffing Levels Act	There is a risk that safe staffing levels are not maintained, compromising patient safety and care.
Staff could fall over storage boxes	• Medical records stored in boxes unsafely in office accommodation	• Staff absence due to injury • Breach of Health & Safety at Work Legislation • Litigation Claims for Injury	There is a risk that the unsafe storage of medical records could cause potential harm to staff and loss to the organisation.
Unable to update electronic patient records	• System downtime • Internet access • IT failure	• Adverse harm to patients • Compliance with record-keeping standards • Litigation claims • Reputational damage	There is a risk that patient records will not be updated with critical information should access to web-based/electronic recording systems be compromised.

APPENDIX 2: NHS Wales Risk Scoring Matrix (5x5 Model)

X-Axis = Likelihood/Frequency of the risk occurring.

Y-Axis = the level of risk **Consequence/Impact**

Color-coding is crucial for a 5×5 risk assessment matrix to represent the combination level of probability and consequence of the identified risks.

Each risk box represents the rating of a risk that is calculated based on its levels of likelihood and impact using a numeric value.

Calculating Risks Using the 5×5 Risk Matrix

The first step is to assign a numeric value from 1 to 5, 1 being the lowest, for each of the categories under Likelihood and Consequence. Then, use the formula of multiplying the value of the Likelihood by the value of the Consequence to determine the Risk Level.

Likelihood x Consequence = Risk Level

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely (61-90%)	4 (Moderate)	8 (High)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible (41-60%)	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely (11-40%)	2 (Low)	4 (Moderate)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare (1-10%)	1 (Low)	2 (Low)	3 (Low)	4 (Moderate)	5 (Moderate)

The 5 risk rating levels under Likelihood/Frequency are as follows:

	Likelihood/frequency score (severity levels) and examples of descriptors				
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen.	This will probably never happen/recur. (e.g., 1 – 10%)	Do not expect it to happen/recur but it is possible it may do so. (e.g.,11 – 40%)	Might happen or recur occasionally. (e.g.,41 – 60%)	Will probably happen/recur but it is not a persisting issue. (e.g.,61 – 90%)	Will undoubtedly happen/recur, possibly frequently. (e.g.,91 -100%)

The 5 risk rating levels under Consequence/Impact are as follows:

	Severity/Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public **(Physical or Psychological harm)**	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring. minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term. incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects	Incident leading to death. Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality **Complaints** **Audit**	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (Stage 1) Local resolution	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry

		Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved	go to independent review) Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on	Low performance rating Critical report	Gross failure to meet national standards
Human resources **Organisational Development** **Staffing** **Competence**	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training.	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis.
Statutory duty **Inspections**	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating Severely critical report
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days Service well below reasonable public expectation. MP concerned. (Questions in the House)

					Total loss of public confidence
Business objectives / Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project/ budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Fraud	Unlikely to result in material loss or reputational damage. Little or no loss to the organisation, material loss less than £500	Material loss or reputational damage likely to be minimal. Some risk to the organisation which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint	Could result in material loss or reputational damage. Moderate risk to the organisation which may result in reduction of service. Material loss of up to £10000. Reputational damage across NHS with a high potential for complaint or a low risk of litigation	Could result in high material loss or reputational damage. May result in temporary loss of service or material loss of up to £50000. Reputational damage widespread and outside of NHS with a likelihood of litigation)	Could result in significant material loss or reputational damage. High risk which may result in prolonged loss of service or material loss of over £50000. Nationwide media coverage causes reputational damage which is likely to lead to criminal prosecution or external investigation)
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

The table below outlines the time frame for implementation of actions based on risk score and level.

Risk Score	Overall Risk	Timeframe
1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit.
4 - 8	Moderate	Actions implemented as soon as possible but no later than a year.
8 - 12	High	Actions implemented as soon as possible but no later than six months.
15 - 25	Extreme	Requires urgent action. The Health Board is made aware, and it implements immediate corrective action. However, where likelihood is rare or unlikely then potential decision needed on tolerance and action timescales.

NB: Depending on the Likelihood and Impact, a score of 8 can indicate a 'moderate' or 'high' risk. For a moderate score of 8, the Likelihood would be 2 (Unlikely) x Impact 4 (Major). For it to be 'High,' the Likelihood would be 4 (Likely) x Impact 2 (Minor).

APPENDIX 3: Risk Assessment Template Divisional / Directorate / Local Risk Assessment

RISK ID:				
Description				
Threat				
Impact				
Risk Handler		Risk Exposure	Current Level	Target
Monitoring Forum		Likelihood		
Initial Date of Assessment		Impact		
Last Reviewed		Risk rating		

Notes for completion:
When a potential risk threatens the achievement of objectives or is deemed a high-level operational risk, it should be escalated through the hierarchical structure and a request to the Lead Executive Director for consideration by the Executive Committee for inclusion on the Corporate Risk Register (CRR).

The **Threshold** for escalation to the:

- Directorate Risk Register is set at **8 and above**,
- Divisional Risk Register **12 and above**,
- Corporate Risk Register **20 and above.**

The timeframe for actions to be implemented must be aligned to the risk score/level.

Score	Overall Risk	Timeframe for implementing Actions
1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit
4 - 8	Moderate	Actions implemented as soon as possible but no later than a year
8 - 12	High	Actions implemented as soon as possible but no later than six months
15 - 25	Extreme	Requires urgent action

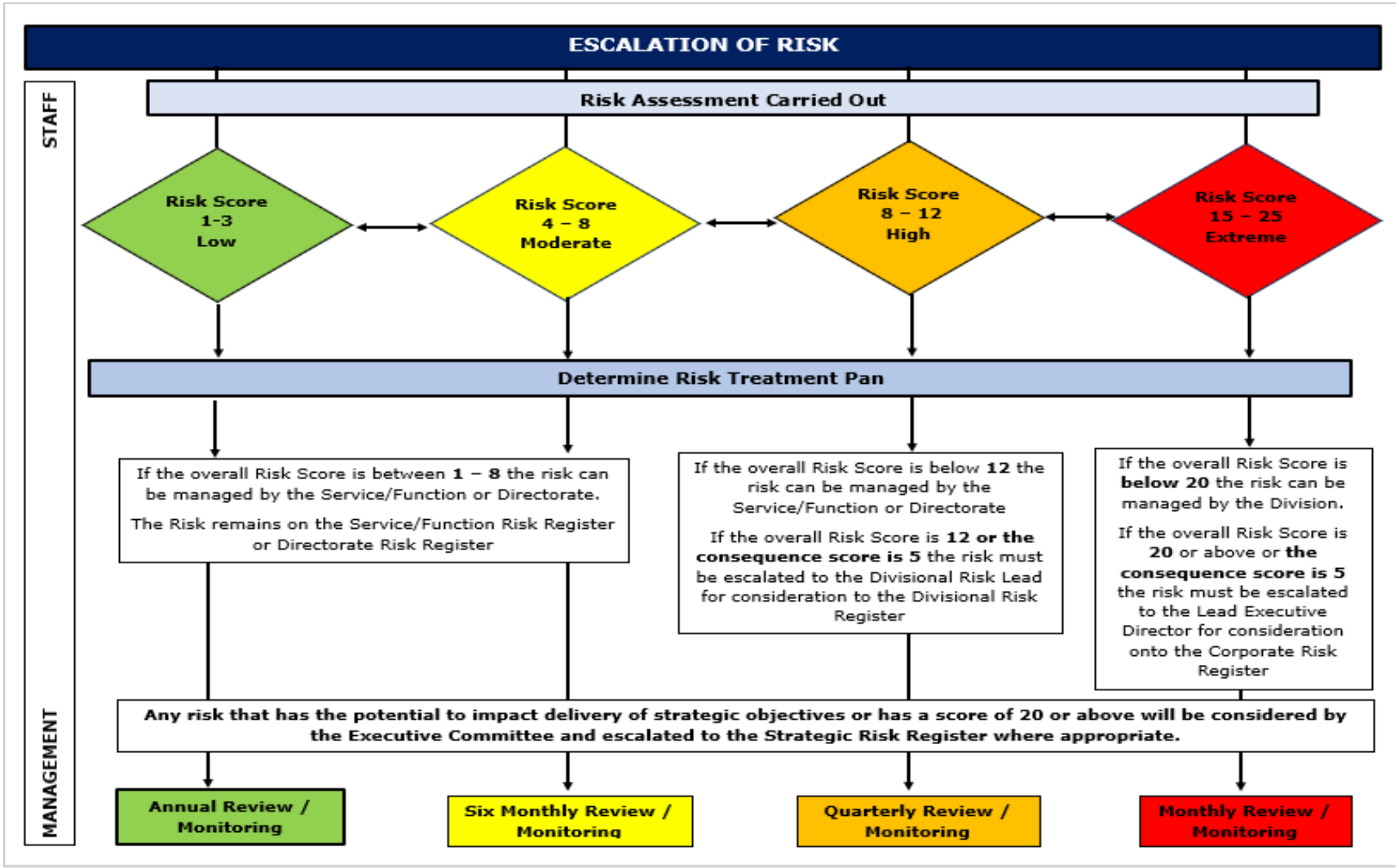
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Gaps Control** *(Are further controls possible to reduce risk exposure to target level)*	**Timeframe to Implement further enhancement of controls**	**Progress against Actions to Improve Control** *(What has been implemented)*

APPENDIX 4: Risk Assessment Template Strategic/Corporate Risk

Risk ID:	STRATEGIC/CORPROATE RISK				
Description					
Strategic Threat					Risk Appetite Level – Use RA Statement to complete.
Impact					Risk Appetite Threshold - Use RA Statement to complete. **SUMMARY** The current risk level is **within/outside** of target level but **within/outside** appetite threshold. The target level to be achieved is **within/outside** the set appetite threshold.
Lead Director		Risk Exposure	Current Level	Target Level	RUN CHART TO BE ADDED HERE
Monitoring Committee		Likelihood			
Initial Date of Assessment		Impact			
Last Reviewed		Risk rating			

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
		Level 1 Operational *(Implemented by the department that performs daily operation activities)*	**Gaps in Assurance**	**Positive Reasonable Negative Assurance**
		Level 2 Organisational *(Executed by risk management and compliance functions.)*	**Action to Address Gaps in Assurance**	
		Level 3 Independent *(Internal and external independent bodies.)*		

APPENDIX 5: Escalation Process



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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update on Single Quotation and Tender Actions –11th November 2023 to 19th January 2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Finance & Procurement
SWYDDOG ADRODD: **REPORTING OFFICER:**	Deputy Head of Procurement

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

ADRODDIAD SCAA
SBAR REPORT

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

Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 11th November 2023 to 19th January 2024.

Cefndir / Background

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

Assurance Committee's work plan includes a standing item for review of the following at each meeting: • Review of Single Quotation and Tender Requests.
Asesiad / Assessment The Audit, Risk and Assurance Committee should note the detail of the attached table (Appendix A) and should monitor the number and value of business that are being submitted for a Single Tender or Single Quotation approval. The overarching guidelines on spending of public money are that it should be carried out in a fair, transparent, and open manner, ensuring that competition is sought wherever possible. Therefore, the number of single action requests should be kept to a minimum. There have been 2 requests submitted which have been approved during the period with an annual value of £123,262.22 Ex VAT. Of these 2 approved requests, both were classified as service or goods type arrangements.
Argymhelliad / Recommendation The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

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

Strategic Equality Objectives 2020-24	

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

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

Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
Community Transport Association	Service	ABUHB have been allocated £50,000 Regional Integrated Funding from the Gwent Regional Partnership Board to fund community transport schemes throughout the ABUHB region. Community Transport Association have been administering the T2H scheme since November 2020 and are therefore familiar with the processes, have built relationships with the local service providers, host the administrator for the scheme and were a key part in the establishment of the scheme 2020/2021. The Community Transport Association are a not-for-profit organisation and do not make profit from this contract. As stated above, all funding bids are assessed using a stringent funding application process. Community transport organisations are required to demonstrate their eligibility to deliver services, a description of the project they are proposing to deliver, a demonstration of the need, how their project fits with the grant's aims and objectives, how their project will be monitored and evaluated, and a breakdown of how the funding will be used.	The STA is supported on the basis that there is no other provider who can provide a similar service in the region. The incumbent supplier has established links and networks within the region that makes them best placed to deliver this service.	Approved	21/12/2023	
Care-Com Systems	Service / Goods	Consideration has been given to the Wales Audit Office guidance relating to circumstances where a single tender can be actioned. The following criteria from this guidance are specifically highlighted: 1) There is a compatibility issue which needs to be met e.g., specific equipment required, or compliance with a warranty cover clause. 2) There is a need to retain a particular contractor for real business continuity issues (not just preferences). This STA has been drafted to address an urgent and critical operational capacity and safety issue on wards D4E and D4W at Royal Gwent Hospital. The current nurse call system on these wards has failed, cannot be repaired, is now obsolete, with parts not available to repair the system. A new system is urgently required. As a consequence of this failure D4E and D4W have been temporarily relocated to other locations on the site which is having a critical and significant impact on hospital capacity. A resolution to this is urgently required to enable the health board to best manage winter pressures and the challenging demand on hospital services, as well as maintaining patient safety. Whilst there are a few locations on the site which have used systems previously these are legacy uses and in last 15 years all wards have used this provider. Introducing a different system would result in an inconsistency of service providers across the site, requiring nursing staff to be familiar in the operation of more than one system. If the Care-Com system was installed, this would also enable the handsets to be moved about between all wards, which would again support business continuity and flexible deployment of bed capacity. This is again a critical requirement to best manage growing service pressures. There is an opportunity to carry out this work through the existing Measured Term Framework operated by ABUHB Works and Estates. However, this route to market would not provide best value as additional costs of at least 10% would be incurred. The deployment of the Care-Com solution ensures business continuity, integration, compatibility, and compliance with the existing system that is in operation at the Royal Gwent Hospital. ABUHB Works and Estates have in-house knowledge and expertise to work on and carry out general maintenance and repair tasks on the Care-Com system. However, the internal Estates team are unable to carry out repairs on other systems and have to rely solely on the provider for these legacy systems.	Due to the urgent requirement and the compatibility of the handsets it is deemed appropriate that a single tender action is completed on this occasion. If this is to be the preferred system for the Health Board going forward then it is proposed that a framework is established which will allow the Health Board to call off requirements and when required.	Approved	24/11/2023	

GIG CYMRU NHS WALES	Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 February 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial governance, reporting & control.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Finance and Procurement
SWYDDOG ADRODD: REPORTING OFFICER:	Assistant Finance Director

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

Approve the updated financial control policy and procedures.

- Petty Cash (Appendix 1)
- Petty Cash – Mental Health (Appendix 2)

Cefndir / Background

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

The FCPs presented have been considered by the Executive Committee and are presented to the Audit, Risk and Assurance Committee for approval.

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

Asesiad / Assessment

1.Financial Control Procedures (FCP)

The FCPs to be reviewed at this Committee as part of the regular programme of updates are:

- Petty Cash (Appendix 1)
- Petty Cash – Mental Health (Appendix 2)

These policy/procedures will be presented for approval at the Executive Committee on 1st February 2024.

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

Both Petty Cash procedures have been revised to strengthen the controls around the transporting of cash to/from the bank and access to the petty cash float. The reconciliation process has also been enhanced to ensure any anomalies are notified to the Treasury team as soon as they become evident.

Petty Cash

Owner: Director of Finance, Procurement and Value
Review Date: December 2023

The procedure sets out the requirements to ensure adequate controls over Petty Cash accounts.

The objective of the procedure is to set out a control framework to ensure that Petty Cash is properly used, secured, and accounted for correctly.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services.
- Head of Financial Services and Accounting.
- Facilities General Offices.
- NWSSP - Audit and Assurance Services.
- Director of Finance and Assistant Finance Directors

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value
All	Intranet links added for internal documents
All	Physical location – All references to Mamhilad House, Mamhilad Park Estate removed
All	Organisational change - Cashier changed to Treasury Officer
7.4	Strengthening of controls – A single officer is not allowed to transport money to/from the bank. Two officers or representatives of the Health Board must be present
7.5	Strengthening of controls – Cash should be kept in a lockable secure box which must be located on a Health Board site
7.8	Change of process – If the Petty Cash holder identifies any issues with reconciliation, these should be highlighted to the Treasury Officer in the first instance and escalated to the Treasury Manager, if required
7.8	Definition added – A group home defined as 'an ABUHB managed care/rehabilitation establishment'
7.9	Change of process - Recommendation added that reimbursement should be monthly, but must be reimbursed every 2 months
7.13	Clarification of process – Treasury Officer will review the balances held on a quarterly basis and take necessary action to reduce balance, if required

Petty Cash – Mental Health

Owner: Director of Finance and Procurement
Review Date: December 2023

The procedure covers the use, reimbursement and security of Petty Cash used within the Mental Health Directorate.

A separate Mental Health petty cash float was implemented a number of years ago due to the nature and needs of the clients within the division and the types of purchase that were deemed acceptable from petty cash to best meet the client and service needs. These purchases are unique to the Mental Health division and as such to avoid any confusion with the normal petty cash held within general offices (which is mainly used for the reimbursement of patient travel expenses) a specific Mental Health petty cash procedure was introduced.

The Mental Health allowable expenditure for reimbursement from Petty Cash cover things like cinema tickets and up to £3 beverage reimbursement by the staff

member when accompanying service user (client) during exercises of engagement or outings linked to their care.

The document has been circulated for comment as follows:

Assistant Head of Financial Services.
Head of Financial Services and Accounting.
Mental Health.
Facilities General Offices.
NWSSP - Audit and Assurance Services.
Director of Finance and Assistant Finance Directors.

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value.
All	Intranet links added for internal documents
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All	Physical location – All references to Mamhilad House, Mamhilad Park Estate removed
7.2	Strengthening of controls – A single officer is not allowed to transport money to/from the bank. Two officers or representatives of the Health Board must be present
7.3	Strengthening of controls – Cash should be kept in a lockable secure box which must be located on a Health Board site
7.5	Definition added – A group home defined as 'an ABUHB managed care/rehabilitation establishment'
7.5	Change of process - Inpatient gifts or celebration cake/event added to acceptable reimbursement list
7.5	Change of process – If the Petty Cash holder identifies any issues with reconciliation, these should be highlighted to the Treasury Officer in the first instance and escalated to the Treasury Manager, if required.
7.10	Clarification of process – Treasury Officer will review the balances held on a quarterly basis and take necessary action to reduce balance, if required

The table below provides an update regarding the review dates for all of the Financial Control Procedures.

Summary Position on Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Petty Cash	23/24	Overdue	Dec-20	03-Dec-23	Feb 24 Audit Committee
Petty Cash - Mental Health	23/24	Overdue	Dec-20	03-Dec-23	Feb 24 Audit Committee
Accounts Receivable	23/24	Due for review	Feb-21	04-Feb-24	Scheduled for Apr 24
Approval of Orders over £100K	23/24	Due for review	Feb-21	04-Feb-24	Scheduled for Apr 24
Salary Sacrifice	24/25	Y	Aug-21	12-Aug-24	
Policy for Out of Area Referrals to Secondary Care	24/25	Y	Aug-21	12-Aug-24	
Overseas Visitors	24/25	Y	Feb-22	03-Feb-25	
Charitable Funds	25/26	Y	Apr-22	19-Jul-25	
Recovery of Overpayments to Employees	25/26	Y	Aug-22	02-Aug-25	
Budgetary Control Policy & Procedure	25/26	Y	Aug-22	02-Aug-25	
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	
Counter Fraud Bribery and Corruption Policy	25/26	Y	Oct-22	25-Nov-25	
Capital Assets and Charges	25/26	Y	Dec-22	01-Dec-25	
Engaging Off Payroll Workers	25/26	Y	Feb-23	02-Feb-26	
Accounts Payable	25/26	Y	Feb-23	02-Feb-26	
Patients' Property	25/26	Y	Feb-23	02-Feb-26	
Purchasing Cards	25/26	Y	Feb-23	02-Feb-26	
General Ledger	26/27	Y	Apr-23	18-Apr-26	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	26/27	Y	Apr-23	18-Apr-26	
Procurement Policy	26/27	Y	Sep-23	12-Sep-26	
Capital Procedures and Guidance Notes	26/27	Y	Nov-23	28-Nov-26	
Patients' Travel Costs Policy	26/27	Y	Nov-23	28-Nov-26	
Cash and Bank	26/27	Y	Nov-23	28-Nov-26	

2.Technical Accounting Issues

Technical updates

There has been one technical accounting update issued by Welsh Government since the last Audit, Risk and Assurance Committee meeting.

Update note 3 covered the following areas.

- 2023-24 Discount rates for general provisions, post-employment benefits, financial instruments, and leases (under IFRS16) – announcement of rates. The new discount rates have already been applied to the relevant provisions and the impact reflected in the 2023/24 financial position.
- Greenbury – Disclosure of Senior Managers' Remuneration (Greenbury) 2023-24. The list of names required for the senior manager remuneration report will be requested from the pension's agency in accordance with the timetable provided.
- Notification of Anticipated Losses and Special Payments – submission required by 19th January. The deadline has been circulated.

The 2023/24 Draft Manual for accounts was also issued by Welsh Government on the 14th of December 2023 with comments requested on content or clarification/amendments required by 26th January 2024. The draft manual has been forwarded to the appropriate employees for comment.

3. Public Sector Payment Policy (PSPP)

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

The following table shows the Public Sector Payment Policy performance for the month of December 2023 and on a cumulative basis.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	95.7 90.0	93.8 88.9
Non-NHS	Value Number	98.5 98.2	97.0 97.2

On a cumulative basis the Health Board have achieved 97.2% compliance of the number of non-NHS creditors paid within 30 days which is slightly above the required performance target.

With regard to the NHS percentage the Health Board percentage achieved is below the 95% target with 90.0% achieved in month and 88.9% on a cumulative basis. The percentage achieved on a YTD basis has improved slightly over the last few months.

4. Payments in Excess of £100K

There were no exceptional issues to report.

5. Standing Financial Instructions

There is no further update on the standing financial instructions.

Argymhelliad / Recommendation

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

- Petty Cash
- Petty Cash – Mental Health

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.5 Record Keeping Choose an item. Choose an item.

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

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure IFRS – International Financial Reporting Standards PSPP – Public Sector Payment Policy
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper?** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper

Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Aneurin Bevan University Health Board

Financial Control Procedure

Petty Cash

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

Status: DRAFT	Issue date: DRAFT
Approved by: Audit Committee	Review by date: DRAFT
Owner: Director of Finance, Procurement & Value	Policy Number: ABUHB/Finance/0251

Contents:

Introduction .....Error! Bookmark not defined.
Policy Statement.....Error! Bookmark not defined.
Aims .....Error! Bookmark not defined.
Objectives.....Error! Bookmark not defined.
Scope.....Error! Bookmark not defined.
Roles and Responsibilities .....Error! Bookmark not defined.
Main Body (General) .....Error! Bookmark not defined.
Implementation 10
Audit 10
Review 10

1 Introduction

Aneurin Bevan University Health Board (ABUHB) procedures state that all purchases should be made via an order through Oracle. However, this may not be appropriate for low value purchases such as refunds of patient travelling expenses etc. where Petty Cash may be used.

This procedure covers the use, reimbursement and security of Petty Cash within ABUHB.

2 Policy Statement

The procedure sets out the requirements to ensure adequate controls over Petty Cash accounts. The controls should ensure that Petty Cash is used appropriately and is kept securely. This procedure is compliant with the ABUHB Standing Financial Instructions and should be read in conjunction with the Health Boards Procurement and Cash and Bank Financial Control Procedures.

3 Aims

The purpose of this document is to set out clearly the responsibilities of staff within ABUHB with regard to Petty Cash.

4 Objectives

The objective of this procedure is to set out a control framework to ensure that Petty Cash is properly used, secured and accounted for correctly.

5 Scope

This document relates to the following staff:

- Staff within the Corporate Finance Department and in particular the Treasury Management Office.
- Staff within the Facilities Management Division and in particular staff with General Offices.
- Other nominated staff in other Divisions.

6 Roles and Responsibilities

6.1 Petty Cash Holders

Are responsible for:

- Contacting Corporate Finance to request that a Petty Cash float be set up.
- Ensuring Petty Cash is held securely.
- Disbursing payments from Petty Cash ensuring that they are for official purposes only and are supported by appropriate receipts and Petty Cash vouchers.
- Routinely request reimbursement of Petty Cash.

6.2 Treasury Officer-Corporate Finance

Is responsible for:

- Issuing a Petty Cash float to the Petty Cash holder once approved by the Treasury Manager or Assistant Head of Financial Services.
- Issuing relevant stationery to Petty Cash holders and providing guidance on its completion.
- Ensuring the appropriate documentation is returned.
- Checking that payments from Petty Cash are appropriate.
- Refunding the Petty Cash holders the appropriate payments.

6.3 Treasury Manager-Corporate Finance

Is responsible for:

- Deciding if a Petty Cash float should be issued. (This may also be carried out by the Assistant Head of Financial Services or Head of Financial Services and Accounting)
- Ensuring a payment request for a float is raised by the Treasury Officer.
- Acting on any payments which contravene the Petty Cash Policy.
- Reviewing frequency of reimbursement made.
- Reviewing levels of floats held and suggest changes where appropriate.

7 Petty Cash

7.1 Request to hold a Petty Cash Float

- Request to hold a Petty Cash Float must be submitted in writing to either the Assistant Head of Financial Services or Treasury Manager.
- Either Officer shall be responsible for deciding if the request and amount requested are appropriate.
- All requests are to be filed and, where approved, details are to be entered in the appropriate register of Petty Cash account holders held in the Treasury department.
- Either officer above shall be responsible for informing the requester whether or not approval has been granted.

7.2 Issue and Reimbursement of Cash Floats

This may be carried out either by delivery of cash by the Health Board's designated Security Company or, where not practical, by the issue of a Payable Order. The Treasury Manager is responsible for ensuring payment is made by the Treasury Officer.

7.3 Delivery of Cash

A contract has been set up with the Health Board's designated Security Company whereby the total amount of Petty Cash required and the denomination there of, is e-mailed weekly to the Security Company cash centre who then deliver the cash to the appropriate sites. The total amount of cash required is debited to the bank account under the terms of the Health Board's bank Mandate.

7.4 Issue of a payable order

If the use of Health Board's designated Security Company is not practical then the issue of a float, or reimbursements of existing floats are made by payable order and Petty Cash holders can cash these at their local branch of the National Westminster Bank.

Two forms of photographic identification, one of which must be the official ABUHB Employee badge, are required to cash a Payable Order up to a limit of £500.

A single officer is not allowed to transport money to or from the bank. Two officers or two representatives of the Health Board must be present when such transactions occur.

7.5 Security of Cash

The designated Petty Cash holder is personally responsible for safe custody of the cash and its correct disbursement (see 7.5).

Cash must be:

- Kept in a secure box
- The cash box, when not in use, must be locked in a place of safe keeping, e.g. a safe or strong room , which must be located on an Aneurin Bevan University Health Board site Ideally access to the petty cash tin should be restricted to only the designated petty cash holder, however if this is not possible, the number of people who have access should be kept to a minimum.

7.6 Appropriate Petty Cash expenditure

Payments from Petty Cash must only be made in circumstances where alternative methods of payment, such as an urgent payable order raised via the Accounts Payable system or the raising of a requisition through the Health Board's procurement system is not possible.

Appropriate items of expenditure should not exceed £50 per item.

Examples of Specific exclusions which cannot be reimbursed through the Petty Cash system include:

- Memory sticks. (Must be purchased through IT to comply with IT Policies)
- Staff uniforms.
- Printers and printer cartridges.
- Employee travel expenses.
- Fleet vehicle repair invoices/parts.
- Furniture.
- Office equipment.
- Shelving.
- Electrical utensils e.g. microwaves
- Mobile phone top ups. (All Health Board mobile phones must be Health Board contract phones)

- Donations and gratuitous (voluntary) payments

Where items cannot be located on Oracle the NWSSP procurement department should be contacted, who will be able to locate the required item code for you or explain how to place a "non-catalogue" requisition if the item that you require is not a catalogue item.

The use of personal credit cards for Petty Cash expenditure is not acceptable on the basis that any subsequent interest arising would not be reimbursed. Personal debit cards are allowable.

Supermarket Loyalty Cards should not be used when making Petty Cash purchases, unless the card is in the name of the relevant Health Board department and it can clearly be demonstrated that its use is for the benefit of the Health Board.

7.7 Mental Health Petty Cash expenditure

A separate Financial Control Procedure has been developed to appropriately manage petty cash expenditure from the Mental Health division. This FCP details the allowable expenditure and exclusions for petty cash in the Mental Health division, exclusively.

This FCP can be found here

7.8 Payments reimbursed through Petty Cash

The provision of a Petty Cash account is to provide the facility, within the Health Board, to enable individuals to purchase one off/urgent items that cannot be purchased through the Oracle Procurement system.

Examples of items that are acceptable for reimbursement through Petty Cash are:

- Specific patient dietary purchases.
- Other postage costs (as postage stamps can be ordered via Oracle)
- Patient's travel expenses.
- Grocery / household purchases within the group homes which involve the service users (client) input as part of their rehabilitation. Group homes are defined as an ABUHB managed care/rehabilitation establishment.

- One off items (required the same day) which must be agreed with finance prior to purchase.

Payments made from Petty Cash which contravene this policy will not be reimbursed and persistent contravention of the policy may result in the Petty Cash balance being withdrawn or reduced to a minimum and the situation being reported to the Health Boards auditors.

Sub- floats must not be made out of Petty Cash.

Petty Cash payments must not, under any circumstances, be made from income received on behalf of the Health Board.

The Petty Cash holder must reconcile the cash held in the Petty Cash box on a weekly basis and at any time the Petty Cash keys are passed to another officer. The reconciliation should account for cash in the box, any recent vouchers paid and any cash reimbursement outstanding from the Health Board.

If the Petty Cash holder identifies any issues with the reconciliation, these should be highlighted and discussed with the Treasury Officer in the first instance, to determine the cause and possible corrections required.

If discrepancies are subsequently unresolved, errors on the reconciliation should be reported to the Treasury Manager immediately.

7.9 Reimbursements

The Treasury Officer in the Finance Department will be responsible for issuing serial numbered Petty Cash vouchers to Petty Cash holders on request. A record of such issues is to be kept in the Controlled Stationery register. Acknowledgement slips are to be signed by the Petty Cash holder and returned to the Finance Department where they are to be filed.

The official Petty Cash account form together with all supporting documentation is to be sent to the Treasury Department at regular intervals for reimbursement.

(It is recommended that Petty Cash should be reimbursed every month, but must be reimbursed every 2 months and at the end of every financial year)

The Treasury Officer will be responsible for the reimbursement of Petty Cash requests. They will need to:

- check reimbursement vouchers and valid receipts,
- check the Petty Cash account forms for arithmetic, and
- ensuring that authorising signatures and coding is correct.
- entering the details of the reimbursement in the appropriate Petty Cash register.

Following the review of the reimbursement, the Treasury Officer will then be responsible for actioning manual reimbursement requests, by:

Either:

- Drawing a payable order in favour of the nominated Petty Cash holder.
- Forward the payable order, remittance advice and acknowledgement slip to the Petty Cash holder

Or:

- Entering the details of the reimbursement on the spread sheet to be e-mailed to Health Board's designated Security Company cash centre for delivery.

The Petty Cash holder will, upon receipt of the payable order, will:

- Sign the acknowledgement slip and return it to the Treasury Department.

- Arrange to cash the payable order at the bank. This cash should be checked before the Petty Cash account holder puts it in the Petty Cash box.

- On receipt of the cash bag from Health Board's designated Security Company they will check the cash in the bag before putting it in the Petty Cash box. If there is an amount to be re-banked, then the designated petty cash holder will arrange for this to take place.

7.10 Monitoring and effectiveness

The Treasury Officer responsible for the Petty Cash will:

- Review items of expenditure recorded on the Petty Cash account form to ensure they conform to the policy.

Report any items which contravene the policy to the Petty Cash holder and the Treasury Manager.

- The Treasury Manager will review the issues raised, and discuss alternative methods of payment with the Petty Cash holder and reiterate the Petty Cash policy. To remind the Petty Cash holder that repeated contravention of the policy will result in the Petty Cash balance being withdrawn or reduced to a minimum and the situation will be reported to the Health Board's auditors.

7.11 Handover procedures for planned leave

On the last working day before planned leave, the Petty Cash holder shall carry out a reconciliation of cash and vouchers in the presence of the officer nominated to take over from the Petty Cash holder for the period of absence.

The value of cash in hand and vouchers shall be entered on the Petty Cash record sheet which both officers shall then sign and date, agreeing to the transfer of the cash box keys, cash and vouchers.

7.12 Change of Designated Petty Cash Holder

Where there is any need to change a designated petty cash holder, for any reason (e.g. termination of employment / change of role), then where practically possible the petty cash remaining in the tin should be banked, and the documentation showing a full reconciliation should be completed and returned to the Treasury Department. This should be completed in sufficient time, so that any discrepancies can be investigated. A new petty cash account can then be created for the new designated petty cash holder.

Where it is not practically possible to do this (e.g. at sites where a large amount of petty cash is held, with frequent transactions being processed), then a full reconciliation should be completed and signed off by the current designated petty cash holder, with the new petty cash holder signing to confirm that they agree that the balance they have taken over, agrees to the cash present in the tin.

7.13 Routine Review of the Petty Cash floats

On a quarterly basis, the Treasury Officer will review the Petty Cash balances held, checking the level and frequency of reimbursement.

Following this review the Treasury Manager will be responsible for reviewing the Petty Cash balances held, and will take the necessary action to reduce the balance accordingly, based on the results of the review by the Treasury Officer.

8 Implementation

This document should be implemented with immediate effect.

9 Further Information

Enquiries regarding this policy should be directed to the Treasury Manager, Head of Financial Services and Accounting or the Assistant Director of Finance - Financial Systems & Services.

10 Audit

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

11 Review

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

Aneurin Bevan University Health Board

Financial Control Procedure

Petty Cash – Mental Health

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Contents:

1. Introduction 3
2. Policy Statement 3
3. Aims 3
4. Objectives 3
5. Scope 4
6. Roles and Responsibilities 4
7. Petty Cash – Mental Health 5
8. CAMHS.....14
9. Patient Meals Monies.....14
10. Exceptional Circumstances 15
11. Patients' Property 16
12. Implementation.....17
13. Further Information 17
14. Audit 17
15. Review 17

1. Introduction

Aneurin Bevan University Health Board, henceforth referred to as ABUHB, general Finance Cash procedure states that all purchases should be made via an order through Oracle; however, this may not be appropriate for certain purchases made within the Mental Health Directorate, particularly for low value purchases, refund of patient travel expenses etc., where petty cash may be used.

This procedure covers the use, reimbursement and security of petty cash used within the Mental Health Directorate of ABUHB.

2. Policy Statement

The procedure sets out the requirements to ensure adequate controls over petty cash accounts within Mental Health Services. The controls should ensure that the petty cash is used appropriately, in line with guidance, and is kept securely. This procedure is compliant with the ABUHB Standing Financial Instructions and should be read in conjunction with the Health Board's Procurement and Cash and Bank Procedures.

3. Aims

The purpose of this document is to clearly set out the responsibilities of staff within the ABUHB Mental Health Directorate with regard to the appropriate use of petty cash within the division, ensuring compliance within allowance limitations.

4. Objectives

The objective of this policy is to set out a control framework to ensure that Mental Health petty cash is correctly used, securely stored and accounted for correctly. The policy will also clearly define those purchases that are/ are not allowable through petty cash, including any ad hoc items.

5. Scope

This document relates to the following staff:

- Staff working within the Mental Health Directorate, including but not limited to:
  - Community Mental Health Teams.
  - Mental Health ward staff.
  - Staff within the Corporate Finance Department and in particular the Treasury Management Office.
  - Staff within the Facilities Management Division and in particular staff within the General Offices.

6. Roles and Responsibilities

6.1 Petty Cash Holders

Petty Cash holders are responsible for:

- Contacting Corporate Finance to request that a petty cash float is set up.
- Ensuring petty cash is securely held.
- Disbursing payments from petty cash, ensuring they are for approved purposes only, in line with policy and are supported by appropriate receipts and petty cash vouchers.
- Routinely request the reimbursement of petty cash.

6.2 Treasury Officer – Corporate Finance

The Treasury Officer is responsible for:

- Issuing the petty cash float to the petty cash holder once this has been approved by the Treasury Manager or Assistant Head of Financial Services.
- Issuing relevant stationery to petty cash holders and providing guidance on its completion.
- Ensuring that all appropriate documentation is returned.

- Checking that payments from the petty cash are appropriate and comply with policy.
- Refunding the petty cash holders the appropriate payments.

6.3 Treasury Manager – Corporate Finance

The Treasury Manager is responsible for:

- Deciding if a petty cash float should be issued, and if so, to what sum the petty cash float should stand. This may also be carried out by the Assistant Head of Financial Services or Head of Financial Services and Accounting.
- Ensuring a payment request for a float is raised by the Treasury Officer.
- Acting on any payments which contravene the Petty Cash Policy.
- Reviewing frequency of reimbursement made.
- Reviewing levels of floats held and suggest changes where appropriate.

6.4 Head of Financial Services and Accounting/ Assistant Head of Financial Services

The Head of Financial Services and Accounting or the Assistant Head of Financial Services are responsible for approving the set-up of a new Mental Health petty cash float.

7. Petty Cash – Mental Health

7.1 Request to hold a petty cash float

- The request will be reviewed and sent to the either the Adult Mental Health Directorate Manager or the Deputy Directorate Manager for Adult Mental Health for consideration and approval where appropriate prior to any request being made to Finance
- On confirmation by the appropriate Mental Health manager that a float is required, a request to hold a petty cash float must in the first

instance be submitted in writing to either the Assistant Head of Financial Services or the Treasury Manager.

- Only the Assistant Head of Financial Services or the Treasury Manager are responsible for deciding if the request and amount requested are appropriate.
- All requests are to be filed and, where approved, details are to be entered into the appropriate register of petty cash account holders held in the Treasury department
- Either officer above shall be responsible for informing the requesting party whether or not approval has been granted.
- The amount of petty cash granted will be reviewed and agreed upon on a case-by-case basis where it is acknowledged ABUHB Mental Health Wards have variable requirements.
- There is no set limit to the amount of petty cash granted whereby the need for the granted sum of money has been evidenced to the Treasury Officer or Treasury Manager in advance.

7.2 Issue and Reimbursement of Cash Floats

This may be carried out either by delivery of cash by ABUHB's designated security company or, where this is not practical, by the issue of a Payable Order. The Treasury Manager is responsible for ensuring payment is made by the Treasury Officer.

Delivery of Cash

A contract has been set up with ABUHB's designated security company whereby the total amount of petty cash required and the denomination thereof is emailed weekly to the security company cash centre who then deliver the cash to the appropriate General Offices sites. The total amount of cash required is debited to the bank account under the terms of the Health Board's bank mandate.

Issue of a Payable Order

If this use of ABUHB's designated security company is not practical then the issue of a float, or reimbursements of existing floats, are made by

payable order and petty cash holders cash these at their local branch of National Westminster Bank.

Two forms of photographic identification, one of which must be the official ABUHB Employee badge, are required to cash a Payable Order up to a limit of £500.

A single officer is not allowed to transport money to or from the bank. Two officers or two representatives of the Health Board must be present when such transactions occur.

7.3 Security of Cash

The designated petty cash holder is personally responsible for safe custody of the cash and its correct disbursement.

The petty cash must:

- Be kept in as secure box
- The cash box, when not in use, must be locked in a safe place suitable for the purpose of secure storage, e.g., safe or strong room, which must be located on an Aneurin Bevan University Health Board site. Ideally access to the petty cash tin should be restricted to only the designated petty cash holder, however if this is not possible, the number of people who have access should be kept to a minimum.
- Storage of petty cash in a locked medication cabinet on a ward is acceptable where the petty cash holder and medication cabinet key holder are the same person

All petty cash must be signed in and out using a countersignature and the appropriate petty cash stationary. The countersignature must be the petty cash holder or their deputy.

Receipts for items purchased using petty cash must be returned to Treasury department as part of the reimbursement process for audit purposes.

In order to prevent lack of access to the petty cash float, the nurse in charge must designate two deputies who are able to access the petty cash float in times where the nurse in charge is absent (planned or unplanned).

All designated deputies must be notified to the Treasury Manager and recorded as approved deputies to the float.

7.4 Appropriate petty cash expenditure

Payments from petty cash must only be made in circumstances where alternative methods of payment is not possible or practical.

Appropriate items of expenditure should not exceed £50 per item. Exceptional circumstances may apply.

Examples of specific exclusions which will not be reimbursed through the petty cash system include:

- Memory sticks (and other IT equipment which should be ordered via IT department)
- Food for a staff member when purchased on shift, during an outing/ accompanying a service user (client). Exceptional circumstances may apply (see Section 10 for exceptions)
- Food for a service user (client) when purchased during an outing. Clients are encouraged to use their own money. Exceptional circumstances may apply (see Section 10)
- Clothing
- Employee gifts or celebration cake/ event
- Employee travel expenses
- Fleet vehicle repair invoices/ parts
- Furniture
- Office equipment
- Shelving
- Electrical utensils
- Mobile phone top-ups (please see Section 10 for exceptions)
- Donations and gratuitous (voluntary) payments

Where items cannot be located on Oracle the NWSSP procurement department should be contacted who will be able to locate the required item code for you or explain how to place a "non-catalogue" requisition if the item that you require is not a catalogue item.

The use of personal credit cards for Petty Cash expenditure is not advisable on the basis that any subsequent interest arising would not be reimbursed. Personal debit cards are permitted.

Supermarket loyalty cards should not be used when making petty cash purchases unless the card is in the name of the relevant Health Board department, ward, or ward manager on behalf of the ward. It must be clearly demonstrable that use of a supermarket loyalty card is for the benefit of the ward or Health Board and not an individual.

7.5 Payments reimbursed through petty cash

The provision of a petty cash account is to provide the facility within the Health Board to enable individuals to purchase one off or urgent items that cannot be purchased through the Oracle Procurement system.

Staff individual disbursements, i.e. hot drinks, should be claimed through the standard expenses portal for reimbursement (i.e. Lunch Allowance up to £5 per day). Where a staff member does not have access to the expenses portal they may use the petty cash float for the purchase of approved items. A receipt will be required for reimbursement. Reimbursement of petty cash expenditure can only be made when supported by a valid receipt.

Examples of items that are acceptable for reimbursement through petty cash are:

- Specific patient dietary purchases.
- Stamps (in case of urgent need where they have not been purchased through Oracle or received in time for use).
- Patient travel expenses.
    - Note: Where clients are encouraged to use their own money as part of their rehabilitation pathway, petty cash is to be used at the discretion of the ward manager or petty cash handler.
- Grocery/ household purchases within the group homes which involve the service users (client) input as part of their rehabilitation (See section 9). Group homes are defined as an ABUHB managed care/rehabilitation establishment.

- One off emergency items (required the same day) up to a value of £50 – these must be agreed with finance prior to purchase.
- A staff member may be reimbursed up to the sum of £3.00 per beverage for themselves and the accompanying service user (client) during exercises of engagement or outings linked to their care.
    - Note: Clients are encouraged to use their own money as part of their rehabilitation pathway.
- Items linked to ward/ client social activities whereby the activity is considered part of the service user recovery programme:
    - Cinema tickets.
    - Sport activities or exercise classes or groups.
    - Note: Clients are encouraged to use their own money as part of their rehabilitation pathway.
- Inpatient gifts or celebration cake/ event
    - Staff are encouraged to look at alternative ways of raising funds if they wish to purchase the above goods for a patient i.e., through supermarket donations, charitable funds. However, celebratory cake up to the value of £10 or a small gift up to the value of £10 are permitted for long-term inpatients. The receipt must be labelled with patient initials.

Consideration for reimbursement for items not on this list but needed under exceptional circumstances will be given on an individual basis. A list of exceptional circumstances, (See Section 10) is provided below. If the petty cash holder or Treasury Officer is unsure about the purchase of a specific item using petty cash, they must contact a member of the Mental Health services management team who will review on a case-by-case basis.

Payments made from petty cash which contravene this policy will not be reimbursed and persistent contravention of the policy may result in the petty cash balance being withdrawn or reduced to a minimum and the situation being reported to the Health Board auditors.

Sub-floats must not be made out of petty cash.

Petty cash payments must not, under any circumstance, be made from income received on behalf of the Health Board.

The petty cash holder must reconcile the cash held in the petty cash box on a weekly basis. The reconciliation should account for cash in the box, any recent vouchers paid and any cash reimbursement outstanding from the Health Board.

If the Petty Cash holder identifies any issues with the reconciliation, these should be highlighted and discussed with the Treasury Officer in the first instance, to determine the cause and possible corrections required.

If discrepancies are subsequently unresolved, errors on the reconciliation should be reported to the Treasury Manager immediately..

7.6 Reimbursements

The Treasury Officer in the Finance Department is responsible for issuing serial numbered petty cash vouchers to petty cash holders on request. A record of such issues is to be kept in the controlled stationery register. Acknowledgment slips are to be signed by the petty cash holder and returned to the Finance Department to be filed.

The official petty cash account form together with all supporting documentation is to be sent to the Treasury Department at regular intervals for reimbursement. Petty cash must be reimbursed at least every two months and at the end of every financial year.

The Treasury Officer will be responsible for the reimbursement of Petty Cash requests. They will need to:

- check reimbursement vouchers and valid receipts,
- check the Petty Cash account forms for arithmetic, and
- ensuring that authorising signatures and coding is correct.
- entering the details of the reimbursement in the appropriate Petty Cash register.

Following the review of the reimbursement, the Treasury Officer will then be responsible for actioning manual reimbursement requests, by:

Either:

- Drawing a payable order in favour of the nominated Petty Cash holder.
- Subsequently, forwarding the payable order, remittance advice and acknowledgement slip to the Petty Cash holder

Or:

- Entering the details of the reimbursement on the spread sheet to be e-mailed to Health Board's designated Security Company cash centre for delivery.

The petty cash holder will, upon receipt of the payable order:

- Sign the acknowledgement slip and return it to the Treasury Department.
- Arrange to cash the payable order at the bank. This cash should be checked before the petty cash account holder puts it in the petty cash box
- On receipt of the cash bag from Health Board's designated Security Company they will check the cash in the bag before putting it in the petty cash box. If there is an amount to be re-banked, then the designated petty cash holder will arrange for this to take place.

7.7 Monitoring of petty cash

The Treasury Officer responsible for the petty cash will:

- Review items of expenditure recorded on the petty cash account form to ensure they conform to policy
- Report any items which contravene the policy to the petty cash holder and Treasury Manager
- The Treasury Manager will review the issues raised and discuss alternative methods of payment with Petty Cash holder and reiterate the Petty Cash policy. To remind the Petty Cash holder that repeated contravention of the policy will result in the Petty Cash balance being withdrawn or reduced to a minimum and the situation will be reported to the Health Board's auditors.

7.8 Handover procedure for planned leave

On the last working day before planned leave, the petty cash holder shall carry out a reconciliation of cash and vouchers in the presence of the nominated deputy who will take over from the petty cash holder during their absence.

The value of cash in hand and vouchers shall be entered on the petty cash record sheet which both officers shall sign and date, agreeing to the transfer of the cash box keys, cash and vouchers.

7.9 Change of Designated Petty Cash Holder

Where there is any need to change a designated petty cash holder, for any reason (e.g. termination of employment / change of role), then where practically possible the petty cash remaining in the tin should be banked, and the documentation showing a full reconciliation should be completed, and returned to the Treasury office. This should be completed in plenty of time, so that any discrepancies can be investigated. A new petty cash account can then be created for the new designated petty cash holder.

Where it is not practically possible to do this (e.g. at sites where a large amount of petty cash is held, with frequent transactions being processed), then a full reconciliation should be completed and signed off by the current designated petty cash holder, with the new petty cash holder signing to confirm that they agree that the balance they have taken over, agrees to the cash present in the tin.

7.10 Routine review of the petty cash float

On a quarterly basis, the Treasury Officer will review the Petty Cash balances held, checking the level and frequency of reimbursement. Following this review On a routine basis the

Treasury Manager will be responsible for reviewing the Petty Cash balances held, checking the level and frequency of reimbursement and will take the

necessary action to reduce the balance accordingly, based on the results of the review by the Treasury Officer

If the petty cash holder wishes to discuss an increase or decrease of their petty cash float, they must contact the Treasury Manager directly.

8. CAMHS

There are occasions where a CAMHS (Child and Adolescent Mental Health Services) service user is under the care of one of the Adult Mental Health wards for any period of time. A CAMHS service user is normally aged between 16-18 years old, though they may be younger. Recognition is given that younger service users are impacted in a different manner to adults and do not have easy access to their own money for day to day usage. It is also recognised that younger service users may respond differently to being away from home for any given period of time whilst under the care of an ABUHB Mental Health Team. Petty cash can be used at the discretion of the petty cash handler / ward manager for the following items for patients only:

- Small nominal gifts to acknowledge special occasions such as a birthday up to the value of £10
- Birthday cake up to the value of £10
- Outings linked to the wellbeing and recovery of the child, to be discussed with the Mental Health services management team and Finance

9. Patient Meals Monies

ABUHB allocation for patient meals is £5 per patient per day, or £35 per week, for all meals as standard for patients who cook their own meals throughout the week. Where patients only cook some meals, and have some provided by the Catering Department, this amount is to be pro rata'd and will be verified by the Finance Department.

Wards have a number of options around meals and available funding for their patients:

Option 1

Wards can claim the full allowance for their patients where patients cook all meals themselves. Should a ward claim the full allowance for their patients, no standard stock items will be supplied, i.e., bread and milk. Wards are able to claim a maximum £5 per day, or £35 per week, per patient for meals, where no basic stock items are supplied and where no meals are supplied by the ABUHB Catering Department. If patients cook some meals, this amount is to be pro rata'd and will be verified by the Finance Department.

Option 2

Wards can claim a reduced allowance of £4.26 per patient per day, or £29.82 per patient per week, where patients cook all meals themselves, but basic stock items, to include bread and milk, are supplied to the ward by the Catering Department. If patients cook some meals, this amount is to be pro rata'd and will be verified by the Finance Department.

Option 3

Wards do not claim any allowance towards patient meals and the Catering Department supplies Service Users where all meals and snacks throughout the week. This option is suitable for patient wards where inpatients are not at a stage of rehabilitation.

Additional information

ABUHB recognises that some patients will have alternative dietary requirements and will facilitate these in with the Catering Policies. We understand that certain food items suitable for allergens can be more costly for patients and that the current allowance may not suffice in order to purchase healthy, balanced required food or drink items. Any extra funding required to provide a patient with required food or drink items will be charged back to the relevant patient ward.

10. Exceptional Circumstances

ABUHB recognises that there can be no one size fits all model suited to all of the Adult Mental Health Directorate. Provision has been given to straight forward allowable and non-allowable items, however it is acknowledged that allowances must be made in certain exceptional circumstances.

For the purposes of this policy, an exceptional circumstance is defined as a time or event with a serious and unusual impact which prevents the ward, its staff, its clients or service users from functioning within their day to day norms.

The following items have been approved for petty cash usage and reimbursement in cases of exceptional circumstance only:
Food items in urgent situations i.e., impromptu overnight stays, unplanned OOH hospitalisation.

- Staff can be reimbursed for food items at a rate of £5 per person per lunch meal and £15 per person per dinner meal (as per allowances in Staff Expenses policy)

- Food items/ meals in cases of exposure exercises for service users with eating disorders.
- Pet food and basic veterinary care. It is acknowledged that pets often represent a safety feature and are an important part of a patient's wellbeing and therapy. Pet food and basic healthcare, including flea and tic treatments, are included.

Queries or permissions relating to ad hoc exceptional circumstance purchases can be requested by contacting the Directorate Manager for Adult Mental Health, or the Deputy Directorate Manager for Adult Mental Health, where reimbursement requests will be examined on a case by case basis.

11. Patients' Property

Where a patient has handed in their money to the Health Board for safekeeping, please refer to the Patients' Property FCP for details on how the patient can retrieve their monies for this purpose.

Petty Cash floats that are maintained for Patients' Monies will follow the guidelines set out within the Patients' Property FCP.

This FCP can be found here

12. Implementation

This document should be implemented with immediate effect.

13. Further Information

Enquiries relating to this policy should be directed to the Treasury Manager, Assistant Head of Financial Services, Head of Financial Services and Accounting or the Assistant Director of Finance - Financial Systems & Services.

14. Audit

The Internal Audit Programme shall periodically review the compliance with this position. In addition, External Audit may review compliance with this procedure as part of their financial accounts audit work.

15. Review

This policy will be reviewed every three years, unless there is a requirement to review it sooner.

Agenda Item: 3.1

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Progress Quarter 3 Report 2023-24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Finance and Procurement
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Counter Fraud

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

Er Gwybodaeth/For Information

To update the Audit, Risk and Assurance Committee of the work progress of the Counter Fraud Team.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report has been prepared for the Aneurin Bevan University Health Board's Audit, Risk and Assurance Committee. It highlights the Counter Fraud work which has been undertaken by the Local Counter Fraud Specialist (LCFS) specifically during Q3 and to date during financial year 2023/24.

Cefndir / Background

This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team to comply with the legal directions and the NHS requirements of the Government Functional Standards S013.

Asesiad / Assessment

1 Staff awareness

Counter Fraud awareness input at Corporate Induction remains a mandatory requirement. During the current financial year 870 members of staff have completed Corporate Induction which includes fraud awareness.

The new ESR Counter Fraud E-Learning training, launched on 20th April 2023 has recorded 61 staff completions. As noted in the Q2 report, it was proposed/agreed that the online Counter Fraud E-Learning would be mandated (pending ratification). Executive Committee approval was received on the 11th January 2024, the date to go live has not yet been decided.

On the 25th October 2023 an in-person fraud awareness presentation was given to the Senior Nurse Monthly meeting, this took place at The Friars and was well attended (12 in person and 6 via Teams). The presentation which normally takes approx. 45 mins with questions took 1 hr 20 mins due to the interaction of those present. The Counter Fraud Team received thanks and positive feedback from the session.

Fraud Awareness Week – 13th to 18th November 2023

The Counter Fraud Team actively participated in International Fraud Awareness week, an annual event/week-long campaign which serves to minimize the impact of fraud by promoting anti-fraud awareness and education. Throughout the week commencing 13th November 2023 members of the Team were based at the major hospital sites (Grange University Hospital, Royal Gwent Hospital, Nevill Hall Hospital, Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan, with promotional material drop-in visits to County Hospital and Cwmbran Clinic). The events were well received, staff actively engaged with the Team who gave an insight into who we are, what we do and how staff can report any suspicions or concerns. The event was advertised on the Intranet, along with a schedule of the dates/sites. It is estimated that more than 150 members of staff engaged/spoke with members of the team throughout the week. Additionally, following these events there has been a notable increase in referrals.

2 Proactive Work

Fraud Prevention Activity /Local Proactive Exercises (LPE)

As noted in the Q2 report, the Head of Counter Fraud together with the Resource Bank Manager has been running a proactive exercise since Q1, this is as a result of an investigation whereby a member of staff managed to allocate herself shifts and finalise those shifts for payment. This highlighted a potential fraud risk so following this, Resource Bank Staffing ran a monthly audit. The monthly audits highlighted self-authorised, self-worked and self-finalised shifts as only one member of staff is permitted to complete one stage of the process.

These results were then sent to the respective managers notifying them of the breach of the process. Counter Fraud followed this email notification with an email requesting discrete enquires to be made to make sure that shifts had been worked. There has to date been no further fraud reported, but even though the numbers have fallen month on month there are still staff that ignore the system warnings and complete more than one part of the process.

A meeting with the E-Systems Lead has highlighted the concerns. During which we were notified of the new E-System called "Self-Care" that works alongside the other two systems. This system eliminates the weakness currently posed by Health Roster and Bank Staffing and allow set rules that does not permit self-authorised, self-worked and self-finalised shifts. But due to the fact that this system can only be slowly introduced into Aneurin Bevan University Health Board it has been decided that a risk assessment will be completed. But it was agreed that in the interim the staff that ignore the current process, highlighted by the monthly audits, would be moved as a priority across to the new system, to prevent them causing further issues.

National Fraud Initiative

As previously mentioned, the NFI has been underway since October 2022. At this time all of the high-risk referrals have now been completed and we are still completing ad hoc requests for information sent to us by other Health Boards.

In the coming weeks of Q4 there will be risk assessments carried out for petty cash, the Omnicell storage of WP10s (as a follow on from the lunch and learn session provided to Pharmacy in the previous quarter) and as already stated for the Bank Staffing LPE.

3 Reactive Work

The table below summarises the Counter Fraud Team operational data and sanctions secured in Q3. The team were investigating **45** cases at the start of the quarter, with a caseload of **33** active cases at the close of Q3 – 19 new referrals were received with 31 cases closed during the reporting period. Q3 has seen a financial recovery of **£83,896** as a result of Counter Fraud's investigation/ intervention into overpayment of salary cases. The majority of these financial repayments were made in one cash lump sum but includes a larger repayment which was made via 3 monthly instalments. A sanitised list of open cases as of 31st December 2023 is included at **Appendix 1**.

During the reporting period, 2 subjects were formally Interviewed Under Caution, both investigations are continuing. Four members of staff were disciplined, of which 2 were dismissed for Gross Misconduct.

Referrals Q3	Cases Closed Q3	Financial / Civil Recovery		Open Cases as at 31/12/23	Sanctions Q3	
		Q3	Cumulative 2023/24		Civil	Internal Disciplinary
19	31	£83,896	£143,883	33	9	4

Argymhelliad / Recommendation
This report is intended for Audit, Risk and Assurance Committee's information and views.

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive

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

APPENDIX 1

No.	Case Ref	Start Date	Subject/Occupation	Fraud Type	Status
1	INV/23/02928	20/12/2023	HCSW	Salary overpayment	Investigation ongoing
2	INV/23/02886	18/12/2023	Non-NHS	Overseas patient using NHS services	Investigation ongoing
3	INV/23/02873	14/12/2023	HCSW (ex-employee)	Salary overpayment	Investigation ongoing
4	INV/23/02860	13/12/2023	Specialty Doctor	Salary overpayment	Investigation ongoing
5	INV/23/02858	13/12/2023	NHS Staff/Facilities	Timesheet / shift allocation	Investigation ongoing
6	INV/23/02837	12/12/2023	HCSW	Working while sick	Investigation ongoing
7	INV/23/02729	01/12/2023	NHS Staff/External Contractor	Contract issues / insider collusion	Investigation ongoing
8	INV/23/02532	10/11/2023	NHS Staff (Nurse)	Salary Overpayment	Referred to Accounts Payable, awaiting confirmation of repayment
9	INV/23/02531	10/11/2023	NHS Staff (Nurse)	Salary Overpayment	Investigation ongoing
10	INV/23/02530	10/11/2023	General Practitioner	Salary Overpayment	Investigation ongoing / repayment pending
11	INV/23/02427	27/10/2023	HCSW	Salary Overpayment	Investigation ongoing
12	INV/23/02348	18/10/2023	NHS Staff(Nurse)	Salary Sacrifice/non-payment	Subject now working for NHS England, payment pending
13	INV/23/02342	18/10/2023	NHS Staff - Consultant	Working privately while sick and during NHS Contracted Hours	Investigation ongoing
14	INV/23/02253	10/10/2023	NHS Staff (Facilities)	False/Misleading information for Special Leave	Investigation ongoing, IUC 07/12/23
15	INV/23/02252	10/10/2023	NHS Staff (Manager)	Salary Overpayment	Arrangements for repayment pending, case to be closed when payment confirmed
16	INV/23/02088	25/09/2023	NHS Staff (Facilities/Chef)	Fail to Disclose & Theft	Failed to disclose previous conviction for theft/theft of NHS equipment and catering supplies. Investigation ongoing. Subject suspended pending HR disciplinary.
17	INV/23/02042	20/09/2023	NHS Staff (Facilities/Hostess)	Fail to Disclose	Allegation that subject failed to disclose conviction for assault.
18	INV/23/01885	06/09/2023	NHS Staff (Medical Secretary)	Timesheet fraud	Allegation that subject is not completing contracted hours, investigation ongoing
19	INV/23/01741	18/08/2023	NHS Staff (Nurse)	Salary Overpayment	Investigation ongoing
20	INV/23/01632	07/08/2023	NHS Staff (Facilities)	Timesheet Fraud	Investigation ongoing
21	INV/23/01532	31/07/2023	NHS Staff (Hospital Doctor)	Salary Overpayment	Investigation ongoing
22	INV/23/01521	28/07/2023	NHS Staff	Timesheet Fraud	Failure to work contracted hours
23	INV/23/01520	28/07/2023	NHS Staff (Nurse)	Salary Sacrifice/non-payment	Lease vehicle, investigation ongoing
24	INV/23/01051	01/06/2023	NHS Staff x4	Timesheet fraud/ Misuse of computers.	Investigation ongoing
25	INV/23/00761	20/04/2023	NHS Staff	Working while sick	Investigation ongoing.
26	INV/23/00920	19/04/2023	NHS Staff	Timesheet / Annual Leave fraud	Investigation ongoing.
27	INV/23/00922	04/04/2023	NHS Staff	Working while sick	Investigation ongoing.
28	INV/23/00258	06/02/2023	NHS Staff	Timesheet fraud.	Investigation ongoing
29	INV/22/01414	04/10/2022	NHS Staff	Salary Overpayment	Investigation ongoing.
30	INV/22/01391	03/10/2022	NHS Staff	Salary Overpayment	NFA on criminal & disciplinary aspect. Recovery of £24,000.00 in progress
31	INV/22/01201	31/08/2022	NHS Staff	Timesheet fraud	Investigation ongoing.
32	INV/22/01184	26/08/2022	NHS Staff	Timesheet fraud	NFA criminal - disciplinary ongoing.
33	WARO/19/00145	17/12/2019	NHS Staff	False WLI payment claims	CPS declined charging decision, No Further Action (NFA) criminal aspect. Civil recovery and GMC action pending.

Agenda Item: 3.1

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Activity
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Assistant Director for Quality & Patient Safety

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services evolve and develop and are responsive to quality and safety risks.

The results of clinical audit are one input into a wider Quality Management System designed to achieve continuous organisational learning and improvement in delivery of safe and effective care. When conducted in accordance with best practice standards, clinical audit provides assurance of compliance with clinical standards, identifies, and minimises risk, waste, and variation in clinical practice from guidelines and defined standards of care.

The Health Board's strategic focus has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan. The Health Board complies with the requirements of Welsh Government by participating in all mandatory national clinical audits. Our clinical audit plan is updated to reflect national and local drivers for quality improvement. The focus for the Clinical Audit Team has been to implement the Health Board's Clinical Audit Strategy by meeting and engaging with Divisions.

Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by the Welsh Government (WG) annually. The plan is one of the cornerstones in the drive to improve quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements. The plan details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided. The Health Board's audit plan is based on NCAORP.

Following the Internal Audit report and recommendations in November 2022, the focus for the Clinical Audit Team has been to implement the Health Board's Clinical Audit Strategy. There has been engagement with Divisions and work undertaken on making the clinical audit process more effective. This included producing standardised audit templates, which has enabled more consistent reporting and improved scrutiny of action plans.

Implementation of the web-based Audit Management and Tracking system (AMaT) has helped facilitate tracking of audit results and the development of action plans. Local audit plans have been developed by Directorates and are also recorded in AMaT. AMaT has been used to build audit proformas, capture data, produce results and develop SMART action plans, all within the same platform. This has allowed many of the recommendations within the internal audit report to be met. See Appendix One for updated action plan.

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided by reporting to the Patient Quality and Safety Outcomes Committee (PQSOC), providing scrutiny of National Clinical Audit performance with robust development and monitoring of improvement plans.

Clinical audit is an important component of our commitment over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system.

Asesiad / Assessment

The Health Board's Annual Clinical Audit Plan and Clinical Audit Activity report was ratified by Patient Quality and Safety Outcomes Committee (PQSOC) in June 2023 and presented to ARA in July 2023. The updated Clinical Audit Plan for 2024/25 and Clinical Activity Report for 2023/24, will be ratified at PQSOC in April 2024. The activity report will summarise all the audits presented at CSEG for the last twelve months.

There is a well-defined process for the scrutiny of National Clinical Audit Reports, which are presented to the Clinical Standards and Effectiveness Group (CSEG)

following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication. The Quality and Patient Safety (QPS) clinical audit team register the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT so completion deadlines can be tracked. Reports discussed at CSEG from April to November 2023 have been presented to PQSOC and can be found in Appendix Two.

The nine-month publication schedule for the NCACORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) has been shared with Directorates. The dates align with presentation of results at Clinical Standards and Effective Group (CSEG). The annual audit plan will continue to ensure mandatory participation in all national clinical audits and national confidential enquiries, including participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP). AMaT is utilised to record compliance with NICE guidance and HTW adoption, which can be used for clinical audit.

Once National Clinical Audits (NCA) are published on the Healthcare Quality Improvement Partnership (HQIP) webpage, they form part of our annual audit plan. We are currently reviewing participation in these audits and ensuring these are discussed at CSEG. If these are discussed at other Groups or Boards (e.g. Stroke, End of Life Care Board) we will reach out for assurance on completion of key results, audit actions and improvement plans. We will be requesting for these to be reported to CSEG and placed on AMaT to align with the reporting of all other audits. See most up to date audit plan submitted at December's PQSOC in Appendix Three.

Audit Management and Tracking (AMaT) also being widely used across the Health Board for conducting and reporting on local audits, as specified in the audit plan. The volume of audits being undertaken and the number of action plans being allocated is rising. See attached Appendix Four for more information. As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads are being asked to confirm their list of audits and identify any other projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits that are required from clinical incidents, complaints or risks.

The audit team will continue to work collaboratively with Divisions, clinicians, service managers, divisional governance and quality managers as well as clinical staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements. Ongoing training to use AMaT will ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

The clinical audit team are developing organisational and governance structures within AMaT to support full engagement in audits. This includes consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

One area of improvement going forward needs to ensure the results of all clinical audits undertaken need to be triangulated and inform future planning. The next audit activity report by the clinical audit team will review how the learning from clinical audit can be fed back to clinical areas.

The plan is to present the next Clinical Audit Activity Report for 2023/24 and Clinical Audit Plan 2024/25 at the Patient Quality and Safety Outcomes Committee in April 2024, once this has been ratified by the committee it can be sent to ARA for assurance.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team in developing an ongoing clinical audit programme for the next 12-24 months. A clinical audit activity report is being updated annually.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

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

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

Appendix One – updated Internal Audit Action Plan

Clinical Audit – Internal Audit Report Action Plan
Purpose - The audit was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance.
Overview We have issued limited assurance on this area. The significant matters which require management attention include: • A Clinical Audit Strategy should be fully implemented, with the draft that is available requiring significant review. • There is no local clinical audit plan. Therefore, the Health Board cannot effectively plan to complete audits in areas with the greatest risk. Audits that should be completed may go unidentified, leading to additional clinical risks. • There is limited tracking / monitoring of actions raised and the delivery of clinical audits.
The risks considered as part of this review were: • Inappropriate governance structure / arrangements in place. • Lack of a clinical risk register or identification of relevant risks. • Failure to have an effective reporting pathway for clinical audit results. • Failure to act upon the results of clinical audits. • Failure to participate in the NHS Wales National Clinical Audit and Outcome Review. • Clinical audits do not provide sufficient assurance to the Board over the management of associated risk. • Internal audit recommendations are not implemented.
Audit objective 1: There is an approved clinical audit strategy and clinical risk register in place. **Conclusion**: The Health Board needs to formalise the Clinical Audit Strategy and consider whether it has given enough resources to those responsible for clinical audit to carry out the Strategy. Therefore, we have given this objective **limited assurance.**
Audit objective 2: An appropriate local clinical audit plan is developed, approved, with progress, conclusions and actions monitored by an appropriate forum / committee. **Conclusion**: Given the absence of a local clinical audit plan, we have provided **limited assurance** for this objective.
Audit objective 3: Where applicable, the Health Board takes part in the Annual Programme, detailed in the NHS Wales National Clinical Audit and Outcome Review Plan. **Conclusion:** National Clinical audits are being completed and results noted in an effective system. Therefore, we have provided **reasonable assurance** for this objective.
Audit objective 4: Results of all clinical audits undertaken are triangulated and inform future planning. **Conclusion:** There is evidence of oversight of the national clinical audit plan. However, there are still weaknesses in the tracking of actions raised and little evidence that the audits affect the Health Board's future planning. Therefore, we have provided **limited assurance** for this objective.

Matter Arising 1: Clinical Audit Strategy
The Health Board has a draft Clinical Audit Strategy (the 'Strategy') setting out its vision for clinical audit for 2022- 2025. The Health Board has four priorities regarding clinical audit. The Strategy includes actions to implement the four priorities, however, many of these actions remain outstanding. There is also no clear plan to implement these actions and parts of the strategy are yet to be completed. Review and renew the Clinical Audit Strategy, which should include:

Recommendations	Priority	Updated Actions	Completion
How the Health Board plans to track and monitor actions raised in national clinical audits	High	New Clinical Audit Strategy fully launched in October 2022 and engaged with Divisions over six months. Implementation of web-based Audit Management and Tracking (AMaT) system. Audit action plans developed in AMaT are SMART, allows clinical lead to assign actions to a named lead within specified timeframe. Over seen by CSEG.	Complete April 2023
The process for designing a plan for local clinical audits and what needs to be taken into consideration when creating a local clinical audit plan	High	An Annual Audit Plan was developed for 2023.24, this included local audits. Implementation and training on AMaT and engagement with Divisions has enabled directorates to develop local audit plans. The QPS team have reintroduced corporate audits that were undertaken pre covid (e.g. consent, DNACPR, medical records).	Complete September 2023
Resourcing requirements to ensure both national and local clinical audits are effectively monitored	High	Currently resource is 0.8WTE for both. With lack of financial resources, the QPS clinical audit team have been using an additional member of the team to focus on local audits. We have sought the resources from other HBs in Wales to consider how audit is managed elsewhere.	Complete September 2023
Role and responsibilities for clinical audit, including the monitoring groups	High	The Terms of Reference for CSEG have been updated. Scrutiny of audit results and action plans take place at CSEG. CSEG oversees the governance relating to clinical audit and reports to PQSOC the outcomes and improvements plans relating to national audit. The functionality of AMaT has allowed monitoring from Directorate and Divisional Leads.	Complete September 2023

How assurance is provided from each applicable divisions / directorates	High	National Clinical Audit assurance is provided by clinical leads at the CSEG and reported to PQSOC. Audit action plans are tracked within AMaT. Where the Health Board has been identified as an outlier on a national audit, we have implemented an SOP, which ensures a standardised approach is undertaken in reviewing, investigating and responding to outlier notification in relation to national clinical audits. This is undertaken by the audit clinical lead and be signed off by CSEG and a summary will be provided for the Exec team.	Complete June 2023
The escalation process for actions raised within audits	High	There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided by reporting to the Patient Quality and Safety Outcomes Committee, providing scrutiny of National Clinical Audit performance with robust development and monitoring of improvement plans. The Clinical Audit Plan is being monitored by CSEG, to ensure lessons are learnt across the Health Board and that the plan is being delivered effectively. Actions and findings from national and local clinical audits will be monitored by this Group and will be utilised to inform future planning within the Health Board.	Complete June 2023

Matter arising 2: Local Clinical Audit plan

There is no local clinical audit plan in place. Until recently, there has been little governance over what local clinical audits have been completed. We were unable to be provided with a list of local clinical audits completed for the past year as this list did not exist. Furthermore, there is no approach or oversight for identifying clinical risks and how these may be incorporated into a local clinical audit plan.

Recommendations	Priority	Updated Actions	Completion
The Health Board should create a local clinical audit plan using a risk-based approach	High	External and internal alerts and safety notices picked up by the corporate QPS team are stratified by risk and review the use of local audit. Engagement with Divisions has stressed the importance or risks identified through incidents and investigations to plan local audits.	Complete March 2023
The clinical audit plan should be monitored at an appropriate forum, to ensure lessons are learnt across the Health Board and that the plan is being delivered effectively	High	This is motored via CSEG. A standardised approach and reporting via AMaT has ensured we are reporting on areas where good practice has been identified, areas of where practice requires improvement and actions to be taken - using SMART objectives. The development of the first Clinical Audit Activity report for 2022/23 demonstrates the improvements in learning.	Complete July 2023
The local clinical audits should be recorded onto AMaT, as is currently being done with national clinical audits	Medium	Engaged with Divisions to share strategy and training of staff on the use of AMaT has ensured all new local audits are being recorded on AMaT. These form part of the local audit plan. This plan is updated every six months for PQSOC to share the number of audits undertaken and the specialities and professions that are undertaking local audits.	Complete July 2023

Matter arising 3: National clinical audits

The Quality and Patient Safety Lead for National Clinical Audit could not identify a deadline by which each national clinical audit had to be completed. This sometimes leads to difficulty obtaining participation from some divisions, particularly where staffing resources may be an issue. We could not therefore confirm whether each audit was completed in a timely manner as this

information is not tracked. We were unable to confirm that national clinical audits inform the HB future planning or that actions raised are monitored and tracked. Clinical audit is only mentioned fleetingly in the HB Integrated Medium Term Plan (IMTP).			
Recommendations	**Priority**	**Updated Actions**	**Completion**
The Clinical Standards Effectiveness Group should monitor when an audit is added to the national clinical audit programme and how long it is scheduled to complete. Those responsible for completing audits that are facing significant delays should be asked to provide reasoning for this, and additional support should be provided where required	Medium	There is a well-defined process for the scrutiny of National Clinical Audit Reports, which are presented to the Clinical Standards and Effectiveness Group (CSEG) following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication. The Quality and Patient Safety (QPS) clinical audit team register the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT so completion deadlines can be tracked. Reports discussed at CSEG from April to November 2023 have been presented to PQSOC and can be found in Appendix One.	Complete June 2024
Actions and findings from national and local clinical audits should be monitored at an appropriate forum and should be utilised to inform future planning within the Health Board	Medium	The standardised approach to reporting audit findings has enabled reporting of successes, concerns and a SMART action plan. The Clinical Standards and Effectiveness Group (CSEG) oversees the governance relating to clinical audit and reports biannually	Complete September 2023

		to PQSOC the outcomes and improvements plans relating to national audit. Actions are recorded and tracked on AMaT for all NCA after presented to CSEG. The clinical audit team are developing organisational and governance structures within AMaT to support full engagement in audits. This includes consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.	

Matter arising 4: AMaT user guide

The AMaT system is used to add the information from national clinical audits and going forward also local clinical audits. Those who are responsible for adding the local clinical audit information to the system may be unfamiliar or unsure how to best utilise the programme. There is an AMaT guidebook available, but this is not held on the Intranet.

Recommendations	Priority	Updated Actions	Completion
Add the AMaT guidebook to the Intranet	Low	The AMaT guidebook was added to the Clinical Audit intranet page for the Health Board. All AMaT guides are on the AMaT platform in video format and accessible to all registered users. PDF training documents are on the QPS intranet page and sent to individuals or groups after attending a training session.	Complete December 2023

Appendix Three

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/10/12	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit (NEIAA). State of the Nation Report 2023 - Summary report. Data collection period: 1 April 2022 – 31 March 2023	Jan-24
2023/10/12	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care State of the Nation Surveillance Report 2023. Surveillance findings from the UK Confidential Enquiries into Maternal Deaths 2019-21	Discuss with MatNeo Board
2023/10/12	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving Lives, Improving Mothers' Care State of the Nation Themed Report. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-21	Discuss with MatNeo Board
2023/10/12	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving Lives, Improving Mothers' Care State of the Nation Themed Report. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth	Discuss with MatNeo Board
2023/10/12	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme (NNAP) - Summary report on 2022 data	Nov-23
2023/10/12	NDA - National Diabetes Audit	National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Overview	Nov-23
2023/10/12	NDA - National Diabetes Audit	National Diabetes Audit 2021-22, Type 1 Diabetes - Overview	Nov-23
2023/10/12	NDA - National Diabetes Audit	National Diabetes Audit National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022)	Nov-23

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/09/14	FFFAP - Falls and Fragility Fracture Audit Programme	15 Years of Quality Improvement: The 2023 National Hip Fracture Database report on 2022 (1 January 2022-31 December 2022)	Jan-24
2023/09/14	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2021 - State of the Nation Report	Discuss with MatNeo Board
2023/08/10	NAD - National Audit of Dementia	National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report	Jan-24
2023/07/13	NPDA - National Paediatric Diabetes Audit	NPDA: Report on hospital admissions of children and young people with diabetes, 2015-2020	Jul-23
2023/07/13	NCMD - National Child Mortality Database	NCMD: Deaths of children and young people due to traumatic incidents: Vehicle Collisions, Drownings, Violence and Maltreatment and Unintentional Injuries	Discuss with Family and Therapies
2023/07/13	Ep12 - National Audit of Seizures and Epilepsies	Epilepsy12 2023 combined organisational and clinical audits: Report for England and Wales Round 4, Cohort 4 (2020-22)	Discuss with Neurology
2023/07/13	NACEL - National Audit of Care at the End of Life	NACEL: Fourth round of the audit (2022/23) report	Discussed at EoLCB
2023/07/13	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA short report: Socioeconomic differences in the impact of oesophago-gastric cancer on survival in England	NO ENGLAND ONLY
2023/07/13	Medical and Surgical Clinical Outcome Review Programme	Making the Cut? A review of the care received by patients undergoing surgery for Crohn's Disease	PARTICIPATION - NO PRESENTED INTERNALLY
2023/06/08	NVR - National Vascular Registry	NVR Short Report: Impact of the COVID-19 pandemic on vascular surgery in the UK	Participated but not presented at CSEG- discuss with vascular

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/06/08	Child Health & Medical and Surgical Clinical Outcome Review Programmes	NCEPOD: The Inbetweeners - A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services.	No - Discuss with Family and Therapies
2023/04/12	NLCA - National Lung Cancer Audit	NLCA: State of the Nation Report 2023	May-23
2023/03/09	FFFAP - Falls and Fragility Fracture Audit Programme	FFFAP: State of the nation Wales report 2022	Discuss with Hospital and Community Falls and Bone Health Group
2023/03/09	PICANet - Paediatric Intensive Care Audit	PICANet: State of the Nation Report 2022	C&VUHB
2023/03/09	NPDA - National Paediatric Diabetes Audit	NPDA: Report on Care and outcomes 2021/22	May-23
2023/03/09	CVDPREVENT- Cardiovascular Disease Prevention Audit	CVDPREVENT: Third Annual Audit Report	No – discuss with cardiology
2023/03/09	Mental Health Clinical Outcome Review Programme	NCISH: Annual Report: UK patient and general population data 2010-2020	No – discuss with mental health
2023/03/09	NACAP - National Asthma and COPD Audit Programme	NACAP: Clinical outcomes Summary report	No – discuss with respiratory
2023/02/09	NELA - National Emergency Laparotomy Audit	NELA: Eighth Patient Report of the National Emergency Laparotomy Audit	Mar-23
2023/01/12	NACAP - National Asthma and COPD Audit Programme	NACAP: Drawing breath - The state of the nation's asthma and COPD care and recommendations for improvement. Partially presented (PC and Paeds)	Mar 2023

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/01/12	FFFAP - Falls and Fragility Fracture Audit Programme	FLS_DB Annual report: Rebuilding FLSs to meet local patient need Data from January to December 2021	May-23
2023/01/12	NPCA - National Prostate Cancer Audit	NPCA Annual Report 2022 Prostate Cancer services during the COVID-19 Pandemic (published January 2023)	May-23
2023/01/12	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA: An audit of the care received by people with oesophagogastric cancer in England and Wales	No
2023/01/12	NBoCA - National Bowel Cancer Audit	NBoCA: Annual Report 2022	May-23
2023	Myocardial Infarction Natioanl Audit Programme (MINAP)	NICOR	Sep-23
2023	Heart Failure	NICOR	Sep-23
23/11/09	NVR - National Vascular Registry	National Vascular Registry 2023 State of the Nation Report (cohort Jan-Dec 2022)	Jan-24
23/11/09	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme (SSNAP) State of the Nation Annual Report 2023 (cohort April 2022-March 2023)	Stroke Board
23/11/09	NCMD - National Child Mortality Database	National Child Mortality Database Child Death Reviews Data year ending 31/03/2023 Data only release	Discuss with Family & Therapies
23/11/09	FFFAP - Falls & Fragility Fracture Audit	Inpatient falls and fractures - one chance to get it right: The 2023 National Audit of Inpatient Falls Report on 2022 clinical data (cohort Jan-Dec 2022)	Discuss with Hospital and Community Falls and Bone Health Group

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
23/11/09	NDA - National Diabetes Audit (adults)	National Diabetes Audit Q1 data only release - Core & Diabetes Prevention Programme, DPP (Non-Diabetic Hyperglycaemia - NDH), 01/01/2023-30/06/2023; Eng only.	No - England only
23/11/09	NDA - National Diabetes Audit (adults)	National Diabetes Audit dashboard data only release: National Diabetes Footcare Audit (NDFA), 01/04/2021 – 31/03/2023, Eng & Wal.	Jan-24
23/12/14	NDA - National Diabetes Audit	National Diabetes Audit Diabetes Prevention Programme (DPP) - Non-Diabetic Hyperglycaemia (NDH) State of the Nation report (01/01/2021-31/03/2022, Eng only, Y1)	No - England only
23/12/14	NDA - National Diabetes Audit	National Diabetes Audit Young Type 2 State of the Nation report (01/01/2018-31/03/2022, Eng & Wal)	2024
23/12/14	NDA - National Diabetes Audit	National Diabetes Audit Core underlying data, 01/01/2022-31/03/2023, Eng & Wal	2024
23/12/14	NCMD - National Child Mortality Database	National Child Mortality Database Thematic report - infection	No - discuss with Family & Therapies
23/12/14	PICANet - Paediatric Intensive Care Audit	Paediatric Intensive Care Audit State of the Nation Report (Jan-Dec 2022)	C&VUHB
23/12/14	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme MNI Perinatal confidential enquiry - the care of black and white women who have experienced a stillbirth or neonatal death (01/07/2019 - 31/12/2019)	No – discuss with MatNeo Board
23/12/14	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme MNI Perinatal confidential enquiry - the care of Asian and white women who have experienced a stillbirth or neonatal death (01/07/2019 - 31/12/2019)	No– discuss with MatNeo Board
23/12/14	Medical and Surgical Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme - Community acquired pneumonia (cohort 01/10/21-31/12/21)	No
24/01/11	NPCA - National Prostate Cancer Audit	National Prostate Cancer Audit State of the Nation report	2024

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
24/01/11	GICAP-NOGCA - National Gastro Intestinal Cancer Audit Prog. - National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit State of the Nation report	2024
24/01/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit data only release – Q1 to Q4 (01/01-31/12/2022 England data only) - national results spreadsheet	No - England only
24/01/11	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme quarterly data only report (Jul-Sep 2023)	Stroke Board
24/02/08	NCISH - Mental Health CORP	Mental Health Clinical Outcome Review Programme Alcohol and Drug report (cohort TBC)	No – discuss with mental health
24/02/08	NCISH - Mental Health CORP	National Confidential Inquiry Into Suicide and Safety in Mental Health Annual Report 2024: UK patient and general population data 2011-2021	No – discuss with mental health
24/02/08	FFFAP - Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLSDB) Annual Report 2024: Improved FLS identification with gaps in monitoring: a call to action for national and regional planners (January-December 2022)	2024
24/02/08	GICAP-NBoCA - National Gastro Intestinal Cancer Audit Prog. - National Bowel Cancer Audit	National Bowel Cancer Audit State of the Nation report	2024
24/02/08	Child Health Clinical Outcome Review Programme	Child Health Clinical Outcome Review Programme - Testicular torsion report	Discuss with Family and Therapies
24/03/14	NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit annual core state of the nation (01/04/2022 - 31/03/2023)	2024
24/04/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	2024

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
24/04/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit data only release – Q1 (01/01-31/03/2023 England data only) - national results spreadsheet	No - England only
24/04/11	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme quarterly data only report (Oct-Dec 2023)	No – discuss with stroke
24/05/09	NDA - National Diabetes Audit (adults)	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021- 31/03/2022 TBC; Eng & Wal.	2024
24/06/13	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report	2024
24/07/11	NDA - National Diabetes Audit (adults)	National Diabetes Inpatient Safety Audit (NDISA) State of the Nation report, May 2018 - Oct 2023; Eng & Wal.	2024
24/07/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit data only release – Q1 to Q2 (01/01-30/06/2023 England data only) - national results spreadsheet	No - England only
24/08/08	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Primary Care Report (cohort TBC)	2024

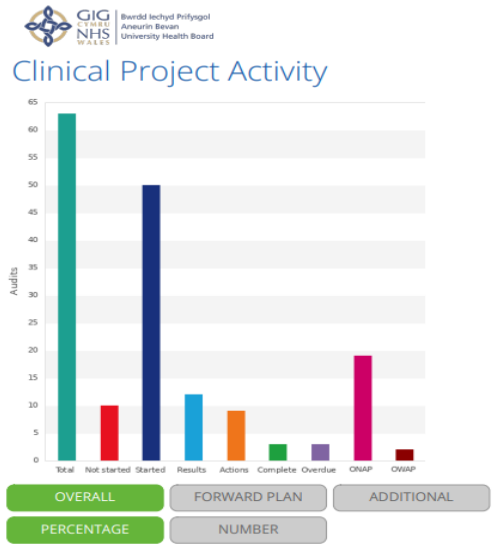
Appendix Four

AMAT UPDATE

This report demonstrates the current usage of AMaT since it was purchased and implementing in March 2022. Since the previous update the number of users has increased from 875 to 1,009 registered users on AMaT within the Health Board.

Clinical Area

This is the Clinical Area overview dashboard:



Total number of projects	63	100%
Total number of open projects	60	95%
Number of open projects with no results	48	80%
Number of open projects with results	12	20%
Number of open overdue projects (no action plans)	19	32%
Total number of active projects (with action plans)	7	12%
Number of active overdue projects (with action plans)	2	3%
Number of closed projects	3	5%
Number of abandoned projects	1	N/A

Forward Plan Year: 2023-2024

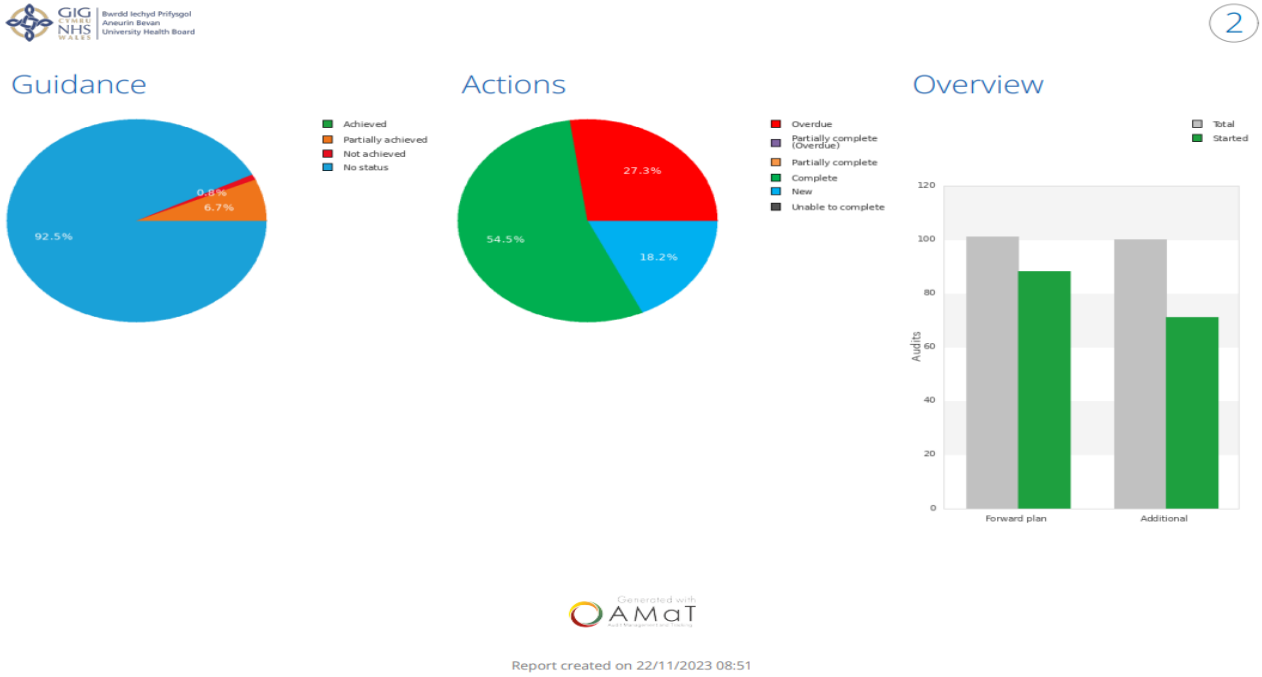


Figure 1.1 Current use of AMaT

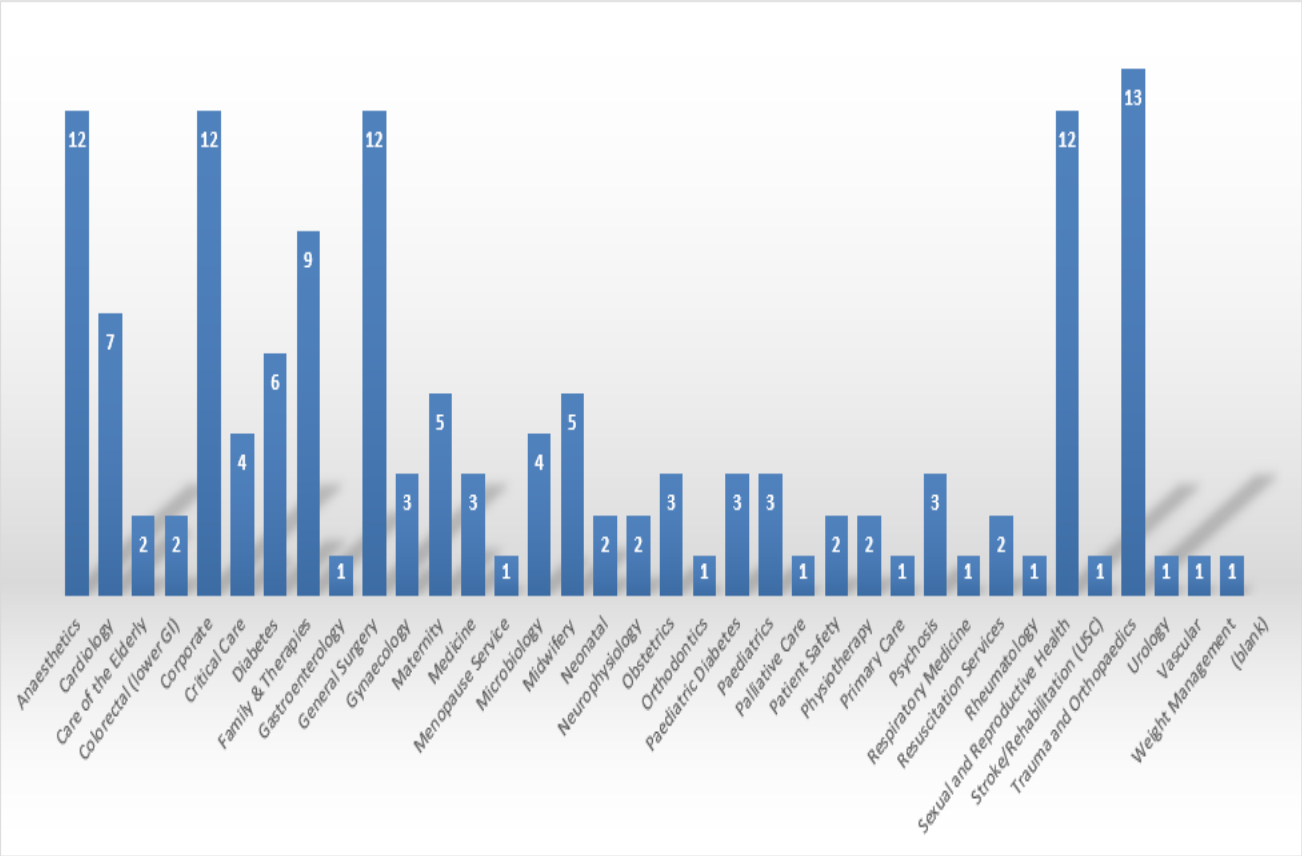


Figure 1.2 Audits in Clinical Area by Specialty

The internal audit report issued in November 2022 reported limited assurance for the local audit process within the Health Board. AMaT has helped improve the reporting of local audits. These audits have completed actions which are tracked in AMaT. The clinical audit team are reviewing the processes and governance structure in relation to users of AMaT. This will allow overdue actions to be followed up.

There are a number of action plans linked to National Clinical Audits which are part of the National Clinical Audit Outcome Review Plan (NCAORP). The management of registered audits is also being reviewed ensuring this links to the standardised registration form.

The number of clinical areas, specialities and variety of health professionals that use this system demonstrates that investment in the system has been worthwhile. It is also currently being utilised for ward accreditation audits. Given its uptake and utilisation, ongoing funding will be pursued to ensure the system can continue to be used.

Ward Area

Within the Ward Area there has been an increase from 12 registered projects containing 56 individual audits to 14 projects containing 65 audits. The audits can be registered to any number of wards or all wards.

Project overview

Project	No. audits	Current compliance	Improvement	Overdue actio
All Wales - DNACPR	1	R 72.9%	N/A	
Cardiac Arrest	1		▼	
Controlled Drugs	1	A 80.4%	▼	
Corporate	1		N/A	
DECi	3	A 82.4%	▲	0
Dietetics	4	R 44.4%	▼	
ED Nursing	1		N/A	
EFU weekly audits	6		N/A	
Haematology	1	A 87.5%	▲	
Health & Safety Monitoring	1		N/A	167
IPC Annual Audits	33	G 90.4%	▲	286
Oral Hygiene	1	A 84.8%	N/A	0
Thrombolysis Audit	1	R 71.8%	N/A	
Ward Accreditation Audits	10	A 86.2%	▼	1

As with the actions in the Clinical Area, there are trial processes underway to ensure governance relating to the overdue actions within ward area.

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

AMaT

SECTION A

Title of Audit & Governing body:	National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Primary Care (PC) – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report		
Audit period	April 2020 and July 2021	**Case Ascertainment:**	COPD – 482 Asthma - 91
Local data available:	Yes	**Number of cases:**	331 (One of the largest services)
Audit Rational:	The primary role of NACAP is to support individual clinical teams to make improvements in the quality of care they deliver. The data included in this report reflect a period during which the COVID-19 pandemic stretched respiratory staff and services to their limits, therefore, direct comparisons with previous reports should be interpreted with caution. The findings enable us to reflect and identify opportunities to restore and strengthen the provision of care for people living with asthma and COPD.	**Audit Objectives:**	State of the Nation is a view of the care of people with asthma and COPD in England and Wales. This report is the first to combine data on asthma, COPD and pulmonary rehabilitation across primary and secondary care services to underpin key messages, optimising respiratory care across the pathway. More than 9 million people are living with a diagnosis of asthma or COPD in the UK. The National Asthma and COPD Audit Programme (NACAP) aims to improve the quality of their care, services and clinical outcomes. We do this by supporting and training clinicians, empowering people living with asthma and COPD and their carer's and informing policy.
Clinical Lead:	Natalie Janes - Deputy Head of Service-Primary Care, Primary Care and Community Division	**Division/Specialty**	Primary Care and Community Division Respiratory

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2**	Medium: requires prompt action (consider local audit)

		(for the action priority)	

Recommendations:
• For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care • Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• Early and accurate diagnosis can only be achieved by conducting physiological diagnostic testing across hospital specialist and primary and community care services. • Over 90% of patients being diagnosed with Asthma or COPD by primary care clinicians. • 61.8% of hospitals across Wales have access to both Fractional exhaled Nitric Oxide (FeNO) and Spirometry as diagnostic tools for children and young people with asthma, FENO is limited across primary care, with only specialist nursing teams having the device. • Data recorded when COVID-19 rates were high (April 2020 to July 2021) and infection controls measures were stringent, indicated that only 43.9% of adults diagnosed with asthma had a record of any objective diagnostic measurement. 1.9% of adults had a record of receiving a gold standard diagnostic test for COPD of post-bronchodilator spirometry, within the past 2 years in primary care across Wales. • 6% of people with COPD and grade 3–5 Medical Research Council (MRC) breathlessness were offered pulmonary rehabilitation in the past 3 years in primary care across Wales. The national issue with regards to the delivery of Spirometry and concerns regarding pulmonary rehabilitation have been highlighted through the Respiratory Alliance Wales group to Welsh assembly Government and health minister. • Following a small scoping exercise regarding spirometry coding on clinical systems, 2 out of 5 practices were coding incorrectly. The concerns have been discussed since publication of the report via the All-Wales Respiratory Health Implementation Group. This has been highlighted as one of the top priorities. The goal is to review and develop an interactive all Wales Template for both COPD and Asthma which will link with All Wales prescribing and management guidelines, referral forms and APPS.

- The Spirometry Hubs at ABUHB based in the North and South of the HB, during COVID-19 were a huge success with over 400 patients reviewed over 140 patients had a change in referral diagnosis, 52 patients were reviewed from Secondary Care (SC) waiting lists.

- Hubs provided an opportunity to provide education and training for staff who had become deskilled requiring revalidating or staff new to spirometry due to the withholding of Spirometry for 2 ½ years during the pandemic. Due to changes/shortages in staff and equipment issues 40 out of 71 practices across ABUHB are currently performing spirometry due to staff with skills etc training and education workshops have since been arranged through the primary and community care academy to upskill the workforce.

- Collaborative working with Paediatrics and Neonatal nursing, regarding training education and All Wales Oxygen Service to replicate the gold standard that have been developed for adults continues. The division have also supported two innovative projects working alongside GSK and AstraZeneca (pharmaceutical industry) reviewing patients at high-risk on asthma/COPD registers in collaboration with signed up general practices.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:

- Education and training 3-day programme delivered by the Primary Care Respiratory Nurse Team via the Primary and Community Academy.
- Level 1, 2 and 3 Spirometry training delivered by the Primary Care Respiratory Nurse Team via the Primary and Community Academy.
- GSK and AstraZeneca (pharmaceutical industry) joint working and donated goods and services projects review of identified high-risk asthma/COPD patients.
- Housebound patient annual reviews Project supported by the Respiratory specialist nursing team in managed practices.
- Spirometry diagnostic Hubs supporting COVID-19 recovery position.
- PCRSN team providing support, education/training, Face to face training/mentorship in GP surgeries.
- Gold standard O_2 service with clinical and operational SOP.
- Prison in-reach.

Aneurin Bevan University Health Board Concerns:

- Only 40/71 practices completing spirometry on scoping review.
- Spirometry equipment needed in 9 practices.
- Inaccurate data recording across general practice, review of templates required.
- Staffing demand for in-house training outweighs nurses who can offer support and education.
- Health care professionals not trained to manage Paediatric asthma patients' annual reviews or provide spirometry testing if deemed appropriate.
- Respiratory Training/funding for ARTP and re accreditation some practices not supporting ongoing costs.
- Some practices not following all Wales management and prescribing guidance

- Not always providing good inhaler technique
- Time for assessment reviews, variable
- Promotion of Apps text dump bundles costs. Uptake poor.
- Pre-screening for COPD. Smokers.
- Asthma/Lung UK expert patient programmes, were previously supported with lottery funding.
- Housebound reviews/care home/residential home/Homeless not always on annual review but when there is an acute episode.

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	No	**Has outlier processes commenced:**	NA
Outlier information: (if appliable)			

Audit discussed at Directorate level:	Yes/No	**Date:** Scheduled for 30/5/23
Audit discussed at Division level	Yes/No	**Date:** Scheduled for 30/5/23
Action Plans agreed with Division/Directorate?	Yes/No	**Date:** Scheduled for 30/5/23
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date:** 30/5/23

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Clinical leads to investigate all issues around spirometry and support training and education over the next six months. • Investigate concerns with coding and develop templates over the next few months. • Continue ongoing work for respiratory pathway/asthma pathway with team. • Training and education to continue and develop via Academy.

When making your action plan, ensure the objectives are:
SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References:

1. Combined_benchm

2. COPD.Asthma%20-

Must be completed and presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

All audits MUST be registered and updates on AMaT

SECTION A

Title of Audit & Governing body:	National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Paediatric Asthma Secondary Care – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report		
Audit period	April 2020 and July 2021	**Case Ascertainment:**	
Local data available:	Yes	**Number of cases:**	211
Audit Rational:	NACAP supports individual clinical teams to make improvements in the quality of care they deliver. This report included a period during the COVID-19 pandemic, which stretched respiratory staff and services to their limits. Direct comparisons with previous reports should be interpreted with caution. Findings enable us to reflect and identify opportunities to restore and strengthen the provision of care for people living with asthma and COPD.	**Audit Objectives:**	State of the Nation - a view of the care of people with asthma & COPD in England & Wales. Combining data on asthma, COPD & pulmonary rehabilitation across primary and secondary care services for the first time. More than 9 million people are living with a diagnosis of asthma or COPD. NACAP aims to improve the quality of their care, services and clinical outcomes. By supporting and training clinicians, empowering people living with asthma and COPD and their carer's and informing policy.
Clinical Lead:	Dr Marcus Pierrepoint - Paediatrician in Child Health	**Division/ Specialty**	Respiratory

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	2. Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:
• For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care.

- For care to be provided to people with asthma and COPD within the recommended timeframe after hospital admission, to support optimal outcomes.
- For people with asthma and COPD to receive care by appropriately trained healthcare professionals, at each stage of their care pathway.
- Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:

Recommendation 1: Most children are not diagnosed in hospital and are diagnosed before they are capable of performing objective bedside tests on clinical grounds. Lack of spirometry facility in paediatrics outside special assessment clinics and is not a diagnostic tool within paediatrics. The Team recently had access to a Fractional exhaled Nitric Oxide (FeNO) machine as part of a multicentre research project, it is used in tertiary respiratory service assessments.

Recommendation 2: An asthma pathway has been shared with ED and has been working well for a number of months. The requirement to prescribe Prednisolone (steroid) within the first hour forms part of the core data and was 33% for ages 6-18 years old. One possibility is due to the clock starting on arrival at ED reception. There are delays with triage due to current pressures. Education with junior doctors in ED is being addressed.
The smoking status is not asked routinely across Wales, as the expectation of a child admitting to smoking in front of the parents is unlikely, this will also be addressed and included in the education pack.

Recommendation 3: Children being discharged 24/7 after respiratory attacks and lack of resource for specialist nursing staff available 24/7. The Health Board has 2.5WTE respiratory/allergy nurses to cover all aspects of respiratory medicine so can only support outpatients and cascade training. 98% of children with acute asthma get appropriately trained staff supervising inhaler techniques. Children requiring 3 courses of steroids or who have been through HDU and those that need >step 3 care get referred to our respiratory clinics.

Recommendation 4: There are different pressures on the care settings in relation to paediatric respiratory conditions. Educations sessions have taken place, predominately attended by primary care nursing staff, with only 1 or 2 GP's attending. Acknowledged more training of GP's needed. In terms of transition to adult services, these numbers are low with more manageable disease and varying profiles of the disease. Transition meetings have been explored however availability is a challenge and meetings have been held to discuss a way forward but not confirmed yet. Welsh Government transition tools are being used and we will educate to be more broadly used also used is an asthma hub, available via QR codes advertised widely and there is a 'wheezy' pathway for young children who are not define as asthmatic.

Aneurin Bevan University Health Board Successes:
• High number of children receive training for inhaler techniques.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• Time to receive prednisolone within the first hour if attendance within the Emergency Department. • Lack of resource for specialist nursing staff 24/7.

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	No	**Has outlier processes commenced:**	No
Outlier information: (if appliable) Alert/Alarm			

Audit discussed at Directorate level:	Yes/No	**Date: TBC**
Audit discussed at Division level	Yes/No	**Date: TBC**
Action Plans agreed with Division/Directorate?	Yes/No	**Date: TBC**
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date:**

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:

• Promulgate the asthma hub for parents.
• Asthma paediatric specialist meetings to review benchmarks.
• Planning an update of the asthma pathway:
  ○ Push for steroids in the first hour.
  ○ Highlight the smoking documentation.
  ○ Develop/utilize smoking advice for parents.
  ○ Sign off formally on the asthma education each time.

- Meet with the adult service to discuss transition.
- Explore FeNO.
- Look for opportunities to liaise with primary care.
- Ensure all CYPs with asthma get follow up, this is unlikely to be within 1 month.

When making your action plan, ensure the objectives are:
SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References:

1. CYP_benchmarking_2021-22.xlsx

2. COPD.Asthma%20-

SECTION A

Title of Audit & Governing body:	National Neonatal Audit Programme (NNAP) Summary report on 2021 data		
Audit period	2021	**Case Ascertainment:**	100%
Local data available:	Yes	**Number of cases:**	
Audit Rational:	It assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes	**Audit Objectives:**	The audit reports key outcomes of neonatal care (mortality, bronchopulmonary dysplasia, late onset bloodstream infection, necrotising enterocolitis and preterm brain injury), measures of optimal perinatal care (birth in the right place, antenatal steroids, antenatal magnesium sulphate, deferred cord clamping and normal temperature on admission), maternal breastmilk feeding (during admission and at discharge), parental partnership, neonatal nurse staffing levels, and other important care processes (screening for retinopathy of prematurity and follow-up at two years of age).
Clinical Lead:	Dr Sunil Reddy – Consultant Neonatologist Dr Susan Papworth – Consultant Neonatologist	**Division/Specialty**	Neonatology

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	2. Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:			
The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care and identifies areas for improvement. The 12 measures reported are:			
1	Antenatal steroids	**7**	Neonatal Nursing staffing

2	Antenatal magnesium sulphate	**8**	On time screening of retinopathy of prematurity (ROP)
3	Deferred cord clamping	**9**	Bronchopulmonary Dysplasia (BPD)
4	Temperature on admission	**10**	Breast milk at 14 days
5	Parental consultation within 24 hours	**11**	Breastfeeding at discharge
6	Parental presence at consultant ward rounds	**12**	Medical Follow up (F-Up) at two years

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:	
1	The Health Board has always been good at ensuring antenatal steroids are administered to women who deliver at 23-33 weeks gestation, with GUH at 95% compared the National Average (NA) of 92.1%.
2	Mothers receiving Magnesium Sulphate within 24 hours of delivery of babies born at less than 30 weeks, the Health Board is a little behind the NA at 81.1% compared to the NA of 86.9%. However, the Health Board has improved 10 approx. 18% from the previous year due to good team working with midwifery colleagues and Quality Improvement (QI) measures put in place.
3	Health Board Cord Clamping rates for the Health Board have always been on the low side which is negative.
4	Babies' temperature is important for their successful outcomes and the Health Board has completed so QI work to raise the level, which is now and improved 80% compared the NA of 73.2%.
5	Interaction and communication between Health Boards staff and the parents is vital and the Health Board has always performed well, currently 95.1% a little behind the NA of 96.3%.
6	Communication as part of the ward round is important the Health Board has improved obtaining 96.1%, more than 10% above the NA of 85.8%. The Health Board is focusing on integrated care with parents such as QI projects called 'delivery room cuddles'.
7	Staffing levels appropriate to guidelines is 59.7% compared to NA 73.9% and there are currently plans to look at this.
8	A colleague Ophthalmologist visits the ward to carry out retinopathy screening of babies born less than 32 weeks which has a target of 4 weeks, and when babies are discharged without screening, they are seen in clinic, which does impact Health Board performance. The NA is 95.4% and GUH 89.2%.

9	The Health Board has always had low Bronchopulmonary Dysplasia (BPD) rates and has been commended for this and asked to present data with advice on how this is maintained. This NNAP report shows the Health Board at 11approx.. 35% which is below the NA of 38%.
10	The Health Board has scope for improvement in terms of babies receiving mothers' milk. Currently at 51.9% compared the NA of 60.6% there are QI projects called 'Golden Drops'.
11	The Health Board and All Wales has always been behind the NA for early breast feeding and breast milk at discharge however the Health Board is moving in the right direction although remain behind the NA of 60.6% at 51.9%.
12	Babies born before 30 weeks who receive a follow up at gestational age of 2 years is 100% within the Health Board and the NA is 72.5%. The Health Board has been recognised as a positive outlier by NNAP for this measure.

Aneurin Bevan University Health Board Successes:

- Antenatal steroids NA 92.1% - ABUHB - 95%
- Antenatal Magnesium Sulphate NA 86.9% - ABUHB 91.1%
- Temperature on admission NA 73.2% - ABUHB 80%
- Parental presence at consultant ward round NA 85.8% - ABUHB 96.1%
- Parental consultation within 24 hours of admission NA 96.3% - ABUHB 95.1%
- Bronchopulmonary Dysplasia (BPD) NA 38.8% - ABUHB 34.9% (low result indicates success)
- Follow up at 2 years NA 72.6% - ABUHB 100%
- Cystic Periventricular Leukomalacia (cPVL) another brain injury from preterm births which can be linked to Cerebral Palsy, the Health Board is approx. 13% and again in the upper half of units reporting.

Aneurin Bevan University Health Board Concerns:

- Early breast-feeding NA 80.5% - ABUHB 70.3%
- Breast milk feeding at discharge NA 60.6% - ABUHB 51.9%
- On time screening of retinopathy of prematurity NA 95.4% - ABUHB 89.2% (due to discharge before screening, so seen in clinic)
- Neonatal nursing staffing levels NA 73.9% - ABUHB 59.7%
- Cord Clamping rates NA 43% - ABUHB 30.2% (the Health Board has always been on the low side which is negative, and the blood stream infection rates have also been low which is a positive).

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	No	**Has outlier processes commenced:**	NA
Outlier information: (if appliable) Alert/Alarm			

Audit discussed at Directorate level:	Yes/No	**Date: TBC**
Audit discussed at Division level	Yes/No	**Date: TBC**
Action Plans agreed with Division/Directorate?	Yes/No	**Date: TBC**
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date: TBC**

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:

1. Directorate to scope for improvement in breast feeding over next six months.
2. Directorate to scope for improvement in deferred cord clamping over next six months.
3. Directorate to scope for improvement in retinopathy screening over next six months.
4. Maternity Badgernet- commencing 2023
5. Perinatal optimisation program adoption over the next six months.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References:

1. NNAPPosterPDF_The GrangeUniversityHos

SECTION A

Title of Audit & Governing body:	Eighth Patient Report of the National Emergency Laparotomy Audit Dec 2020-Nov 2021 Royal College of Anaesthetists		
Audit period	Dec 2020 - Nov 2021	**Case Ascertainment:**	100%
Local data available:	Yes	**Number of cases:**	331 (One of the largest services)
Audit Rational:	8th annual NELA report. It examines care received by NHS patients in England and Wales undergoing emergency laparotomy (emergency bowel surgery) 1.12.20 and 30.11.21. The pandemic continued to have a significant impact on patients, staff, and hospitals during this period, and maintaining adequate staffing levels was a major challenge. Recognition and applause for maintaining high standards of care for patients. The dedication of clinical teams in achieving this is commended.	**Audit Objectives:**	Specific concerns remain around delays in pathways of care for many patients between time of arrival in hospital and definitive surgical intervention. Time to administration of first antibiotics, and overall time to arrival in theatre are unacceptably long and detrimental for many patients with suspected intra-abdominal infection. Surgeons, emergency and general physicians, radiologists, anaesthetists, intensivists and geriatricians, together with their respective hospital management teams, are encouraged to work together near address these delays.
Clinical Lead:	Dr Helen Williams - Anaesthetics Dr Babu Muthuswamy - Intensivist Miss Charlotte Thomas – General Surg Dr Sara Long - Geriatrician	**Division/Specialty**	Anaesthetics, Intensivist, General Surgery, Care of the Elderly

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	2. Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action

Recommendations:	
1.1	Hospitals should continue to engage further with NELA data collection. In particular, make use of real-time data and resources available from NELA to drive clinical and service quality improvement. These include quarterly hospital, regional and national data reports; excellence and exception case-reporting tools; and process measure and mortality monitoring tools available via the NELA website.

1.2	Funded time within consultant job plans should be available to support invaluable work and contributions by members of clinical teams in collecting data, and coordination and service improvement overseen by NELA surgical, anaesthetic, radiology and emergency medicine local clinical leads. This requires trust/health board recognition of the value of this work.
1.3	Trusts and health boards should support NELA data collection and analysis with funded audit and governance assistance.
2.1	Ensure NELA leads for radiology are appointed in each department, with specific job planned time to facilitate coordination of multidisciplinary review meetings and radiology events and learning meetings (REALM). Conclusions should be shared where applicable with providers of outsourced reporting services.
3.1	Multidisciplinary teams in emergency, surgical, perioperative, acute and critical care should work to produce and implement locally agreed optimised pathways of care, with the aim of streamlining diagnosis with as little delay for patients as possible.
4.1	Clinical teams should be supported by management teams to work together to identify where and why existing standards around antibiotic administration are not being met.
4.2	Clinical teams should establish and introduce locally agreed pathways for administration of antibiotics preoperatively for those with suspected intra-abdominal infection or sepsis, following guidance around timeliness from the Academy of Medical Royal Colleges and the Surviving Sepsis Campaign.
4.3	Clinical/nursing teams should ensure that locally agreed pathways support the administration of antibiotics, without delay, at the time of prescribing.
5.1	Surgeons, anaesthetists and intensivists should ensure a formal assessment of mortality risk has been performed around the time of decision to operate, taking into account the significant impact of frailty.
5.2	Clinical teams should not hesitate to refer a high-risk patient for postoperative monitoring in critical care, even if not currently critically ill.
5.3	Trusts/health boards should ensure critical care capacity is able to meet demand. Any critical care capacity shortfall should be reviewed as part of departmental and hospital-level clinical governance.

6.1	A formal assessment of frailty should be performed for all patients aged 65 or over.
6.2	Surgeons, anaesthetists and intensivists should ensure frailty has been taken into account when assessing the mortality risk of their patients as the NELA risk score does not take frailty into account.
6.3	Trusts/health boards should work towards improving capacity for experts in elderly care to review all elderly, frail and vulnerable patients postoperatively. This liaison work on surgical wards should happen on a systematic and consistent basis rather than in an ad hoc manner. In many hospitals this goal is likely to require specific trust/ health board support and funding.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:

- In-hospital mortality rate has not been published in the report; however, the Health Board's numbers for year 8 was 28 deaths and year 9 recorded 32 deaths. All deaths are reviewed with no areas of concern. The deaths are high risk patients with other co-morbidities.
- During 2022 set up bi-monthly M&M meetings and the Health Board is fortunate to also have an ED Lead, Dr James where ED have been doing some QI work to improve sepsis screening, also inviting staff from SAU to the M&M meetings to learn from their experiences.
- Single site working has improved results, but there is still room for further improvement.
- Require better flow plans, with patient transfers for Critical Care Unit (CCU).

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:

- Documented risk factors recorded preoperatively for the Health Board are green at 88.5% year 8 and expected higher at 94.9% for year 9 data.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:

- Preoperative CT with Year 7 data reported by in house consultant 63.2%, Year 8 reduced to 53.8%. Year 9 not expected to show any better.
- Access the theatre for the Health Board 61.3%, below the National Average (NA) of 71.8%.
- Preoperative input by clinical staff – Cons Surg & Anaes - 74.5%, Surgeon only – 81.2% (expected over 95% for yr 9), Anaes only – 80% (expected over 95% for yr 9) and intensivist 50.9% (expected yr 9 73%).
- 55.6% of ABUHB patients had a decision to operate within 24 hours of admission. This is difficult to interpret as some patients are managed medically initially and then develop to requiring surgical intervention.

- High risk patients who have a risk of death >5% with consultant surgeon (84.2%), consultant Anaesthetist (88.5%) or both (77.6%) in theatre for year 8 (all set to improve for yr9).
- Older patients or those assessed as high risk seen by a geriatrician is 7% for this reporting period, however due to the input of Dr Sara Long, Consultant Geriatrician, this has increased to 64% for year 9 data.
- Admissions to critical care for patients with an estimated mortality of >5%, with the NELA target 80% and the Health Board year 8 result is 70% with year 9 increasing to 74%.
- Length of Stay (LoS) deteriorated within the Health Board however remains better than the NA.

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	No	**Has outlier processes commenced:**	No
Outlier information: (if appliable) Alert/Alarm			

Audit discussed at Directorate level:	Yes/No	**Date: TBC**
Audit discussed at Division level	Yes/No	**Date: TBC**
Action Plans agreed with Division/Directorate?	Yes/No	**Date: TBC**
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date: TBC**

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
1. Business case being explored for Dr Long's role to continue improving >65 and frail and >80-year Multidisciplinary Team meeting (MDT).
2. ICU lead is to write to the CD for critical care lead and divisional director for scheduled care outlining our concerns.
3. QI work on antibiotic administration in patients with suspected sepsis.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References:

1. Reports - National Emergency Laparotomy Audit (nela.org.uk)

2. NELA%20Year%208%20Annual%20RAG%

3. CSEG%20NELA%20Presentation%2023032

Title: National Prostate Cancer Audit Annual Report 2021Results of the NPCA Prospective Audit in England and Wales for men diagnosed from 1 April 2019 to 31 March 2020 and the Impact of COVID-19 in England during 2020

Code: GS/CA/2019-20/02

Date registered: 01/03/2023

Speciality: General Surgery

Other associated specialities: N/A

Business unit: General Surgery

Division: Scheduled Care

Is your project related to particular sites?: No

Is your project related to particular wards/areas?: No

Category: National (NCAORP)
Quality, Safety and Outcomes Committee

Reported type(s): Clinical Standards Effectiveness Group, Patient

Lead participant: Adam Cox

Audit lead: Charlotte Thomas

Rationale

The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales. The audit determines whether prostate cancer care is consistent with current recommended practice, and it provides information to support healthcare providers, commissioners, regulators, patient groups and patients in helping to improve prostate cancer diagnosis and treatment.

Objectives

This report presents results from the prospective audit for men diagnosed with, or treated for, prostate cancer between 1st April 2020 and 31st March 2021 in England and Wales. 4 The basis of the audit is routine data sources. However, this year, as last year, data flows have been subject to COVID19-related disruption and standard (fully processed) cancer registration data for the reporting period are currently unavailable.

Guidance

Code	Title
NG131	Prostate cancer: diagnosis and management (May 2019)

Project progress

Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	25/05/2023 14:00	Teams	Awaiting approval

Results

The Clinical Lead (CL) stated that the Health Board has a larger proportion of metastatic disease, Performance Indicator 1 (PI1), at 30% compared to the 17% National average.

Disease Presentation

	Specialist MDT	National
No. of men with disease status determined	178	23477
Percentage of men diagnosed with metastatic disease	30%	17%
No. of men diagnosed with M1 (metastases)	54	N/A

PI2, the proportion of patients who had an emergency readmission within 90 days of radical prostate cancer surgery is reported as 24% (21 cases), AC stated that this figure is not accurate as there is not ¼ readmitted and hasn't seen anyone readmitted within the last 3 years. AC looked at local data and states the number of cases is between 60-65 cases every year, not 21 as the report states. If the Health Board had their own robot, these numbers would be higher, but the anaesthetic team will not allow patients to be operated on in UHW if they are of questionable fitness.

Outcome

	Treatment Centre
No. of men who received radical prostatectomy (2020-2021)	21
Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy (%)	24%
No. of men who received radical prostatectomy (2019)	58
Adjusted percentage of men experiencing at least one GU complication (%)	10%

The CL stated that PI3, the proportion of patients experiencing at least one genitourinary (GU) complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy is inaccurate and the data requires investigation as the expected result is about 1-2%.

Outcome

	Treatment Centre
No. of men who received radical prostatectomy (2020-2021)	21
Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy (%)	24%
No. of men who received radical prostatectomy (2019)	58
Adjusted percentage of men experiencing at least one GU complication (%)	10%

There is no local data for PI4, the proportion of patients receiving a procedure of the large bowel and a diagnosis

indicating radiation toxicity (gastrointestinal (GI) complication) up to 2 years following radical prostate radiotherapy as these are seen in Velindre and recorded as Cardiff & Vale UHB.

PI5 the proportion of men with low-risk localised prostate cancer undergoing radical prostate cancer therapy is reported as 1 patient, 4.2% (n. 24), more patients are placed on active surveillance. PI6 the proportion of men with locally advanced disease receiving radical prostate cancer, the Health Board is 75.1% compared the Wales average of 72.3%.

Specialist MDT	Performance indicator 5			Performance indicator 6		
	No. of men diagnosed with low-risk localised disease	No. of men with low-risk localised disease receiving radical treatment		No. of men diagnosed with locally advanced disease	No. of men with locally advanced disease receiving radical treatment	
		N	%		N	%
Overall	92	8	8.7	487	352	72.3
Aneurin Bevan University Health Board	24	1	4.2	48	37	75.1
Betsi Cadwaladr University Health Board	5	0	0.0	161	119	73.3
Cardiff and Vale University Health Board	40	4	10.0	94	80	81.7
Swansea Bay University Health Board	23	3	12.0	184	116	65.3

The issues with data reported may change with the new iteration of CANISC, this would need to be clarified by Cancer Services. The CL stated that the number of men with prostate cancer diagnosed for a year in the Health Board is approximately 180, which is more cases than the average centre. There are concerns from clinicians in other Health Boards.

The CL confirmed that the local data requires further investigation for accuracy, however this requires the appropriate workforce which currently is not in existence.

Through the pandemic the Health Board ceased MRI as suspected high mode of transmission of COVID-19 and there was a halt to surgery.

The CL informed the group that surgery is performed by a Health Board collective team at Cardiff and Vale UHB premises as

there is a surgical robot where 90-95% of the Health Boards cases go for surgery. The divisional management stated that a business case has gone to PIP and will go to Executive Board early June, to secure a surgical robot for use at the Health Board. It was discussed that the robot would improve waiting lists, reduce Length of Stay (LoS) and improve patient outcomes therefore it is financially viable.

Assurance & risk

Assurance Assurance not selected.

Risk

Risk not selected.

Key successes & concerns

Successes

Description
The proportion of men with locally advanced disease receiving radical prostate cancer, the Health Board is 75.1% compared the Wales average of 72.3%.

Concerns

Description
Data reported is not accurate and there are concerns flagged from other Health Boards. Linking with Cancer data to improve accuracy.
Emergency re-admission rate within 90 days of radical prostate cancer surgery is reported at 24% (21 cases) this is not the case as a re-admission has not been seen in the last 3 years.
More case of radical prostate cancer surgery happen that is reported, local data evidences 60-65 cases (not 21 as reported)
The proportion of patients experiencing at least one genitourinary (GU) complication requiring a procedural/surgical interventior within 2 years of radical prostatectomy is inaccurate and the data requires investigation as the expected result is about 1-2% not 10% as reported. Poor data is being escalated via information to review data capture.

Action plan

	National Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
1	R17 Review of the NPCA indicators for providers should be undertaken within the region and nationally, and fed through to providers. Pay particular attention to variations in service provision (diagnostics, treatment and support services) and treatment outcomes. Where variation is apparent, agree quality improvement action plans and present these to the Trusts and Health Boards which should put in place follow-up procedures to monitor the implementation of practice changes to address problems identified.	To Contact NPCA and SBUHB to discuss the data published versus local data/ CANISC to ensure accuracy of data within the next annual report published early 2024.	Mr Adam Cox	01/06/2023	20/07/2023		Partially complete
2	R17 Review of the NPCA indicators for providers should be undertaken within the region and nationally, and fed through to providers. Pay particular attention to variations in service provision (diagnostics, treatment and support services) and treatment outcomes. Where variation is apparent, agree quality improvement action plans and present these	Chase up on contact with Head of Cancer Services for Wales for discussion regarding data immediately	Mr Adam Cox	01/06/2023	20/07/2023		New

	to the Trusts and Health Boards which should put in place follow-up procedures to monitor the implementation of practice changes to address problems identified.						

Clinical Audit Summary Checklist:		
Date of CSEG attendance:	25th May 2023	
Risk register (as above) Provide details:		CL asked to provide assurance and risk (27/06/2023) – Made contact for update.
Action plan signed off by Directorate:		
Patient Centred Care Group comments:		
Llais involvement:		
Specific, **M**easurable, **A**chievable, **R**elevant, **T**ime actions **MUST** be updated on AMaT		

Title: Fracture Liaison Service Database

Code: Med/CA/2020-21/01

Date registered: 14/02/2023

Speciality: Medicine

Other associated specialities: Rheumatology

Business unit: General Medicine

Division: Medicine

Is your project related to particular sites?: No

Is your project related to particular wards/areas?: No

Category: National (NCAORP)

Reported type(s): Clinical Standards Effectiveness Group

Lead participant: Inder Singh

Audit lead: Andrew Yeoman

Rationale

A fracture liaison service (FLS) ensures that patients aged 50 and over with a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture.

Objectives

Made up of a team of healthcare professionals, FLSs bring clear benefits to the patient in the long term and have been shown to be clinically and cost-effective.

Guidance

Code	Title
CG161	Falls in older people: assessing risk and prevention
CG146	Osteoporosis: Assessing the risk of fragility fracture

Presentations

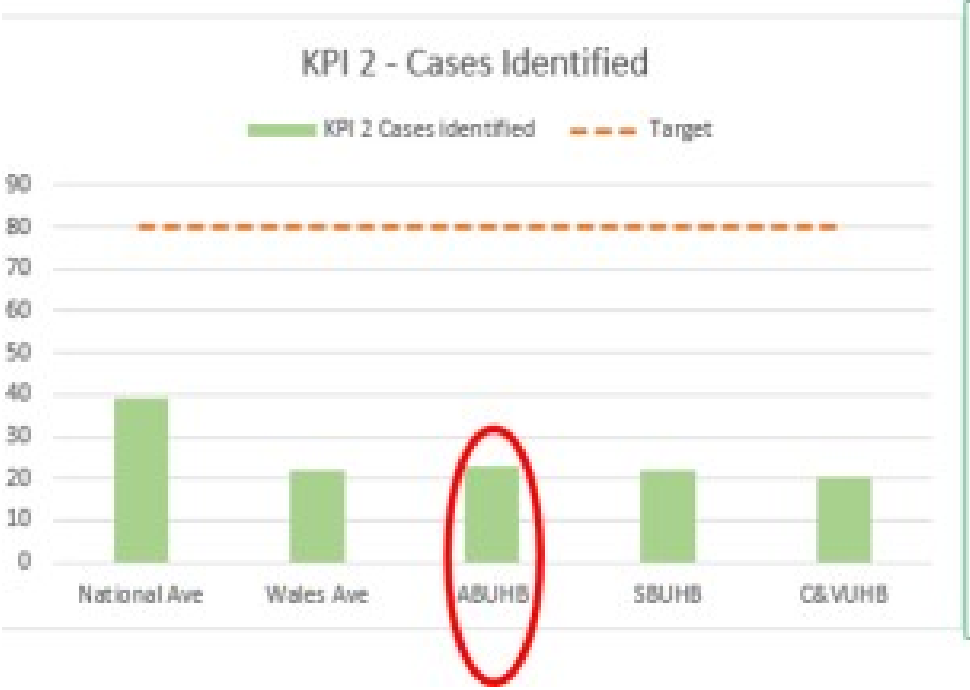
Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	25/05/2023 14:00	Teams	Awaiting approval

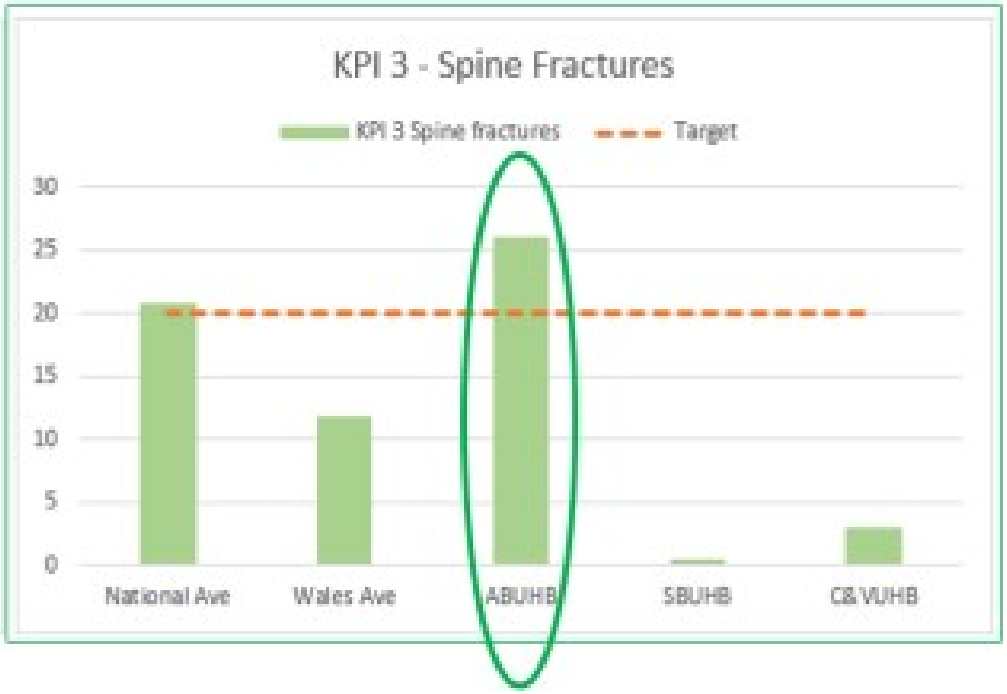
Results

Identification KPIs 2 and 3

KPI 2 - All FLSs submitting less than 80% of their expected caseload to the FLS-DB should review the underlying causes for this and agree an action plan to improve identification rates - **ABUHB performing at 22.7%**

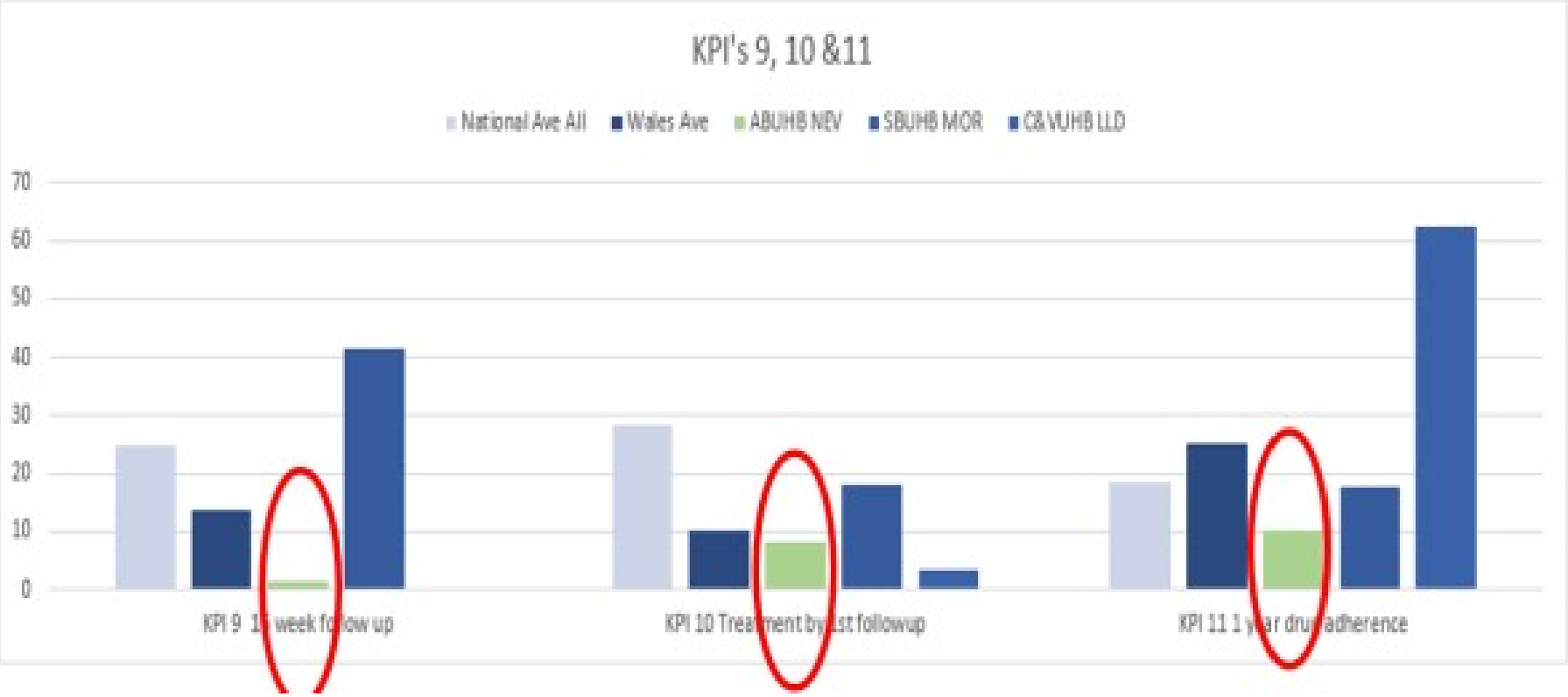
KPI 3 - All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee, given that they have a higher risk of subsequent fractures - **The target is 20% with ABUHB above target at 26.1%**





Monitoring, follow up and adherence (KPIs 9, 10 and 11)

All three KPIs for monitoring and follow up have improved in 2021 in comparison with 2019. For example, the percentage of patients who were followed up within 16 weeks of their fragility fracture has increased from 41% in 2019 to 47% in 2021 – **These performance targets in ABUHB are much lower than the National Average (NA)**

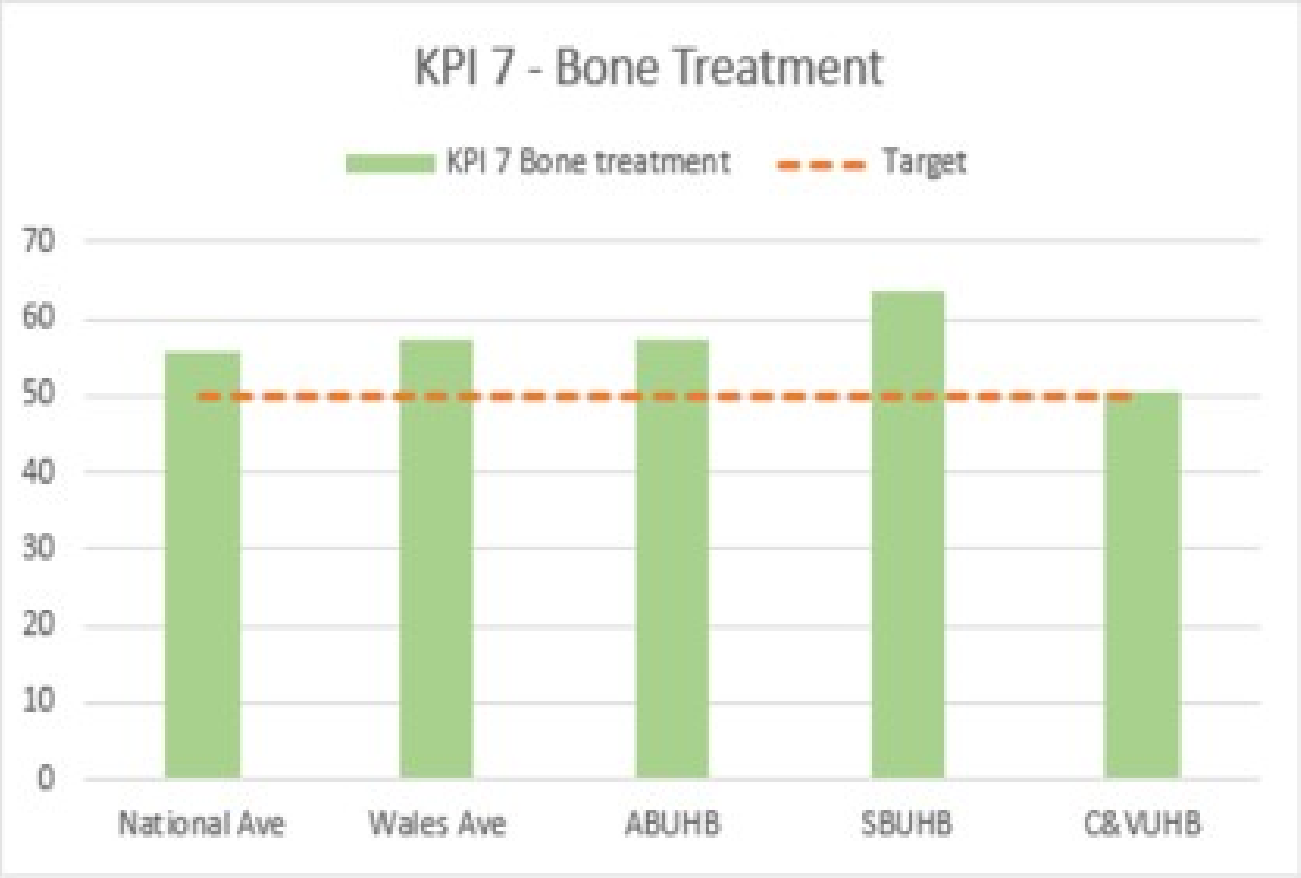


Bone therapy recommended (KPI 7)

More patients were recommended anti-osteoporosis medication in 2021 than in 2019 (56% vs 52%).

Once we identify a fragility fracture, we do commence treatment

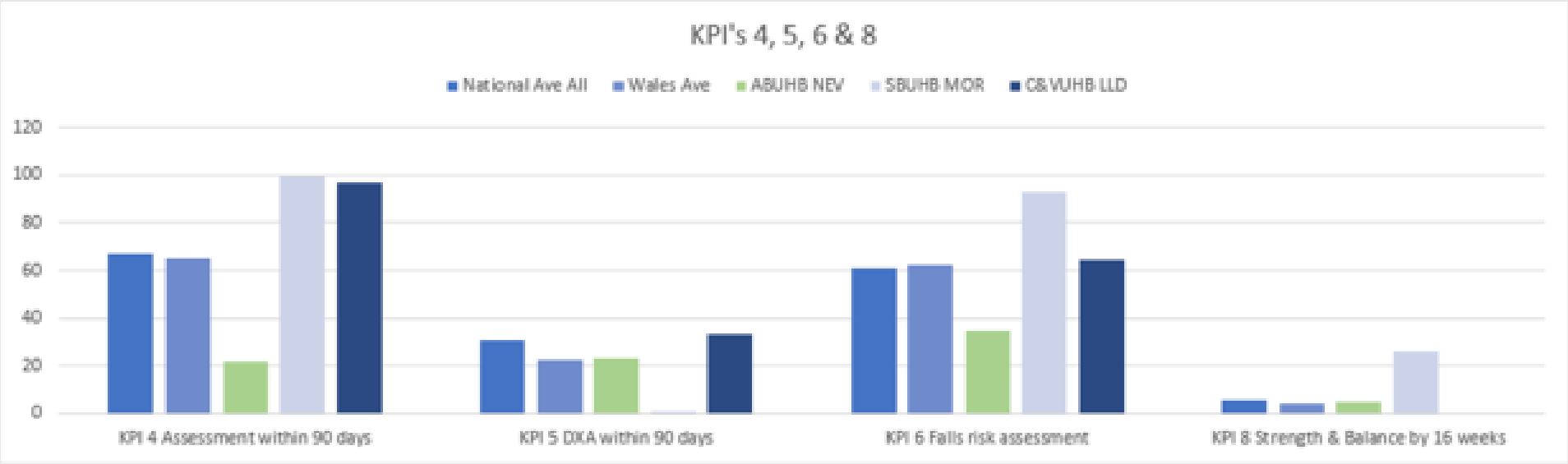
ABUHB is performing at the Welsh average of 57.5% which is better than the National Average of 55.8%



Missed opportunity for ABUHB

- We identified – 22% of patients (n=875) (missed 58% as per rule) – **Expected fragility fractures – ABUHB = 3875**
- We treated 56% - so treated 12% of identified patients
- We reviewed 1.4% patients at 16 weeks = 0.1% patients reviewed at 16 weeks
- We reviewed 10.1% - one year drug adherence = 1.2%

- Missed opportunity = 99%



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Written Statement: Update on Fracture Liaison Services in Wales (24 February 2023) | GOV.WALES

Home > Announcements > All announcements > Written Statement: Update on Fracture Liaison Services in Wales

CABINET STATEMENT

Written Statement: Update on Fracture Liaison Services in Wales

Eluned Morgan MS, Minister for Health and Social Services

First published: 24 February 2023
Last updated: 24 February 2023

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I am issuing this statement to ensure Members are aware of the commitment to achieving 100% coverage for all health boards by Fracture Liaison Services (FLS) and to strengthen the mandate to support the development of services in this area. I expect health boards to achieve 100% by September 2024.

A fracture liaison service ensures that patients aged 50 and over with a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture. Made up of a team of healthcare professionals, fracture liaison services bring clear benefits to the patient in the long term and have been shown to be clinically and cost-effective.

In early 2022, officials surveyed the provision of fracture liaison services. This data showed significant variation and room for improvement and, together with strong campaigns from the third sector and patients, led to the inaugural Wales Fracture Liaison Service Conference being held on 20 October 2022.

WG expects all Health Boards to achieve 100% coverage by September 2024

Assurance & risk

Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Add to risk register: Yes

Key successes & concerns

Successes

Description
KPI 3 Spine Fracture - A major improvement was observed both in comparison to the previous and also against the national benchmark for spine fracture improved from 26% to 35% (National average=21%);
KPI 7 Bone Treatment - Bone treatment improved from 58% to 66% (National average=54%)

Description
FLS-DB showed 42.6% (n=1651) patients identified in the year 2022, Case volume has increased by 88% compared to previous year 2021
Process mapping supported the establishment of the two FLS-DB pathways: Rheumatology team to provide care for patients under 75 with the current Clinical Nurse Specialist (CNS) and COTE team to assess all patients above 75 years. Medical Division supported the pilot for 12 months by funding two new CNS. Collaboration with the Radiology assisted to generate separate weekly fracture data for the Rheumatology and COTE teams.
Falls assessment improved from 35% to 81% (National average=61%)

Concerns

Description
KPI 2 Cases identified - Only 22.7% (n=879) of patients were identified by the FLS team, Aneurin Bevan University Health Board, Wales in 2021 (National average=40%).
KPI 4 Assessment within 90 days
KPI 5 DXA within 90 days
KPI 6 Falls Risk Assessment
KPI 8 Strength and Balance by 16 weeks
KPI 9 - 16 weeks Follow Up

KPI 10 - Treatment by first Follow Up
KPI 11 - 1 year drug adherence - with ABUHB, we are not able to review patients at 1 year and currently working to improve for follow ups
Cases remains lower than the national recommendation of 50% (currently seeing 43% in ABUHB)
Further resource required for CNS/Admin
Wider partnership with radiology and T&O and A&E to identify new fragility fractures

Action plan

	Recommendation (s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
1	To write a business case	Write a business case for CNS support and Admin support for the team and review consultant sessions	Dr Inder Singh	30/03/2023	01/09/2023		New
2	To write a business case	We will continue to collaborate with the ROS and ensure that Health Board's focus on the strategic planning for the FLS is delivered	Dr Inder Singh	11/04/2023	01/09/2023		New
3	To write a business case	Medical Division is supporting us with the two WTE CNS and have funded and have supported us to write a business case. The initial results of the pilot have already supported the further extension of the pilot for another year with the aim of improving drug adherence by engaging with the Community and Primary care teams. This pilot also highlights the importance of improving culture and multi- professional awareness of fragility fractures and FLS.	Dr Inder Singh	11/04/2023	01/09/2023		New

Clinical Audit Summary Checklist:			
Date of CSEG attendance:	25th May 2023		
Risk register (as above) Provide details:	**Yes**	**Limited Assurance**	Major Risk under review with Division
Action plan signed off by Directorate:			
Patient Centred Care Group comments:			
Llais involvement:			
Specific, **M**easurable, **A**chievable, **R**elevant, **T**ime actions **MUST** be updated on AMaT			

Title: National Lung Cancer Audit (NLCA) State of the Nation Report 2023

Code: GS/CA/2020-21/02

Date registered: 27/04/2023

Speciality: General Surgery

Other associated specialities: N/A

Business unit: General Surgery

Division: Scheduled Care

Is your project related to particular sites?: No

Is your project related to particular wards/areas?: No

Category: National (NCAORP)**Reported type(s):** Clinical Standards Effectiveness Group

Lead participant: Mat Jones

Audit lead: Charlotte Thomas

Rationale

The aim of the NLCA is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales, and to support services to improve the quality of care for these patients. National guidelines underpin the management of patients with lung cancer and the NLCA evaluates current patterns of care against these standards.

Objectives

The NLCA is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) is response to the need for better information about the quality of services and care provided to patients with prostate cancer in England and Wales.

Guidance

Code	Title
QS17	Lung cancer in adults (March 2012)

Presentations

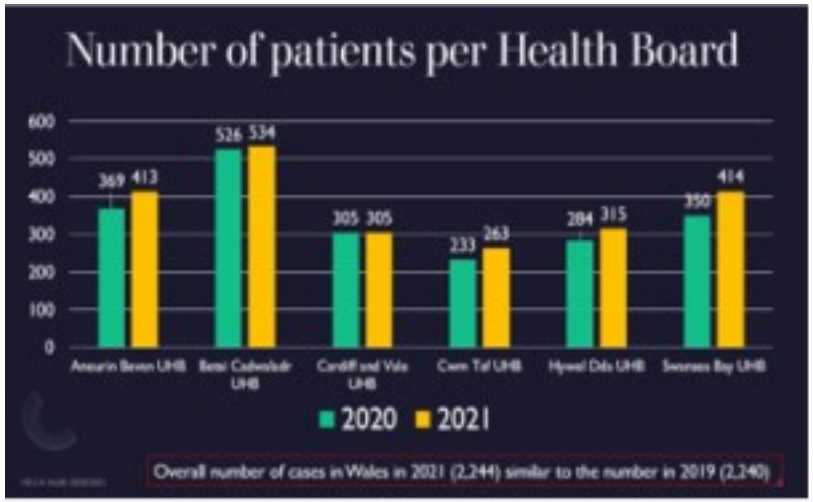
Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	25/05/2023 14:00	Teams	Awaiting approval

Results

The Clinical Lead for this audit is Mr Mat Jones and the Health Board (HB) has a large Multidisciplinary Team (MDT) diagnosing over 400 cases for Lung Cancer per year, and the HB is the second largest MDT in Wales. The majority of patients are referred with end stage disease and with multiple co-morbidities placing a strain on the workforce. Early stage across Wales is very similar.

This data relates to 2020-2021 during the pandemic and is the first publication since the HB joined two MDT's, NHH and RGH, which had been pursued for a few years previously.

Data shows reduced numbers during 2020 and increased in 2021 and the HB is performing well in relation to Data Quality Indicators (graph below). The HB MDT are reliant upon Velindre Cancer Centre for oncology support and Cardiff & Vale for surgical support, this is where data integrity can cause issues.



The Performance Status (PS) is based on what the patient can do day to day and frailty index. This determines the type of investigations patient can tolerate and reflect their overall health status, the majority of the HB patients presented with stage

two disease.
PS three and four, the HB is lower than the mean across Wales, and for PS two, the HB is above the Welsh mean.

ECOG PERFORMANCE STATUS

ECOG Performance Status
Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.*

GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair
5	Dead

*Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol. 1982;5:649-655.

The target is high for patients with pathological confirmation of early-stage disease, Good PS lung cancer at 90% with the Health Board at 73% in 2020 and 75%, with the Wales mean at 83.3% and 84.8% for the same years, other characteristics of the patient can influence this result. For surgical resection target at 17%, however the HB was 11.5% and 9.5%, versus the Wales mean of 11% and 13.2%, below NLCA targets for both years, declining in 2021. The only HB performing well is Betsi Cadwaladr UHB. It is notable that this is the only HB where surgery is carried out in England.

Patients with Stage I/II with PS 0-1
Confirmed pathological staging

- ABUHB patients with pathological confirmation of early stage, good PS lung cancer below All Wales mean in both 2020 and 2021:
  - 2020 (n=44): 73.9% Wales mean = 83.3%
  - 2021 (n=42): 74.5% Wales mean = 84.8%
- NLCA target is ≥ 90%
- Lowest proportion within any health board in Wales

Needs exploratory audit of data compared to NLCA target and then set recommendations

NSCLC patients having surgical resection

- ABUHB patients with NSCLC having surgical resection:
  - 2020 (n=38): 11.5% Wales mean = 11%
  - 2021 (n=35): 9.5% Wales mean = 13.2%
- NLCA target is ≥ 17%
- Significantly below NLCA targets for both years, declining in 2021
- Are patients receiving other means of radical treatment with radiotherapy?

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage I/II with PS 0-2 having curative treatment

- ABUHB patients with good performance status, early stage NSCLC having curative treatment:
  - 2020 (n=75): 66.7% Wales mean = 66.1%
  - 2021 (n=73): 56.9% Wales mean = 64.8%
- NLCA target is > 80%
- Significantly below NLCA targets for both years, declining in 2021
- Could this relate in part to higher proportions of patients with PS2 not receiving curative treatment
- ? Integrity of data ? effect of co-morbidities/patient choice

Role of pre-habilitation in these patients (particularly PS2)

Needs exploratory audit of treatment and decisions and then set recommendations

SCLC patients having chemotherapy

- ABUHB patients with SCLC receiving chemotherapy:
  - 2020 (n=32): 50% Wales mean = 57.5%
  - 2021 (n=37): 67.6% Wales mean = 70.82%
- NLCA target is > 70%
- Below NLCA targets for both years, improving in 2021 - ?Covid related
- Highly variable presentation with differences in PS and stage of disease potentially accounting for differences

Need to ensure rapid prioritisation of patients for investigation and treatment

NSCLC patients Stage IIIA with PS 0-2 having curative treatment

- ABUHB patients with good performance status, Stage IIIA NSCLC having curative treatment:
  - 2020 (n=29): 44.8% Wales mean = 46.8%
  - 2021 (n=41): 31.7% Wales mean = 48.6%
- No set NLCA target - England mean = 60% in 2021
- Declining proportion of patients in 2021 compared to 2020
- Could this in part relate to higher proportions of patients with PS2 not receiving treatment
- ?Integrity of data ?effect of co-morbidities/patient choice

Heterogeneous population of patients with expanding treatment options

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage IIIB/IV with PS 0-1 having SACT

- ABUHB patients with good performance status, Stage IIIB NSCLC having SACT:
  - 2020 (n=69): 50.7% Wales mean = 52.5%
  - 2021 (n=68): 48.5% Wales mean = 56.6%
- NLCA target: > 60%
- Below NLCA target and Wales mean in both years
- Could this relate to delays in obtaining pathology results on patients, oncology access, patient choice – many potential aspects to explore

Needs exploratory audit of treatment and decisions and then set recommendations

Non-Small Cell Lung Cancer (NSCLC) patients Stage I/II with PS 0-2 having curative treatment, are below NLCA targets for both years, declining in 2021, at 56.9% compared the Wales mean of 64.8% and the target of 80%. The Stage IIIA with PS 0-2 having curative treatment has no set target although England's mean is 60% and the HB saw a decline in 2021 compared to 2020 and 2021 by almost half. The Welsh mean of 60.6% at 31.7%. This could be low for many reasons such as HB access to oncology, access to treatment options for these patients, effects of comorbidities, patient choice, documentation of data and potentially not offering patients curative therapy.

NSCLC patients Stage IIIB/IV with PS 0-1 advanced disease where it's metastatic, spreading to outside of the lungs, having Systemic Anti-Cancer Therapy (SACT) below NLCA target and Wales mean in both years, this can also be impacted on by other factors such as co-morbidities and the HB has delays in the pathology pathway and rely on sending samples to Cardiff, if this was done within the HB, this would speed up the pathway getting results to patients quicker and possibly providing an option for oncological intervention before deteriorating to a lesser PS. Possible issues regarding therapeutic nihilism and patient choice, for exploration.

Small Cell Lung Cancer (SCLC) is below NLCA targets for both years, improving in 2021 in the HB and across Wales. There is a need to ensure rapid prioritisation of patients for investigation and treatment.

The HB currently has 5, and not all WTE, Lung Clinical Nurse Specialists (LCNS) working tirelessly to back up the service daily, and the number of patients seen exceeds the NLCA target of >90%.

Patients diagnosed after emergency admission has always been about 40-50% and it was surprising to see a reduction to 6.3% in 2021, which saw the patients as a referral of an inpatient by a consultant, which is then not captured as part of this, so highlights data integrity issues. Patients who present as an emergency presentation usually often have greater co-morbidities and poorer performance status. This will be investigated when validating the data for the 2022 report.

Patient with adjusted one year survival rate for the HB is low and of concern and requires investigating the factors driving these figures.

Bench marking across the network area and comparisons against other HB's, does not take into account the vast populations differences in South Wales. The bench marking target has increased every year and is an indication that we should be treating

Lung Cancer more aggressively but does not wholly take into account deprivation and co-morbidities or the differences in what treatment is appropriate based on individual patient circumstances.

Conclusions

Exploration analysis and recommendations for practice required.

Assurance & risk

Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Risk level	Description
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved

Add to risk register: **Yes**

Key successes & concerns

Successes

Description
Successes: • Merging of MDTs across health board • Structured and streamlined services with adoption of Lung Cancer Physician of the Week (LCPOW) • High throughput of patients from multiple referral sources • Excellent input to patient care from nurse specialists

Concerns

Description
Concerns: • High proportion of PS 2 patients • Low proportion of confirmed pathological staging for good PS, early stage disease. Reviewing plan • Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy, NSCLC Stage IIIA and NSCLC advanced stage good PS treated with SACT • Issues on data integrity – sources, validation

Action plan

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
1	1. Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and COSD in England. - Completeness should be at least 95% for performance status (PS), ethnicity and disease stage, and at least 90% for "trust first seen", route to diagnosis, seen by a lung cancer clinical nurse specialist (LCNS) at diagnosis and smoking status (to highlight inequalities and inform future strategies).	· Explore the data integrity	Mr Mat Jones	20/06/2023	31/12/2023	●	New
2	1. Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and COSD in England. - Completeness should be at least 95% for performance status (PS), ethnicity and disease stage, and at least 90% for "trust first seen", route to diagnosis, seen by a lung cancer clinical nurse specialist (LCNS) at diagnosis and smoking status (to highlight inequalities and inform future strategies).	Discuss at MDT	Mr Mat Jones	20/06/2023	08/06/2023	●	Fully Complete

	2. Ensure at least 85% of patients with stage I/II PS 0–2 NSCLC undergo curative intent treatment in line with NICE guidance. 3. Ensure at least 70% of patients with NSCLC stage IIIB-IV and PS 0-1 receive systemic anti-cancer therapy in line with NICE guidance. 4. Ensure at least 90% of lung cancer patients are seen by a lung cancer clinical nurse specialist at diagnosis. NHS 5Resource lung cancer MDTs according to the commissioning guidance set out by the Lung Cancer Clinical Expert Group, and update the guidance to reflect current best practice.						

Clinical Audit Summary Checklist:			
Date of CSEG attendance:	25th May 2023		
Risk register (as above) Provide details:	**Yes**	**Assurance - Limited**	**Risk - Minor**
Action plan signed off by Directorate:			
Patient Centred Care Group comments:			
Llais involvement:			
Specific, **M**easurable, **A**chievable, **R**elevant, **T**ime actions **MUST** be updated on AMaT			

National Clinical Audit reporting template (AMaT) - NBoCA

Title: **National Bowel Cancer Audit Annual Report 2022**

Date registered: **16/02/2023**

Category: **National (NCAORP)**

Speciality: **General Surgery**

Division: **Scheduled Care**

Lead participant: **Keshav Swarnkar**

Audit lead: **Usman Khan**

Rationale
The NBOCA aims to describe and compare the quality of care and outcomes of patients diagnosed with bowel cancer in England and Wales

Objectives
The NBoCA collects data on items which have been identified as good measures of clinical care

Guidance	Title
NG151	Colorectal cancer (January 2020)

• Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	20/07/2023 14:00	Teams	Awaiting approval

Results - Key Findings

Chapter 3 – Quality Improvement (QI)

- The proportion of hospitals/trusts/MDTs meeting each local NBoCA QI target has reduced for 7 out of 10 targets during the COVID-19 pandemic compared to the previous audit period. This is most marked for the 18-month unclosed diverting ileostomy QI target.
- The local QI targets with the highest proportion of hospitals/trusts/MDTs meeting the targets are 2-year survival (98%) and 90-day post-operative mortality (96%).
- The local QI target with the lowest proportion of hospitals/trusts/MDTs meeting it is "the proportion of patients seen by Clinical Nurse Specialist (CNS)" (31%).

QI Metric	Local Target	RGH	NHH
Proportion of patients seen by Clinical Nurse Specialist (CNS)	< 10%	89%	97%

- In the last audit period (2019/20), of those hospitals/ trusts/MDTs with information for all 10 local QI targets, 8% met all 10 targets, 44% met 9 or more targets and 72% met 8 or more targets. During this audit period (2020/21), 3% met all 10 targets, 18% met 9 or more targets and 53% met 8 or more targets.

Key:
> 80%
50 - 80%
< 50%

Data Submission- Quality

Data Quality	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021
Total number of patients	300	302	140	71
Case Ascertainment	Good	Good	Good	Good
TNM staging	100%	81%	100%	92%
Performance status	100%	100%	100%	100%
Major Resections	176	190	83	49
7 audit items for risk adjustment	100%	100%	100%	100%

Management of ALL patients

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Seen by Keyworker	97%	89%	99%	97%	86%
Potentially curative	69 (86% resected)	57 (89% resected)	30 (90% resected)	26 (100 resected)	83% resected

Major resections- QA

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Total number	176	190	83	49	
Distant Metastasis (%)	9%	13%	5%	6%	7%
At least 12 LN resected	87 %	91%	83%	73%	86%
Attempted Lap Surgery	48%	56%	49%	31%	71%

Stage 3 Colon cancer management

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Number of patients	52	109	44	54	
Adjuvant Chemotherapy	54%	47%	48%	50%	63%

Key:
> 80%
50 - 80%
< 50%

Rectal Cancer management -QA

Key:
> 80%
50 - 80%
< 50%

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Total number of pts	43	47	17	11	
CRM recorded	93%	96%	94%	91%	90%
CRM negative	81%	89%	94%	64%	84%
APER	30%	30%	24%	61%	39%
Permanent stoma	36%		61%		37%

Outcomes

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
30 day unplanned admissions	14%		9.1%		13.9%
30 day unplanned return to theatre	12.8%		4.3%		12.9%
90 day mortality	4.1%		1.2%		4%
2 year mortality	22.1%	17%	27.7%	29%	27.4%
18 month stoma unclosed	40.9%		56.1%		40%

National level QI targets
The current national level QI targets are summarised below, according to the five CQC domains:

Well-led:
1. All trusts/hospitals/MDTs with >80% case ascertainment
2. All trusts/hospitals/MDTs with >70% data completeness of seven items for risk adjustment in patients having surgery
3. >95% of trusts/hospitals/MDTs undertaking rectal cancer surgery to participate in and recruit to at least one NIHR portfolio trial in rectal organ preservation

Responsive:
4. >95% of trusts/hospitals/MDTs with annual resectional rectal cancer surgery volume of more than 20 patients
5. Increase proportion of patients with synchronous liver metastases at time of diagnosis with colorectal cancer discussed at specialist liver MDT
6. All trusts/hospitals/MDTs with >80% of patients with Stage IV disease with genetic tumour profiling (KRAS, NRAS, BRAF)
7. All trusts/hospitals/MDTs with >90% patients with mismatch repair immunohistochemistry or microsatellite instability

Caring:
8. All trusts/hospitals/MDTs with >95% of colorectal cancer patients seen by Clinical Nurse Specialist (CNS)

Effective: - Reduce variation between trusts/hospitals/MDTs in:
9. risk-adjusted unplanned return to theatre after colorectal cancer resection
10. rates of neoadjuvant treatment in rectal cancer patients undergoing resection
11. rates of adjuvant chemotherapy after colon cancer resection
12. colorectal cancer operations via laparoscopic approach
13. risk-adjusted 30 day unplanned readmission rates after colorectal cancer resection
14. rates of diverting ileostomies after rectal cancer surgery unclosed by 18 months
15. risk-adjusted survival at 2 years after colorectal cancer resection
16. patients referred to palliative care or enhanced supportive care clinic in last year of life
17. patients receiving palliative systemic treatment in final 30 days of life

Safe:
18. Reduce variation between trusts/hospitals/MDTs in riskadjusted mortality after colorectal cancer resection

Local QI targets

The local QI targets selected to deliver on the national targets are:

1. >80% case ascertainment
2. >70% data completeness of seven items for risk adjustment in patients having surgery
3. Participation in and recruitment to at least one NIHR portfolio trial in rectal organ preservation
4. Annual resection rectal cancer surgery volume of more than 20 patients
5. >95% of patients with synchronous liver metastases discussed at specialist liver MDT*
6. >80% patients with Stage IV disease with genetic tumour profiling (KRAS, NRAS, BRAF)
7. >90% patients with mismatch repair immunohistochemistry or microsatellite instability
8. >95% colorectal cancer patients seen by Clinical Nurse Specialist (CNS)
9. <10% risk-adjusted unplanned return to theatre after colorectal cancer resection
10. 10% to 60% rate of neoadjuvant treatment in rectal cancer patients undergoing resection
11. >50% rate of adjuvant chemotherapy after colon cancer resection
12. >50% colorectal cancer operations via laparoscopic approach
13. <15% risk-adjusted 30 day unplanned readmission rates after colorectal cancer resection
14. <35% diverting ileostomies rectal cancer surgery unclosed by 18 months
15. >70% risk-adjusted survival at 2 years after colorectal cancer resection
16. >95% patients referred to palliative care or enhanced supportive care clinic in last year of life
17. <20% patients receiving palliative systemic treatment in final 30 days of life
18. <6% risk-adjusted mortality after colorectal cancer resection

Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Key successes & concerns

Successes
Good diagnostics to date with cancer cases.

Concerns
Lack of capacity with operating space for high loop ileostomy cases. Failure to book number of patients in for theatre and a concern of waiting lists increasing.
Patients waiting for chemotherapy with Velindre is out of our control of the Health Board. Need to escalate time to be seen by oncologists to cancer lead (Dr Williamson) to discuss concerns with caecal cancers.
Current job plans for colorectal surgeons requires providing cover for emergency surgery, reducing capacity for cancer cases.
With number of on calls provided by surgeons who have to cover at GUH for one week, this leads the Health Board approx. 84 cases short.

Action Plan

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG
1	Participation and engagement with the NBoCA quality improvement plan to focus on improving cancer outcomes targeting the areas most relevant to the hospital/trust/MDT, with particular emphasis on the performance measures with the most national variation: a) 18-month diverting ileostomy closure, b) 30- day unplanned return to theatre, c) Administration of adjuvant chemotherapy following major resection for stage III colon cancer	18-month closure of loop diverting ileostomy needs targeted action. This will require more theatre space under current conditions (i.e less theatre access to non cancer cases.)	Dr Tom Morgan-Jones	09/06/2023	15/07/2023	

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG
2	Participation and engagement with the NBoCA quality improvement plan to focus on improving cancer outcomes targeting the areas most relevant to the hospital/trust/MDT, with particular emphasis on the performance measures with the most national variation:	Audit the stage 3 colon cancers for adjuvant chemotherapy and investigate reasons for having not been offered chemotherapy.	Mr Keshav Swarnkar	09/06/2023	01/09/2023	

	a) 18-month diverting ileostomy closure, b) 30- day unplanned return to theatre, c) Administration of adjuvant chemotherapy following major resection for stage III colon cancer					

Title: **National Paediatric Diabetes Audit (NPDA) report on Care and Outcomes 2021/2022**

Date registered: **05/07/2023**

Speciality: **Paediatric Diabetes**

Division: **Family and Therapies**

Category: **National (NCAORP)**

Reported type(s): **Clinical Standards Effectiveness Group**

Lead participant: **Ramya Venkataramakrishnan**

Audit lead: **Davida Hawkes**

Rationale

The NPDA is part of the National Clinical Audit Outcome Review Plan and is part of the NHS Digital directory of audits relating to Diabetes care. The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological well-being, and assessment of diabetes- related complications including acute hospital admissions, all of which are vital for monitoring and improving the long-term health and well-being of children and young people with diabetes. In 2021/22, 100% of paediatric diabetes teams participated in the NPDA.

Objectives

Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.

Aims and priorities

- Build on and improve the previous joint adult and paediatric audit
- Collect a clinically meaningful dataset
- Engage clinicians, patients and parents
- Improve awareness of NPDA findings and maximise their use to drive national policy
- Develop the use of NPDA data in local and national quality improvements
- Use a regional network approach to data collection
- Capture patients' experiences
- Collaborate with the suppliers of the adult audit to ensure information around transition to adult care is captured
- Report at timely and regular intervals
- Develop user-friendly tools to interrogate the dataset
- Support centres wishing to develop local action plans to improve diabetes care
- Maximise the use and availability of data for research

Guidance

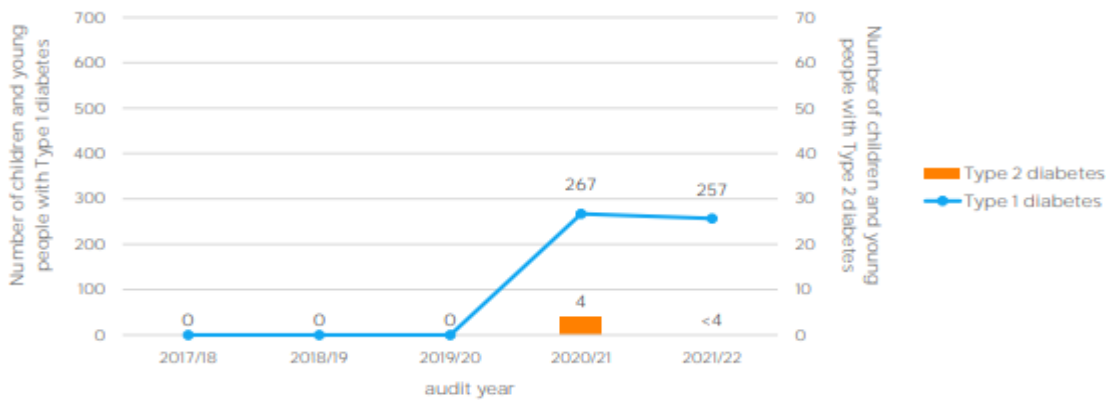
Code	Title
NG18	Diabetes (type 1 and type 2) in children and young people: diagnosis and management (August 2015)

Results

- How many children and young people were receiving care from paediatric diabetes services in England and Wales in 2021/22?

The chart below shows Grange University Hospital (GUH) data only.

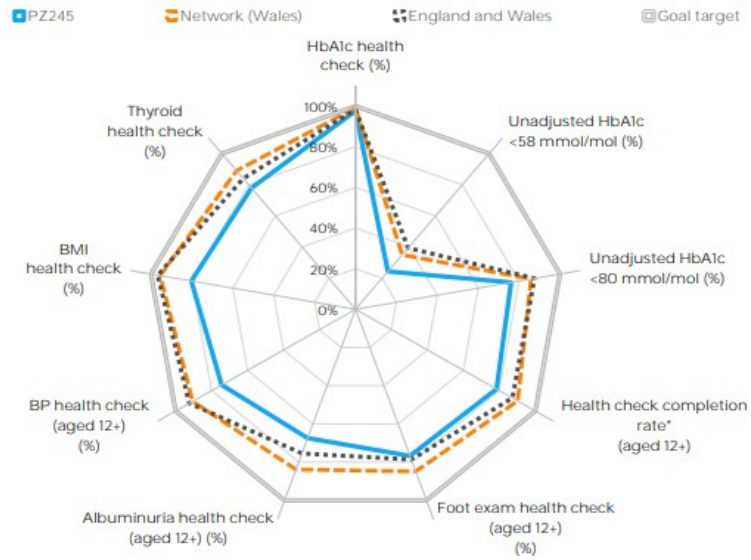
Figure 8: Number of children and young people according to diabetes type by audit year



- What percentages of children and young people received all six recommended health checks in 2021/22?

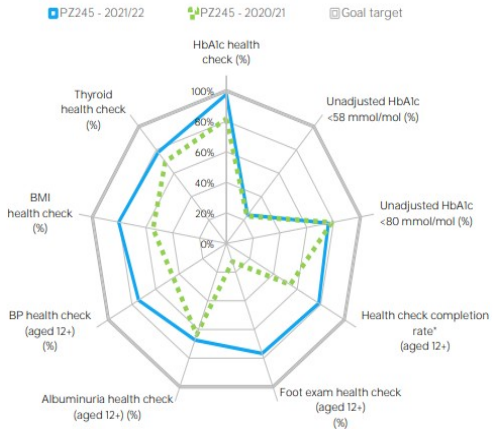
The plot below shows The Grange University Hospital (blue) compared to Wales (orange) and UK (black dotted line).

Figure 1: Radar plot showing unit, region and national performance on the six key health checks, % achieving an HbA1c of below 58 mmol/mol and % achieving an HbA1c of below 80 mmol/mol

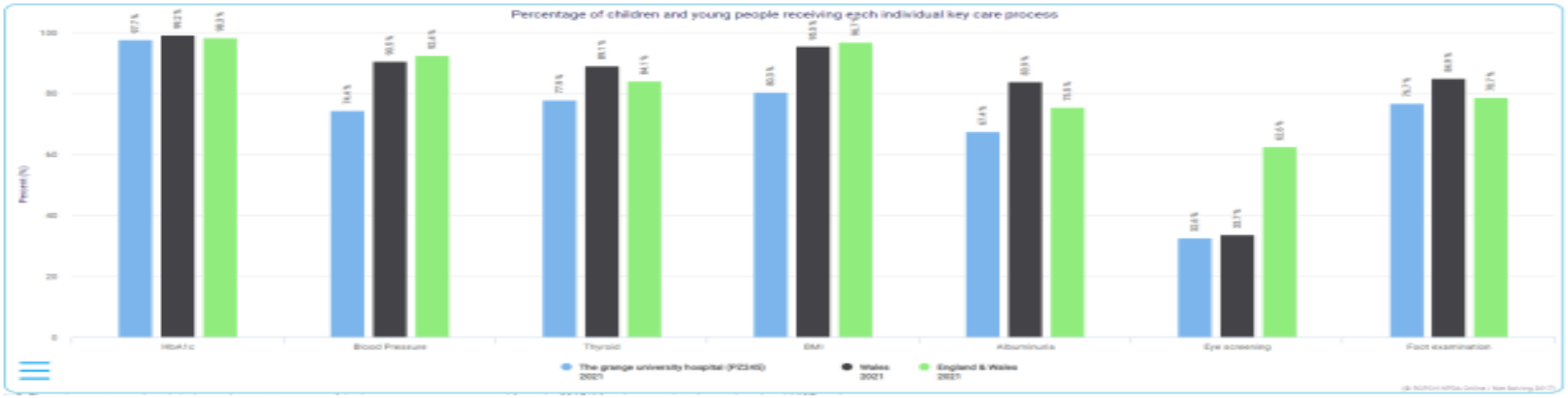


The below plot shows an improvement in 5 of the 6 key health checks (64.7% 2020/2021 & 67.4% 2021/2022).

Figure 2: Radar plot showing unit performance in 2020/21 and 2021/22 on the six key health checks, % achieving an HbA1c of below 58 mmol/mol and % achieving an HbA1c of below 80 mmol/mol

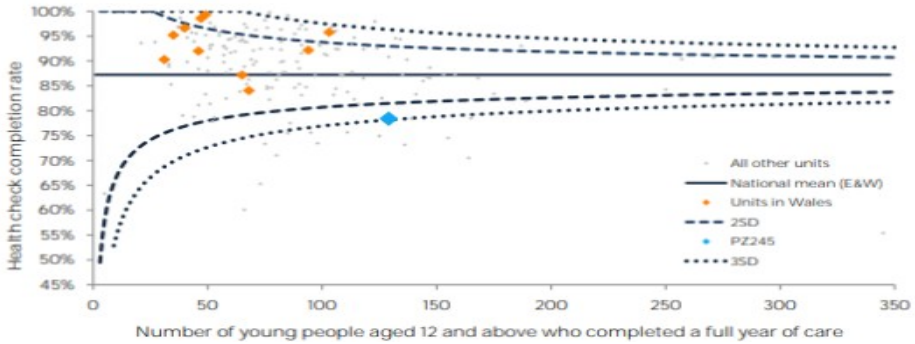


The graph below demonstrates the key care process results for 2021/2022. GUH compared to Wales and UK by health Check. Please note that Eye Screening is managed by The Diabetic Retinopathy Screening Service for Wales which means the management of target sis outside of the health boards control.



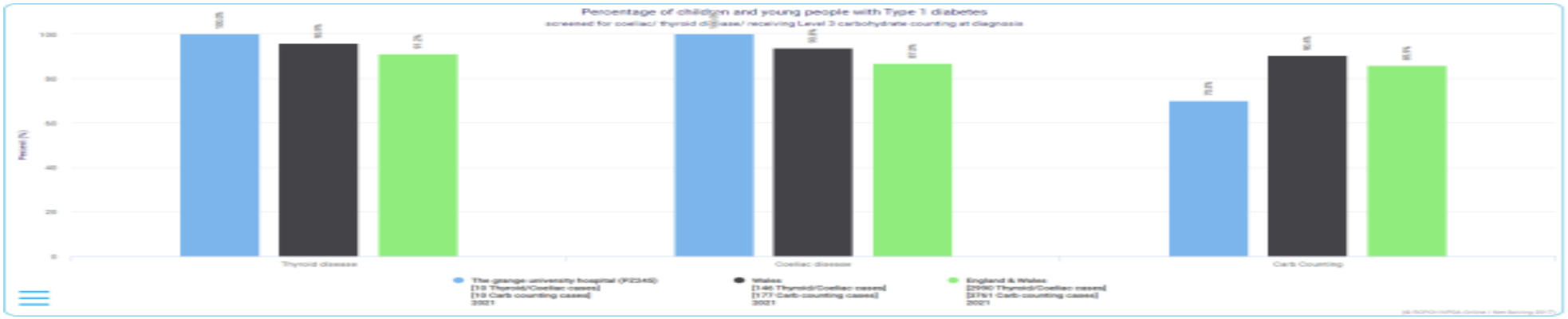
The below funnel chart outlier status of GUH, on the performance indicator for health check completion rate for 2021/22 is: ALERT.

Figure 12: Health check completion rate for children and young people with Type 1 diabetes aged 12 or older who completed a full year of care



The Clinical Lead (CL) presented the 2020/2021 report to the Standards and Effectiveness Group (CSEG) in September 2022 informing that the lack of face-to-face clinics resulting from the pandemic, was impacting on this result. During 2023 the face-to-face clinics have resumed and the impact should be seen in the next report.

- What percentage of all recommended health checks were delivered by PDUs in 2021/22? Outlier
- What percentages of children and young people with Type 1 diabetes received recommended checks at diagnosis in 2021/22?



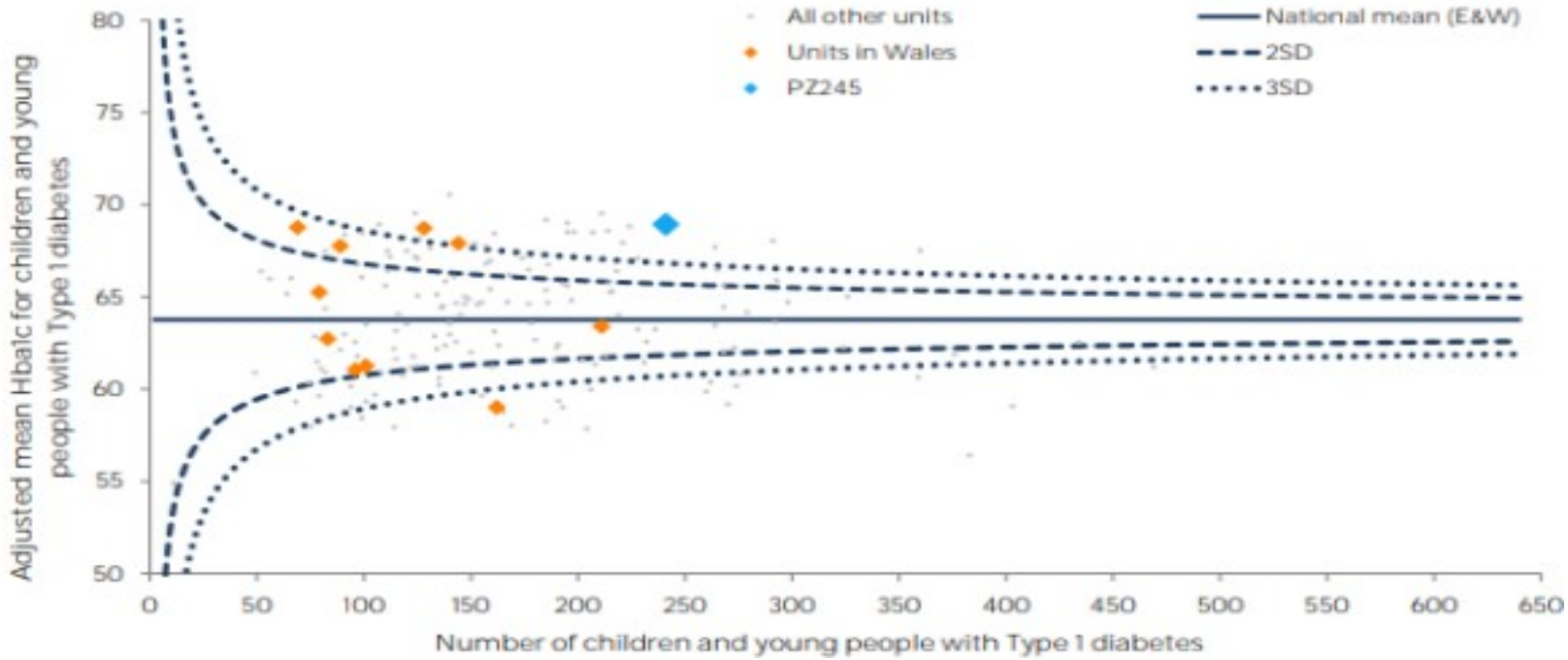
In CSEG September 2022, the CL stated that the Carb Counting at diagnosis was a data entry error as this is commenced at diagnosis. This remains an issue and requires an action to ensure the data reflects accurately.

- Has there been longitudinal improvement in national HbA1c?

The GUH mean HbA1c for children and young people with Type 1 diabetes was 69.7 mmol/mol. The adjusted mean was 68.9 mmol/mol. The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: ALARM.

The CL stated in September 2022 that the lack of resource funding to manage the technologies for controlling HbA1c is impacting this target and the Health Board will remain an outlier until the cost for consumables linked to vital technologies needed for children to reduce their HbA1c, therefore improving their health as children and as they grow into the adult diabetes service. A collaborative business case submitted by adult services and the paediatric diabetes team which was supported however not funded.

Figure 21: Adjusted mean HbA1c



- What percentages of children and young people with Type 1 diabetes were using diabetes-related technologies in 2021/22?

Graphs above demonstrate the link between CYP not using technologies and the reduction in the Health Boards HbA1c measure making the Health Board ALARM status.

- What was the average HbA1c for children and young people with Type 1 diabetes using different diabetes-related technologies in 2021/22?

The graphs below demonstrate the lower HbA1c when using advanced technologies across the UK and The Grange University Hospital displays low use of the technologies, therefore increasing and HbA1c and contributing to the ALARM status. This will not improve without the resources to obtain and manage the technologies.

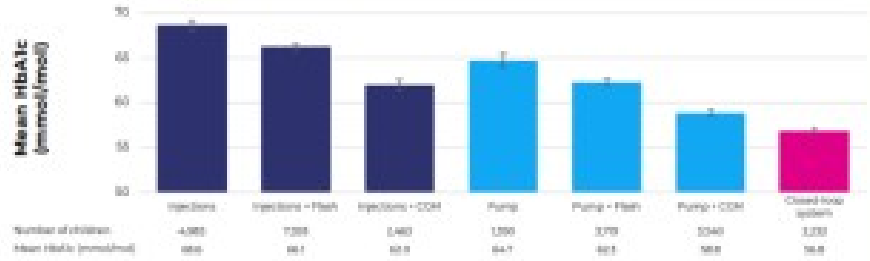
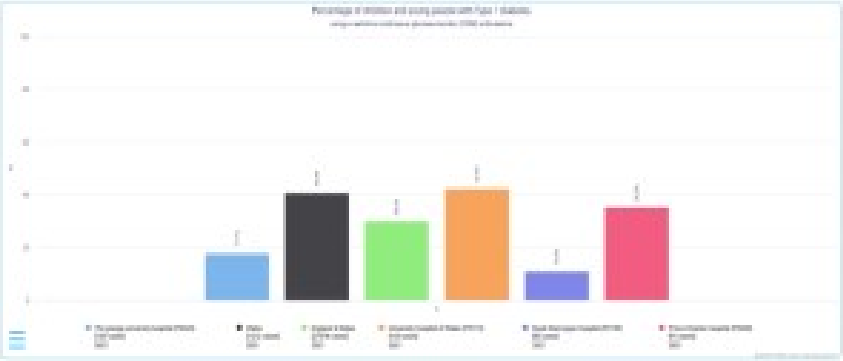
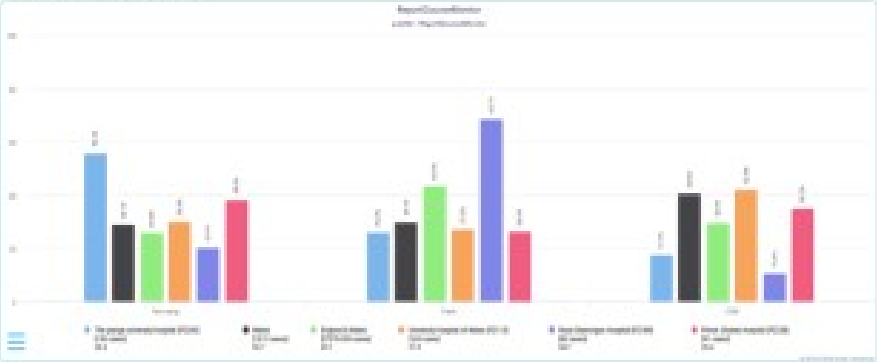
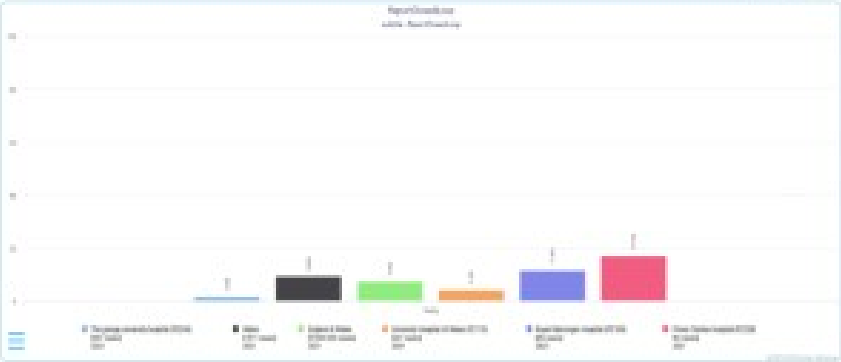


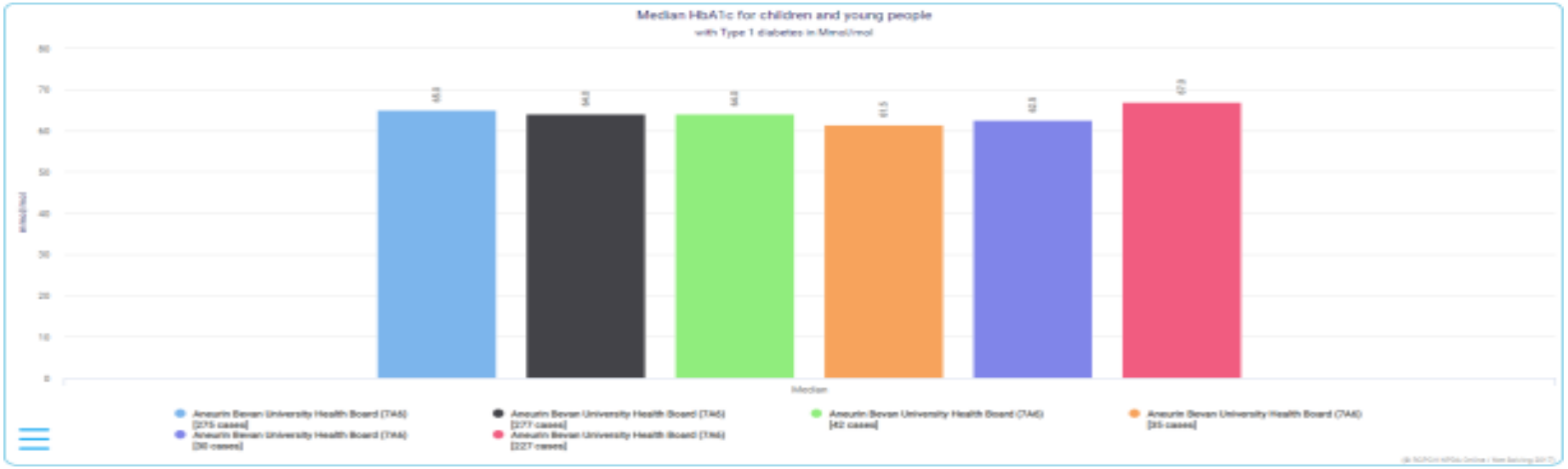
Figure 6: Mean HbA1c for children and young people with Type 1 diabetes using different combinations of treatment regimen and glucose monitoring in 2020/22.





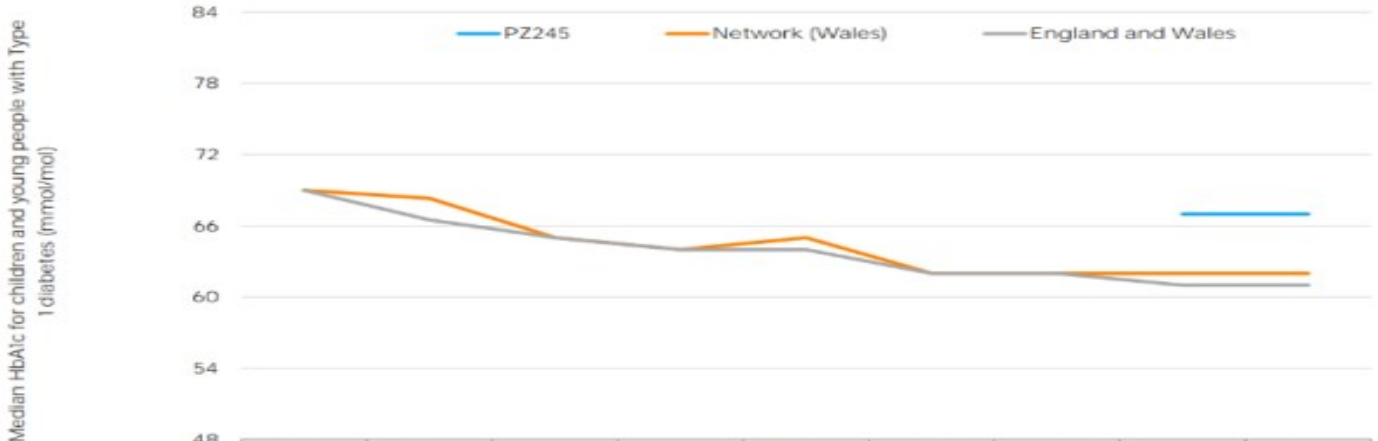


The graph below, shows the reduction in the Health Boards HbA1c recent years.



Below is only The Grange University Hospital for 2 years.

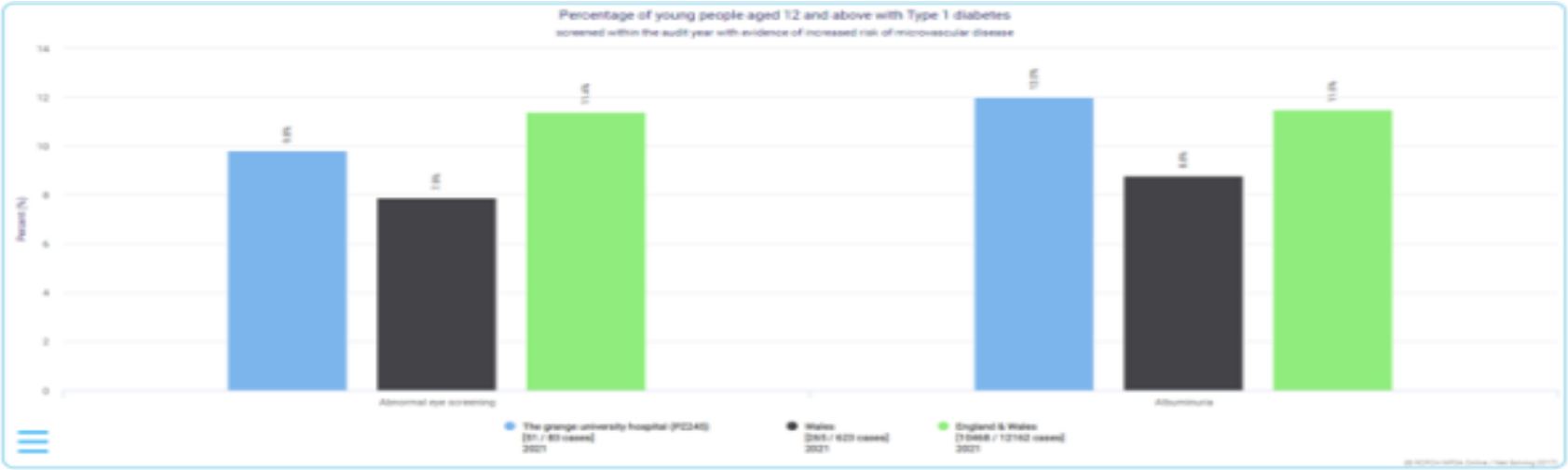
Figure 18: Median HbA1c for children and young people with Type 1 diabetes

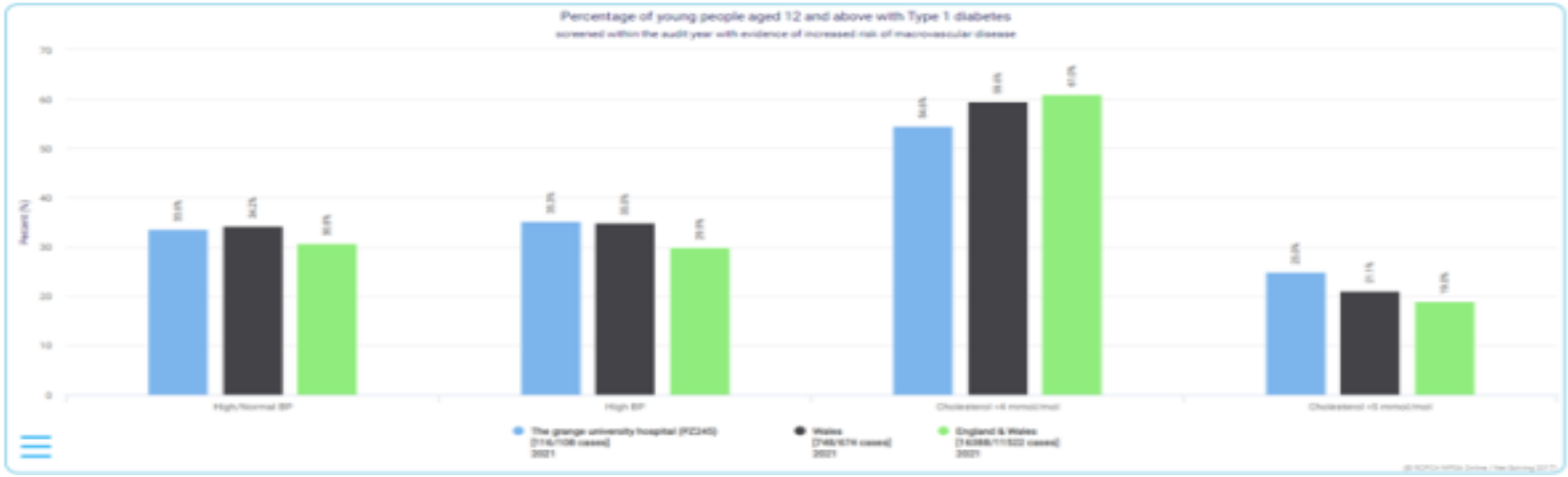


	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
PZ245								67.0	67.0
Network (Wales)	69.0	68.3	65.0	64.0	65.0	62.0	62.0	62.0	62.0
England and Wales	69.0	66.5	65.0	64.0	64.0	62.0	62.0	61.0	61.0

- What percentages of children and young people with diabetes were at risk of macrovascular and microvascular

complications in 2021/22?

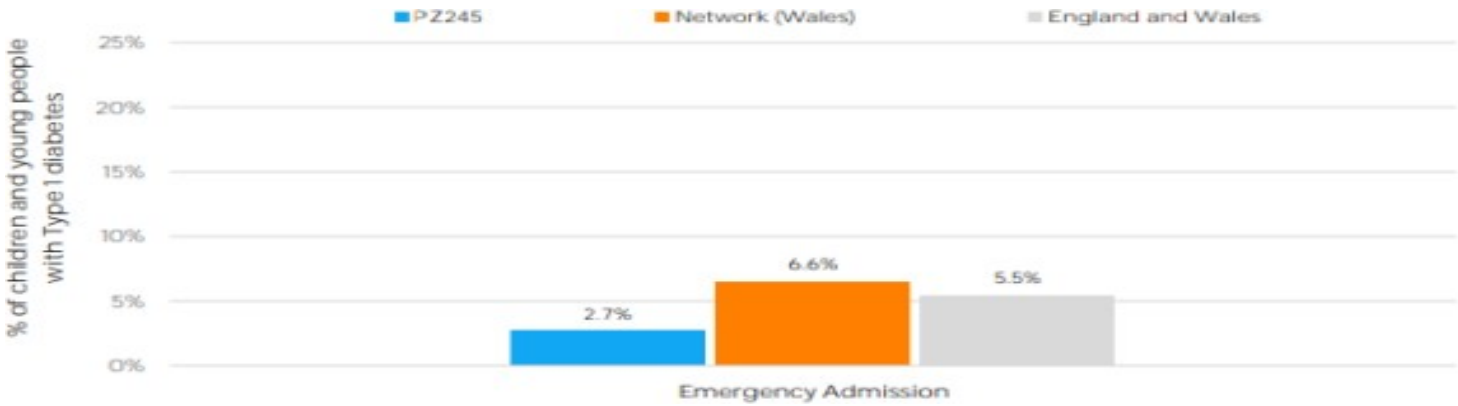




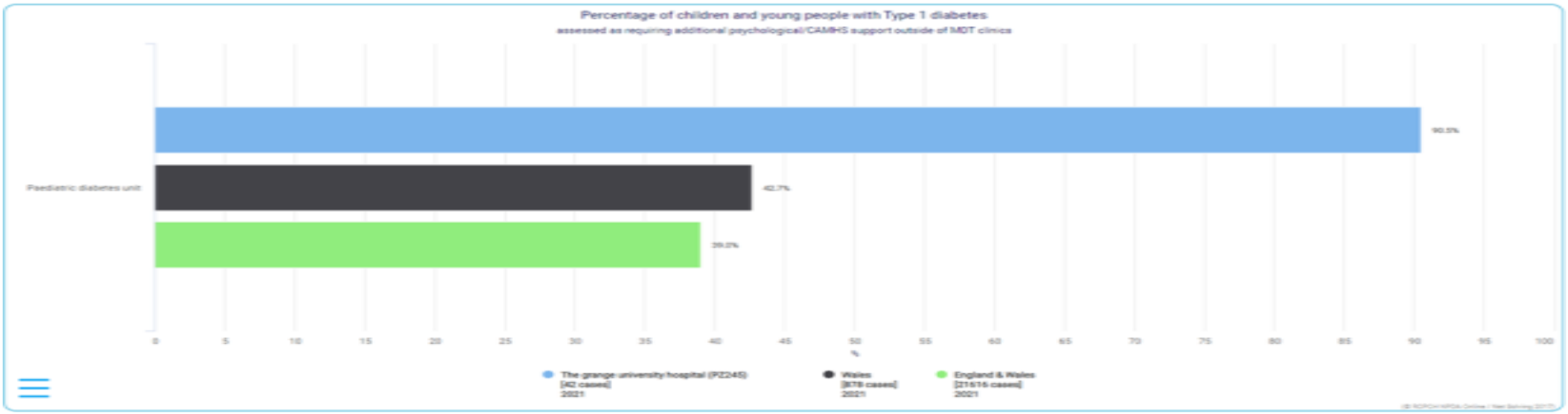
- What percentages of children and young people with Type 1 diabetes had diabetes-related hospital admissions in in

2021/22?

Percentage of children and young people with Type 1 diabetes who had at least one diabetes-related emergency hospital admission during the audit period, that was not associated with diagnosis.

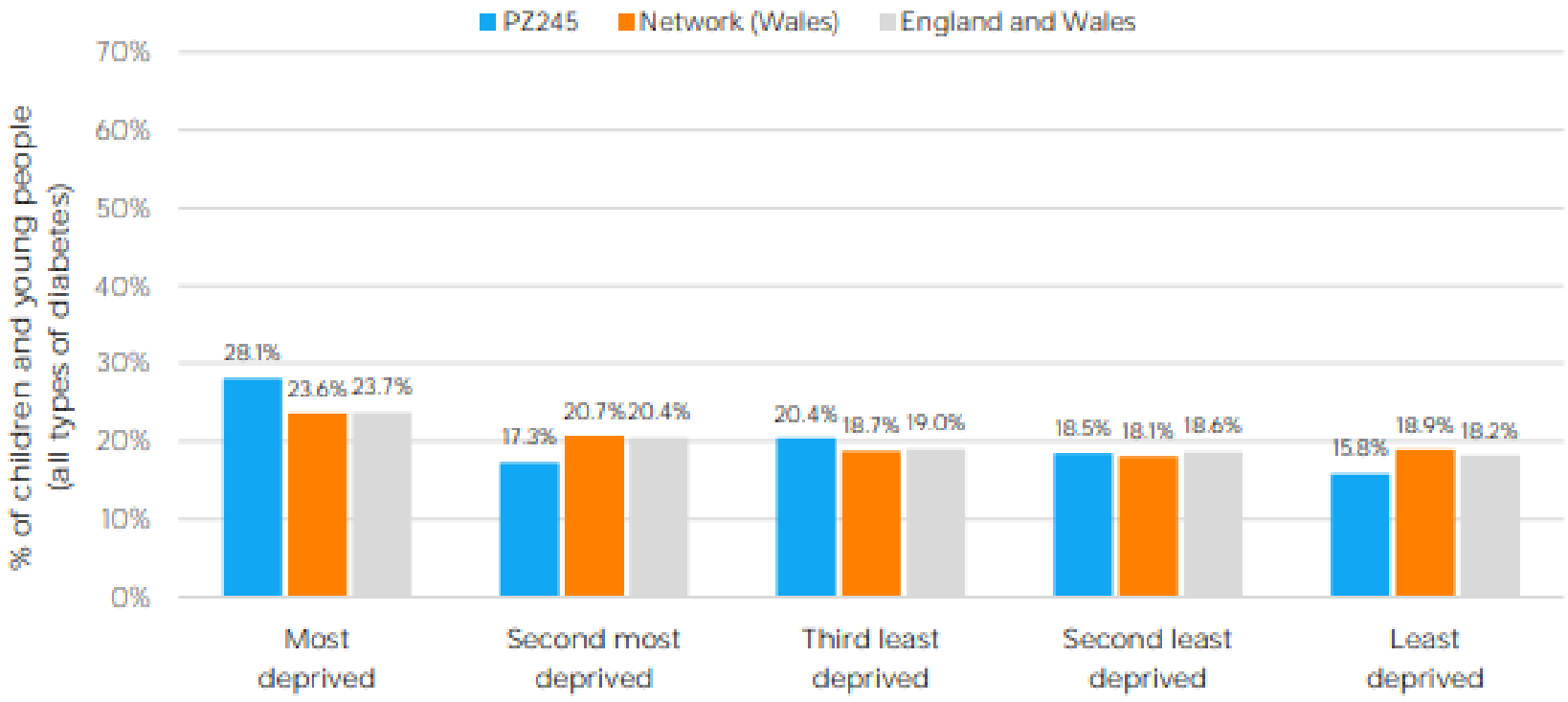


- How many children and young people with diabetes were assessed as requiring additional psychological support following assessment in 2021/22?



Also noted is that Aneurin Bevan University Health Board a higher rate of CYP in the deprived areas compared to the rest of Wales and the UK.

Figure 6: Percentage of children and young people within each deprivation quintile by unit, region and overall



Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Risk level	Description
Major	Non-compliance with national standards/Significant risk to patients if unresolved

This has been added to the Divisional Risk Register.

Key successes & concerns

Successes
The Paediatric Diabetes Team attended the Gwent Children's Diabetes Family Evening 2023. Attendees: Thirty-two families (80 people) initially confirm their attendance, with approximately 60 people attending on the evening. Great feedback, document attached in the results page.

Concerns
A business case was submitted to PIP for the required funding for the diabetic pumps. The case was approved, but there has been a lack of funding and has contributed to the outlier status. This Health Board, Standard Operating Procedure for outlier status has been followed and there has been acknowledgement of the outlier status.
There is a noticeable gap in access to pump technology for Gwent children and young people with diabetes.
The outlier status of The Grange University Hospital, on the performance indicator for health check completion rate for 2021/22 is: Alert. It is noted that this will continue to be an outlier and remain on the risk register with the lack of funding for the devices.
The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: Alarm.

Action plan

	Recommendation(s)	Actions	Responsible	Date raised	Due date	Action RAG
1	**National recommendations 1.** Commissioners should ensure adequate staffing of full multidisciplinary diabetes teams to manage the increasing numbers of cases of Type 1 and Type 2 diabetes observed since 2020, who are trained to facilitate the optimal use of new diabetes-related technologies. Action by: Integrated Care Boards across England and Health Boards and Regional Partnership Boards across Wales. **National recommendations 2.** Children and young people with Type 1 diabetes should have equitable access to diabetes care, irrespective of social deprivation, ethnicity or geography. They should be offered a choice of diabetes technology that is appropriate for their individual needs with families being made aware of the potential	The alarm status related to diabetes technologies, for the audit has been on the Divisional F&T risk register for some time. A joint business case submitted to PIP by adults and F&T was supported but not funded. Unfortunately, there has been no change to finances to be able to put in any additional workforce to improve this situation. Issues flagged at F&T Divisional Assurance meetings. The costs for consumables was reflected and the gap in ability to improve HbA1C levels still stand.	Sara Garland	01/08/2023	21/09/2023	

	differences in outcome with different modalities of insulin delivery and blood glucose monitoring. Action by: Integrated Care Boards across England in line with the aims for diabetes care set out within Core20PLUS5 – the national NHS England approach to reducing health inequalities for children and young people. Health Boards and Regional Partnership Boards across NHS Wales and Public Health Wales. The RCPCH, to provide a better understanding of ethnic and social deprivation variability. **National recommendations 3.** Health checks for children and young people with diabetes are essential for early recognition of complications. The need for tests and the results should be clearly communicated to families as part of their individual care package, and completion rates of checks should be monitored through the year. Action by: Clinical teams within Paediatric Diabetes Units in NHS Health Boards and Trusts across England and Wales.	Further actions from this is to submit the costs associated to diabetes to be submitted to Chief Operating Officer (LW). This will be undertaken jointly by both adults and paediatric finance teams.				

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
2	**National recommendations 1.** Commissioners should ensure adequate staffing of full multidisciplinary diabetes teams to manage the increasing numbers of cases of Type 1 and Type 2 diabetes observed since 2020, who are trained to facilitate the optimal use of new diabetes-related technologies. Action by: Integrated Care Boards across England and Health Boards and Regional Partnership Boards across Wales. **National recommendations 2.** Children and young people with Type 1 diabetes should have equitable access to diabetes care, irrespective of social deprivation, ethnicity or geography. They should be offered a choice of diabetes technology that is appropriate for their individual needs with families being made aware of the potential differences in outcome with different modalities of insulin delivery and blood glucose monitoring. Action by: Integrated Care Boards across England	Risk to remain of register and further work as above. PQSOC to be made aware of risk when submitting audit activity report Work underway to address the gap in access to pump technology for Gwent children and young people with diabetes.	F&T Division working with Exec lead for diabetes	01/08/2023	21/09/2023	●	New

	in line with the aims for diabetes care set out within Core20PLUS5 – the national NHS England approach to reducing health inequalities for children and young people. Health Boards and Regional Partnership Boards across NHS Wales and Public Health Wales. The RCPCH, to provide a better understanding of ethnic and social deprivation variability. **National recommendations 3.** Health checks for children and young people with diabetes are essential for early recognition of complications. The need for tests and the results should be clearly communicated to families as part of their individual care package, and completion rates of checks should be monitored through the year. Action by: Clinical teams within Paediatric Diabetes Units in NHS Health Boards and Trusts across England and Wales.						

Title: **Management of Heart Attack: analyses from the Myocardial Ischaemia**

Date registered: **11/07/2023**

Category: **National (NCAORP)**

Speciality: **Cardiology**

Division: **Medicine**

Lead participant: **Nigel Brown (NB)**

Audit lead: **Lalit Bhalla**

Rationale
Quality of care is assessed against a set of quality improvement (QI) metrics derived from national and/or international standards and guidelines. These cover patients diagnosed with higher-risk ST-segment elevation myocardial infarction (STEMI) heart attacks and those with non-ST-segment elevation myocardial infarction (NSTEMI) heart attacks. The data used are drawn from the Myocardial Ischaemia National Audit Project (MINAP), which are part of the National Cardiac Audit Programme (NCAP).

Objectives
To improve the patient experience and outcomes by appropriate treatment.

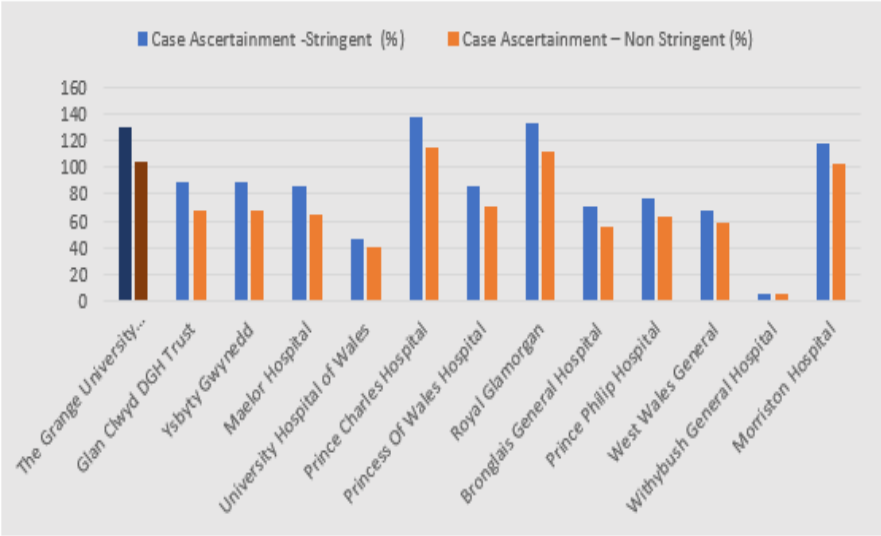
Guidance	Title
QS68	Acute coronary syndromes in adults (Sept 2014)

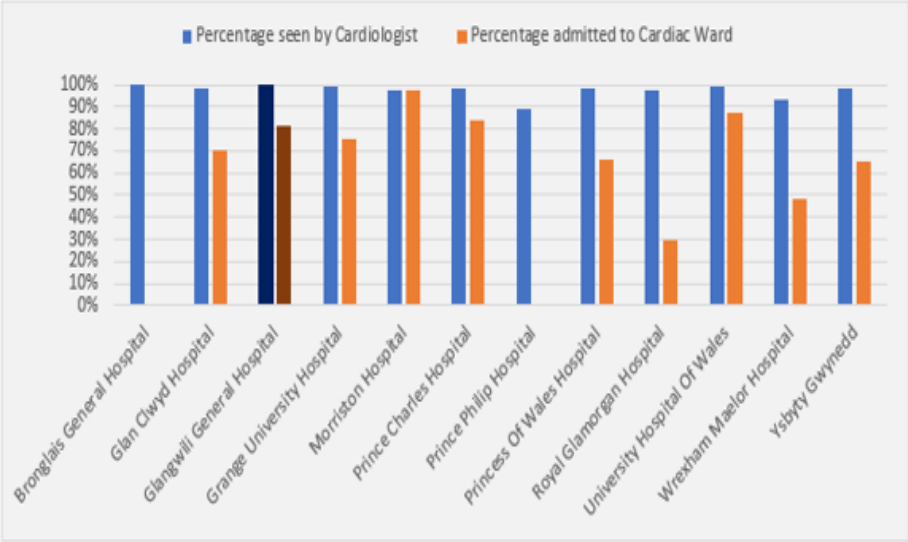
Meeting title	Date & time	Location
Clinical Standards and Effectiveness Group	21/09/2023 14:00	Teams

Results - Key Findings

Case ascertainment figures for MINAP	
STEMI	102
NSTEMI	439
Total	541
PEDW cases stringent	415
CA Stringent %	130.36%
PEDW cases non-stringent	521

Nationally 97%, ABUHB 99.09% of patients were seen by a cardiologist, or their team, during the admission, a consistently high performance. Median of Welsh HB's 98.62%.



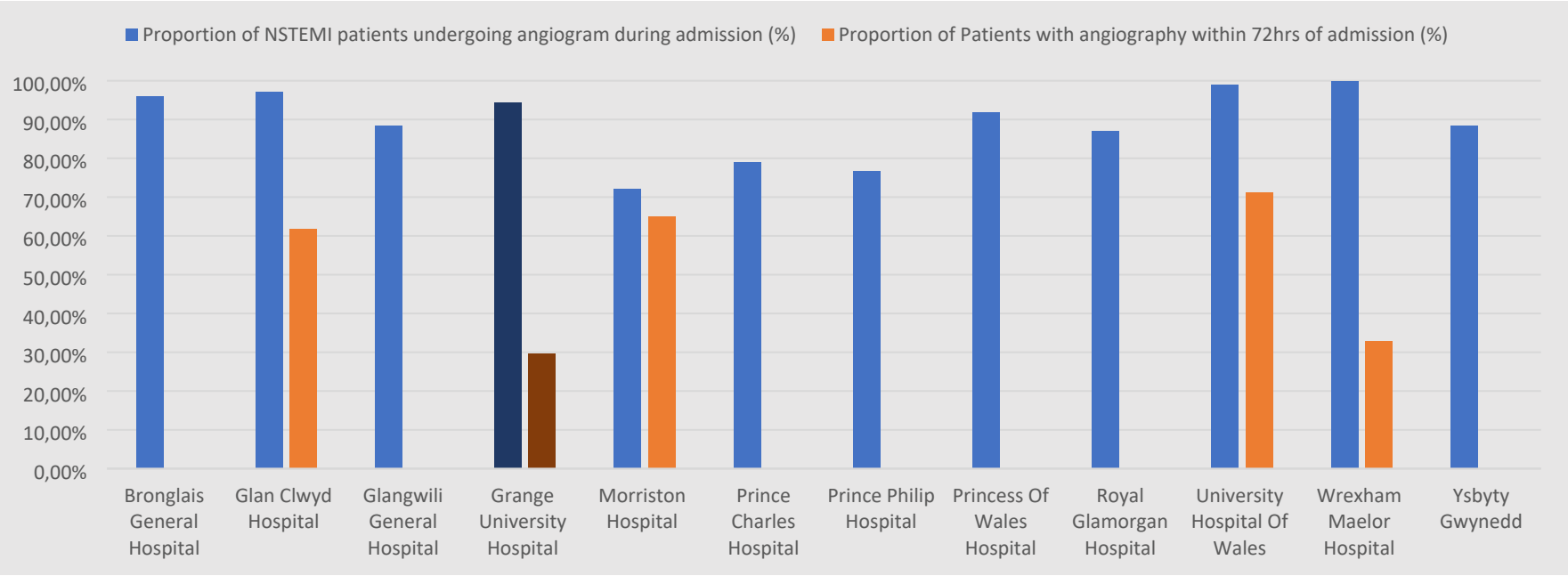


- **Proportion of Patients with angiography within 72hrs of admission (%)**

ABUHB 29.56%, 7 out of 12 Welsh hospitals performance is not reported as there are fewer than 20 eligible patients, the median between the 5 scoring HB's was 48.96% with the target set at 66%.

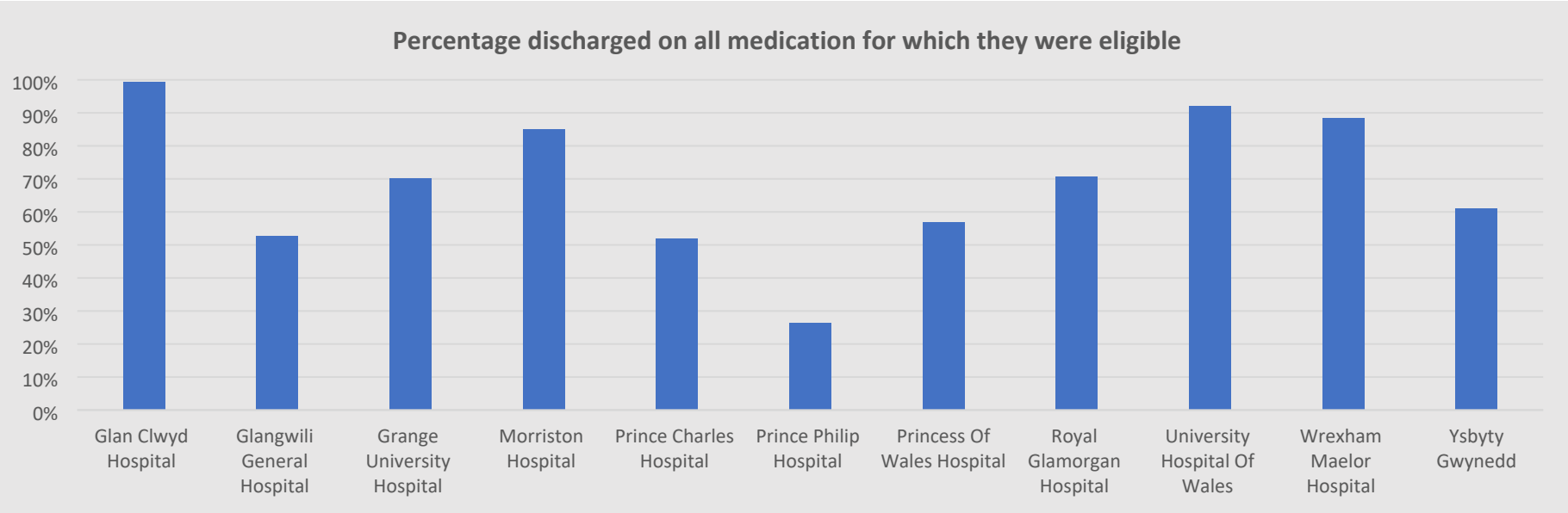
Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI.

Action - Delays to angio/PCI will be discussed at Cardiology Directorate meeting and added to the risk register. This risk will increase further if current financial constraints continue and may hamper major improvement. The Directorate will also be undertaking a more detailed look at MINAP regarding legitimate delays (not in the formal annual report) to understand the impact on waiting times.



Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI.

- Percentage discharged on all medication for which they were eligible for **ABUHB is 70.13%** compared the **Welsh Median of 70.44%. The National result is 89%.**

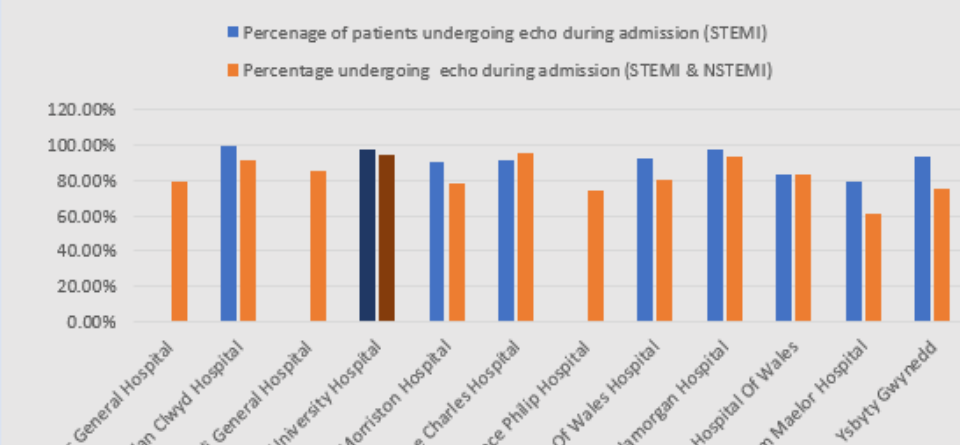


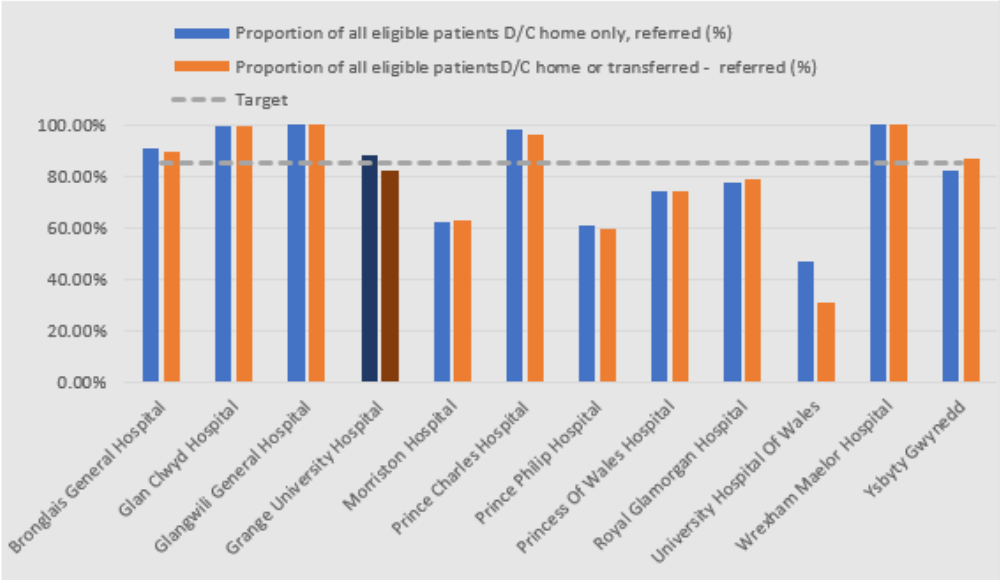
Action - We've historically done well on secondary prevention medicines at 70% equal to the Wales average this year. N.B. this may equate to only one out of 4 drugs. This may relate partly to the addition of aldosterone antagonists into a combined single data metric and/or relate to poor documentation on drug intolerance or legitimate reasons not to prescribe. We should not be complacent as a Directorate and it requires a deeper look and perhaps a checklist for discharge meds should be considered and developed alongside our pharmacy lead.

Primary PCI

It is noted that the number of cases for ABUHB is fewer than 20 due to Grange University Hospital (GUH) not being a designated Heart Attack Centre, patients are sent to UHW, Cardiff. GUH will provide primary PCI opportunistically to a limited number of patients, which does provide data relating the Door to Balloon time (DTB) and Call To Balloon Time (CTB), both of which are significantly higher in minutes than the Heart Attack Centres.

Performance of an echocardiogram in patients with a final diagnosis of either STEMI alone, or STEMI and NSTEMI combined, during admission for **ABUHB is 97.96%** compared to the **Welsh Median of 92.59%,** this is based on 9 of the 12-hospitals providing this service. Combined STEMI and NSTEMI undergoing Echo for **ABUHB is 94.64%** compared to all **12 Welsh hospitals median of 81.84%.**





Performance of hospitals with respect to referral of patients with either STEMI or NSTEMI to cardiac rehabilitation programmes, for patient discharged home, **ABUHB is 88.37%** compared to the **Welsh Median of 85.34%**, with the inclusion of patients transferred to another hospital as well as discharged home, **ABUHB is 82.39%** where the **Welsh Median is 84.56%. The UK national result is 85%.**

National Key Messages:

Key message 1:
The overall number of cases of heart attack reported this year, 85,630. This is 16% higher than the previous year, and represents a 'bounce-back' to 'pre-pandemic' levels.

Key message 2:
Proportions both of patients referred to cardiac rehabilitation programmes following heart attack and of eligible patients receiving an echocardiogram prior to discharge from hospital are at the highest recorded level. Referral to rehabilitation exceeds the aspiration that 85% of patients should being referred.

Key message 3:
Percutaneous coronary intervention (PCI) is used, appropriately, in the majority of cases despite a greater number of patients being managed this year – immediate (primary) PCI in 84% of cases of 'high-risk' STEMI heart attacks; urgent PCI in 83% of lower-risk NSTEMI heart attacks.

Key message 4:
A smaller proportion of patients receive PCI in a timely fashion. For STEMI, the proportion of patients receiving primary PCI fell to 30% within 120 minutes, and to 55% within 150 minutes, of calling for help. For NSTEMI, whereas 66% underwent angiography within 72 hours of admission to hospital in 2020/21, performance has returned to pre-pandemic levels; 56% of patients with NSTEMI received an angiogram within 72 hours in 2021/22.

Key message 5:
A larger proportion of patients make their own way to hospital, rather than arriving by ambulance. While this represents the minority (18.6%) of all cases of heart attack, there appears to be an upward trend in self-presentation during the year. For those with STEMI undergoing primary PCI, the monthly proportion who self-presented to hospital rose from 4% during April 2021 to 8% during March 2022. The proportion of patients requiring transfer between hospitals for primary PCI rose from 14% in 2020/21 to 18.7% in 2021/22. These patients are less likely to receive timely primary PCI.

Assurance
Significant – the project has mostly achieved the standards or criteria being audited against.

Risk
For overall audit –Minor risk: Minor implications for patient safety.

Moderate risk for delays to Angio/ PCI will be discussed at Cardiology Directorate meeting and added to the risk register.

Key successes & concerns

Successes
Achieving most targets, including high provision of echocardiography.
Case ascertainment has improved considerably.
High levels of assessment by a cardiologist and angiography.
High referrals rates for rehabilitation.

Concerns
Delays to angiography/intervention.
Delays in step-ups from eLGH's.

Staffing levels and catheter laboratory constraints.

Action Plan

	Recommendation(s)	Comments and Action	Lead	Date raised	Due date	Action RAG
1	Where CTB time standards are not being met in STEMI cases, emergency departments, PCI centres, neighbouring non-interventional hospitals and ambulance trusts should work together to reduce delays in the provision of primary PCI. This may include improving the hospital response to patient arrivals as well as pre-hospital Call-To-Door (CTD) times. Hospitals not able to offer primary PCI to patients with STEMI who self-present, especially if geographically remote from such services, should consider re-introducing care pathways that include immediate administration of intravenous thrombolytic drugs.	Currently the Health Board is designated a non-Heart Attack Centre, small numbers of PPCI are undertaken (mainly self-presenting patients during working hours) but the numbers are < 20 per annum and therefore not reported. Ensure harm e.g. events in patients waiting intervention captured Retrospective review of the MINAP database to better understand detail behind delays	Dr NB	21/09/2023	21/09/2023	Fully Complete

2	Hospitals with lower rates of echocardiogram provision, for STEMI and NSTEMI, should ensure that their data are being collected accurately and, if needed, should identify opportunities for echocardiography during the index admission. Use of limited 'bedside' echocardiograms should be considered if there are difficulties obtaining timely detailed tests. Patients discharged to another hospital before an echocardiogram is performed must be accompanied by a clear request for the test at the receiving hospital.	The Health Board performs very well with 94.64% of patients undergoing echo during admission (STEMI & NSTEMI). This reflects excellent work by the Physiology Team at Grange University Hospital (GUH)	Dr NB	21/09/ 2023	21/09/ 2023	Fully Complete
3	Hospitals not sufficiently admitting heart attack patients to a cardiac ward should review their systems and bed allocations to maximise access to cardiac care. This may require novel use of dedicated multi-specialty 'high care' beds and provision of cardiac outreach services to those cared for elsewhere.	The proportion of patients admitted to a cardiac ward in ABUHB is 75.4%. This compares favourably to the national average of 64%. Please note this figure represents admission *within 24hrs* so delays on the assessment unit or patients awaiting transfer from eLGH sites reflects the remainder and sits at approximately 24.6%. The cardiology team have developed a draft SOP which	Dr NB	21/09/ 2023		Ongoing

		proposes an alternative use of additional bed capacity on B4 (currently GIM step down patients) to allow rapid transfer within 24hrs of all accepted eLGH patients.				
4	Hospitals reporting low rates of cardiology involvement in heart attack patient care should ensure their data are accurately reflecting practice. If they do, provision of cardiac care during admissions should be improved (eg by increased staffing or more flexible use of members of the cardiology team, such as nurse specialists and physician associates).	ABUHB perform exceptionally well with 99 % of patients were seen by a cardiologist (97% nationally).	Dr NB	21/09/2023	21/09/2023	Fully Complete
5	Low rates of angiography in eligible NSTEMI patients require hospitals to review their systems for managing acute coronary syndromes (ACS).	ABUHB perform well with angiography during admission in 94.43% of patients (Wales median 90.1%, 83% nationally in UK)	Dr NB	21/09/2023	21/09/2023	Fully Complete
6	Where angiography for NSTEMI takes more than 72-hours, hospitals and commissioners should review pathways, referral networks and service commissioning to make quality improvements. Any lessons regarding more timely care that were learned during the pandemic should be	29.6% patients underwent angiography within 72hrs compared to a median of 49% in Wales and 56% nationally. A previous notional target of 60% had been set in England (tariff based). This figure does not take account of patients with legitimate reasons for delay such as anaemia or infection and the	Dr NB	21/09/2023	21/09/2023	Fully Complete

	incorporated within existing pathways. There should be an emphasis on early and reliable identification of suitable patients, streamlined referrals, and adequate capacity for transferring patients into (and out of) interventional hospitals. This will involve weekend angiography lists for such patients.	proportion of our patients with co-morbidities/legitimate delays may be higher and will be investigated further. Preliminary review of 2022-2023 data suggests approximately 25% will have a legitimate delay. Nevertheless, several issues that contribute to delays are listed in order of importance including; a) catheter laboratory time (elective patients/lists/complex case work/CTO's compete) and staffing constraints (medical, nursing, radiographer and physiology) b) delayed transfer from eLGH's (e.g.1 patient taking a week in 2022) c) weekend cover is limited to Saturday am so Friday admissions will generally wait more than 72 hours unless urgent. Ensure harm e.g. events in patients waiting intervention captured. Divisional discussion re investment in uplift in catheter laboratory capacity and possibly more formal "trigger points" for review of e.g., elective activity	Dr NB & directorate	Sept 2023		Ongoing

		Report to be discussed in Quality Improvement Group and at divisional level and added to the risk register.				
7	Hospitals not meeting the prescribing standard for all secondary prevention medication prior to discharge of both STEMI and NSTEMI patients should assess the quality of their data and, if sub-optimal performance is confirmed, pursue quality improvement. These might include the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists or ACS nurse specialists.	The percentage of patients discharged on all appropriate secondary prevention medication was 70.13%, identical to a median figure of 70.44% in Wales but lower than the UK average of 89%. This has fallen and may reflect issues with prescribing aldosterone antagonists in impaired LV function (newly added to this combined endpoint) but inadequate documentation of intolerance/CI (e.g., due to hypotension with ACE, or hyperkalaemia in the case of aldosterone antagonist's) or a legitimate decision not to prescribe. The MINAP database will be further analysed and we will discuss the role of an additional checklist on discharge.	Dr NB	Sept 2023		Ongoing
8	Hospitals with lower rates of prescribing aldosterone antagonists for patients with impaired LV function identified by	This data for aldosterone antagonist's is now included within the standard above for secondary preventative	Dr NB	21/09/ 2023	21/09/ 2023	Fully Complete

	echocardiography (or some other reliable assessment method) should act to ensure appropriate treatment. This could involve discharge pro-forma/checklists and the direct involvement of specialist cardiac pharmacists, ACS nurses and sonographers.	medications. Clear documentation of medication decision may be an issue and will be the focus of another discharge medication checklist to put together with our pharmacy lead.				
9	Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI heart attacks should ensure early identification of patients who might benefit (eg through routine distribution of cardiac rehabilitation information/invitation in discharge checklists and in leaflets given to all patients). All hospitals should ensure equitable access to cardiac rehabilitation. Rehabilitation staff who were redeployed to ward-based duties during the pandemic should return to their original practices.	A high proportion of 88.37% of patients were referred to cardiac rehabilitation programmes (Welsh Median 85.34%, UK almost 89%). The national UK aspirational target is 85%.	Dr NB	21/09/2023	21/09/2023	Fully Complete

AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2023/24

DRAFT

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

This Annual Programme of Business has been developed with due regard to guidance set out in NHS Wales' Audit Committee Handbook (June 2012), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board (March 2023);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Preliminary Matters								
Attendance and Apologies	Standing Item	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2023/24	Annually	Chair & Director of CG	√					√
Review of Committee Programme of Business	Standing Item	Chair	√			√	√	
Annual Review of Committee Terms of Reference 2023/24	Annually **(April)**	Chair & Director of CG	√					
Annual Review of Committee Effectiveness 2022/23	Annually **(September)**	Chair & Director of CG					√	
Committee Annual Report 2022/23	Annually **(April)**	Chair & Director of CG	√					
Corporate Governance, Risk & Assurance								
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	Quarterly	Director of CG					√	
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG			√			√
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG			√			√
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		√	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		√	
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG						√

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Audit Recommendations Tracking Report	Standing Item	Director of CG	√	√	√	√	√	√
Annual Review of Risk Management Strategy	Annually	Director of CG						√
Report on the Implementation of the Risk Management Strategy Realisation Plan	Bi-Annually	Director of CG	√				√	
Annual Review of the Board Assurance Framework Process	Annually	Director of CG	√					√
Committee Risk & Assurance Report	Standing Item	Director of CG	√	√	√	√	√	√
Financial Governance and Control								
Report of the use of Single Tender Action	Standing Item	Director of FPV	√			√	√	√
Report of Losses and Special Payments *(May report will be included in the Accounts)*	Bi-Annually	Director of FPV		√			√	
Reviewed and Updated Financial Control Procedures	As Required	Director of FPV	√			√	√	√
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	Annually	Director of FPV & Director of CG	√					
Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)	Annually	Director of CG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)	Annually	Director of CG		√	√			
Review Draft/Final Annual Accounts and Financial Statements (Part 3)	Annually	Director of FPV		√	√			
Audit Enquiries to those charged with Governance and Management	Annually	Director of FPV		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	Annually	External Audit			√			
Final Annual Accounts Memorandum	Annually	External Audit					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	Annually	Internal Audit			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	Annually	Chair			√			
Anti-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (Feb 2026)	Director of FPV	-	-	-	-	-	-

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Receive the Counter Fraud Annual Report	Annually	Head of CF	√					√
Agree the Counter Fraud Annual Workplan	Annually	Head of CF	√					
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	Head of CF			√		√	
Agree the Counter Fraud Functional Standard Return Declaration	Annually	Head of CF			√			
Receive the Post Payment Verification Annual Report	Annually	PPV Manager (Amanda Legge)				√		
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager		√				
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Annually	PPV Manager					√	
Clinical Audit								
Ratify the Clinical Audit Plan 2023 – 2024 to be overseen by the PQSO Committee	Annually	Medical Director			√			
Receive an Annual Report 2023 – 2024 on Clinical Audit Activity	Annually	Medical Director						√
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	Annually	Head of Internal Audit		√				
Receive Internal Audit Progress Reports	Standing Item	Head of Internal Audit	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Head of Internal Audit Plan						
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	Annually	Head of Internal Audit with Chair			√			
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	Annually	Audit Wales						√
Agree the External Audit Annual Plan	Annually	Audit Wales		√				
Receive the 2023 Structured Assessment	Annually	Audit Wales					√	

DRAFT

Updated 07.12.23

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Receive External Audit Progress Report 2023-24	Standing Item	Audit Wales	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Audit Wales						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Ad-hoc	Audit Wales						
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	Bi-Annually	Chair	√					√
Internal Audit Team	Bi-Annually	Chair					√	
Local Counter Fraud Team	Bi-Annually	Chair				√		

KEY	
D of CG	Director of Corporate Governance
D of FPV	Director of Finance, Procurement and Value
Head of CF	Head of Counter Fraud
PPV	Post Payment Verification

KEY	
√	Received at the scheduled meeting
X	Not received / Deferred to future meeting
Received √	Received deferred Item
	Draft & Final Accounts

DRAFT

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Recommendations Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk, and Assurance Committee (referred to as the Committee throughout the report) with an overview of all identified internal and external audit recommendations and current implementation status as at 31 December 2023.

The paper also seeks to provide an update on recommendations that have progressed since the last reporting period, where a revised deadline has been proposed, recommendations that remain outstanding, and an overview of management action plans that have now been completed in their entirety.

Cefndir / Background

The Committee's role is to provide focused scrutiny of all recommendations resulting from Internal and External Audit findings, as well as to ensure that the actions in place to implement the recommendations are carried out and completed within an appropriate time frame based on the assurance outcome and the priority rating of individual recommendations.

In recent months, the Committee has focused on recommendations that have passed their original and revised implementation deadlines and remain outstanding.

As a result of the progress made in completing recommendations, the Audit Tracker as at 31 December 2023 only contains **five** active external audit recommendations, with only **two** due for an update during this reporting period. For the purposes of this report, internal and external recommendations have been combined and presented as a single set.

Following the previous reporting period, which ended on 30 September 2023, several revised timeframes were agreed upon, leaving a residual position of **38** overdue internal and external recommendations. A further **35** recommendations were triggered as overdue in **Q3** (October – December). In total **73** updates against overdue recommendations were requested.

The position reported in Table 1 reflects the position following updates received against all **73** overdue recommendations up to 31 December 2023. In addition, the Dashboard in **Appendix 1** presents an overview of all residual live recommendations, both '**Overdue**' and **'Not Yet Due**,' separated by 'Year,' 'Executive Lead,' and 'Priority Rating' should the Committee accept the recommendations to approve the completed recommendations and revised deadlines as set out within the report.

Table 1

Overview of Recommendation Position following Updates for Quarter 3 Reporting Period										
Lead Director	**Chief Operating Officer**	**Director of Corporate Governance**	**Director of Digital**	**Director of Finance and Procurement**	**Director of Nursing**	**Director of Public Health**	**Director of Strategy, Planning, and partnership**	**Director of Workforce and OD**	**Director of Therapies and Health Science.**	**Total**
IA Overdue	**23** (*12)	**-**	**12** (*12)	**-**	**2** (*2)	**1** (*1)	**-**	**1**	**2** (*2)	**41** (*29)
EA Overdue	**-**	**-**	**2** (*2)	**-**	**-**	**-**	**-**	**-**	**-**	**2** (*2)
Completed	**5**	**-**	**8**	**6**	**4**	**-**	**4**	**3**	**-**	**30**
									Total	**73** (*31)

NB: (*x) denotes the revised number of deadline(s) requested; these are included in the overdue figures as they have not yet been approved by the Committee.

Asesiad / Assessment

Audit recommendations 2017 – 2021

Since the last Committee meeting in November 2023, efforts have continued to reduce the number of outstanding legacy recommendations. As at 31 December 2023, **24** recommendations from **nine** legacy audit reports were overdue. Table 2, overleaf, categorises the **24** recommendations by 'Year,' 'Executive Lead,' and 'Priority Rating.

Appendix 2 contains greater detail of the **24** recommendations.

Table 2

Breakdown of the 24 legacy Recommendations (2017-2021) that have breached original and revised implementation dates as at 31 December 2023						
Executive Lead	**Year**	**2017**	**2018**	**2020**	**2021**	**Total**
Director of Therapies & Health Science		**1**	**-**	**-**	**-**	**1**
Director of Digital		**-**	**1**	**6**	**1**	**8**
Chief Operating Officer		**-**	**-**	**-**	**2** / **12**	**14**
Director of Workforce & OD		**-**	**-**	**-**	**1**	**1**
Total		**1**	**1**	**6**	**16**	**24**

To provide the Committee with greater assurance about the progress being made in implementing the **24** legacy recommendations, detailed assurance reports and risk assessments were requested, which are included as **Appendices 2.1 and 2.2.**

Table 3 provides a breakdown of the 24 legacy recommendations. In Summary, of the **24** assurance reports, **15** have requested a revised deadline, with **seven** having previously requested revised deadlines that were approved by the Committee. The remaining **nine** have not been given a revised deadline for implementation.

Table 3

Audit Year and Title	Rec No and Priority	Original Date Agreed in the Report	Revised Date Approved by the Committee	Revised Date to be Approved by the Committee	Appendix the Assurance Report is included
2017 Medical Equipment and Devices	R1	30/03/2018	-	**31/03/2024**	Appx 2.1
2018 Structured Assessment	R3	01/03/2020	-	**30/06/2025**	Appx 2.1
2020 IM&T Control & Risk Assessment	R4	31/12/2021	30/12/2023	**29/02/2024**	Appx 2.1
	R5	31/03/2021	-	**31/03/2024**	Appx 2.1
	R8	30/06/2021	30/12/2023	**29/02/2024**	Appx 2.1
	R9	30/09/2021	30/12/2023	**31/07/2024**	Appx 2.1
	R13	31/12/2021	-	**30/06/2024**	Appx 2.1
	R14	31/12/2021	-	**30/06/2025**	Appx 2.1
2021 Mental Health & LD Divisional Review	R3	30/09/2021	-	**31/01/2025**	Appx 2.1
2021 Audit of Accounts	R3	31/12/2021	-	**30/06/2025**	Appx 2.1
2021 Pathology	R8	24/02/2022	01/09/2023	**01/09/2026**	Appx 2.1
2021 Occupational Health	R1	31/03/2022	06/10/2023	-	Appx 2.2

2021 IT Systems (WRIS)	R1	01/03/2022	-	-	Appx 2.2
	R2	31/03/2022	30/09/2023	**30/09/2024**	Appx 2.1
	R4	31/03/2022	-	-	Appx 2.2
	R5	31/03/2022	-	-	Appx 2.2
	R5.1	30/06/2022	-	-	Appx 2.2
	R6	01/03/2022	-	-	Appx 2.2
	R7	30/04/2022	-	-	Appx 2.2
	R8	31/03/2022	-	-	Appx 2.2
	R9	30/04/2022	-	-	Appx 2.2
	R10	30/04/2022	-	**30/09/2024**	Appx 2.1
2021 Facilities – Care After Death	R3	31/03/2022	30/04/2023	**30/09/2024**	Appx 2.1
	R4	31/03/2022	-	**30/09/2024**	Appx 2.1

Audit Recommendations 2022 – 2023

Table 3 displays the **49** overdue recommendations from audits conducted in the 2022/23 audit year that required an update. Further details can be found at **Appendix 3**

Table 3

All Overdue Recommendations from 2022/23 Audit year as at 31 December 2023 requiring an update					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2022	**8**	**28**	**4**	**6**	**46**
2023	**3**	**-**	**-**	**-**	**3**
Total	**11**	**28**	**4**	**6**	**49**

Table 4 summarises the position reported as at 31 December 2023 by the year of audit in respect of completed recommendations. **30** overdue recommendations have been completed in this reporting period. Further detail can be found at ***Appendix 5.***

Table 4

All Completed Recommendations post update					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2022	**3**	**15**	**3**	**6**	**27**
2023	**3**	**-**	**-**	**-**	**3**
Total	**6**	**15**	**3**	**6**	**30**

Table 5 below summarises the position reported as at 31 December 2023 by the year of audit in respect of overdue recommendations. Further detail can be found at ***Appendix 6.***

Table 5

Overdue Audit Recommendations for 2022-23					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2022	**5** (*5)	**13** (*11)	**1**	**-**	**19** (*16)
2023	**-**	**-**	**-**	**-**	**-**
Total	**5** (*5)	**13** (*11)	**1**	-	**19** (*16)

NB: (*x) denotes the revised number of deadline(s) requested; these are included in the overdue figures as they have not yet been approved by the Committee.

Summary of All Audit Recommendations

The overall position reported in this paper reflects the position as at 31 December 2023 in which there were **<u>73 overdue</u>** recommendations. Following the update, **31** have been assigned a revised timescale represented in Table 6 as (*number of revised timescales) for approval by the Committee. **12** remain overdue *(9 legacy and 3 for 2022-23)* as shown in the Dashboard at **Appendix 1** and **30** have been completed, shown in Table 7

Table 6

All Overdue Audit Recommendations (*Revised deadline requests)					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	**-**	**-**	**1** (*1)	**-**	**1**(*1)
2018	**-**	**-**	**1** (*1)	**-**	**1** (*1)
2019	**-**	**-**	**-**	**-**	**-**
2020	**-**	**-**	**-**	**6** (*6)	**6** (*6)
2021	**4** (*3)	**12** (*4)	**-**	**-**	**16** (*7)
2022	**5** (*5)	**13** (*11)	**1**	**-**	**19**(*16)
2023	**-**	**-**	**-**	**-**	
Total	**9** (*8)	**25** (*15)	**3** (*2)	6 (*6)	**43** (*31)

Table 7

All Overdue Audit Completed Recommendations					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	**-**	**-**	**-**	**-**	**-**
2018	**-**	**-**	**-**	**-**	**-**
2019	**-**	**-**	**-**	**-**	**-**

2020	**-**	**-**	**-**	**-**	**-**
2021	-	-	**-**	**-**	-
2022	3	**15**	**3**	**6**	**27**
2023	**3**	**-**	**-**	**-**	**3**
Total	**6**	**15**	**3**	**6**	**30**

Since this reporting period 31 December 2023, recommendations with deadlines in quarter 4 of the financial year 2023/24 would have become overdue. These will be updated in preparation for the next reporting cycle.

For information, there are **0** overdue recommendations for the Audit Year 2023-24. **Appendix 7** shows all the recommendations Not Yet Due as at 31 December 2023.

Argymhelliad / Recommendation

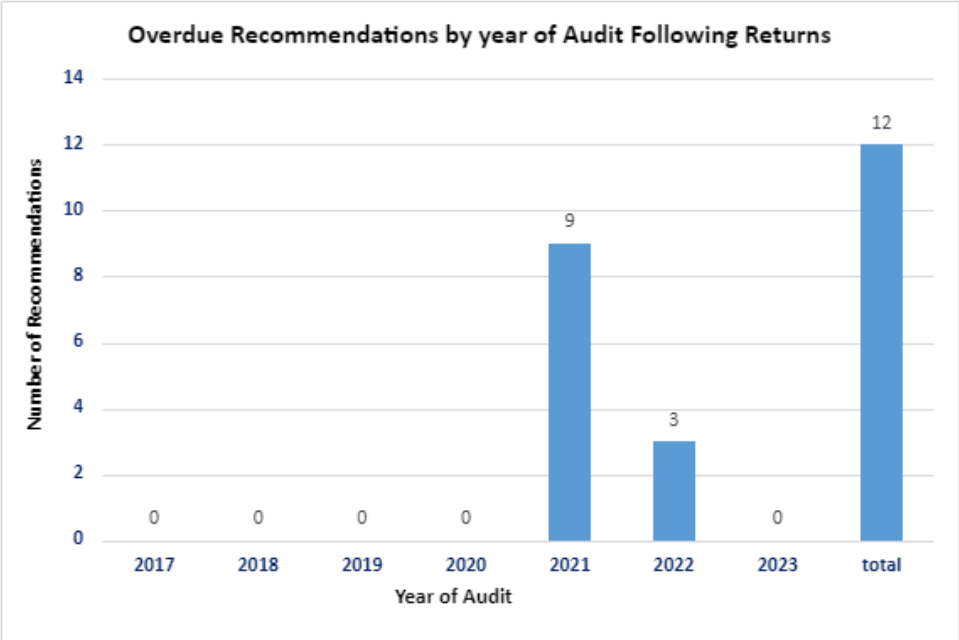
- **NOTE** the position in respect of **12** overdue audit recommendations;
- **NOTE** the position in respect of **30** complete audit recommendations;
- **APPROVE** the revised timescales for the **31** Recommendations; and,
- **AGREE** to move to quarterly reporting.

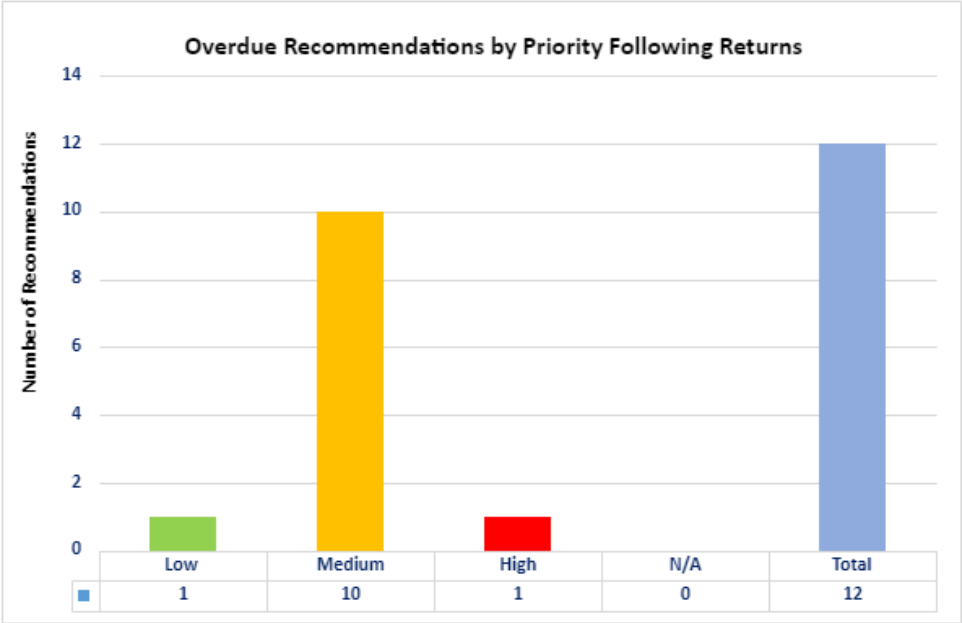
Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

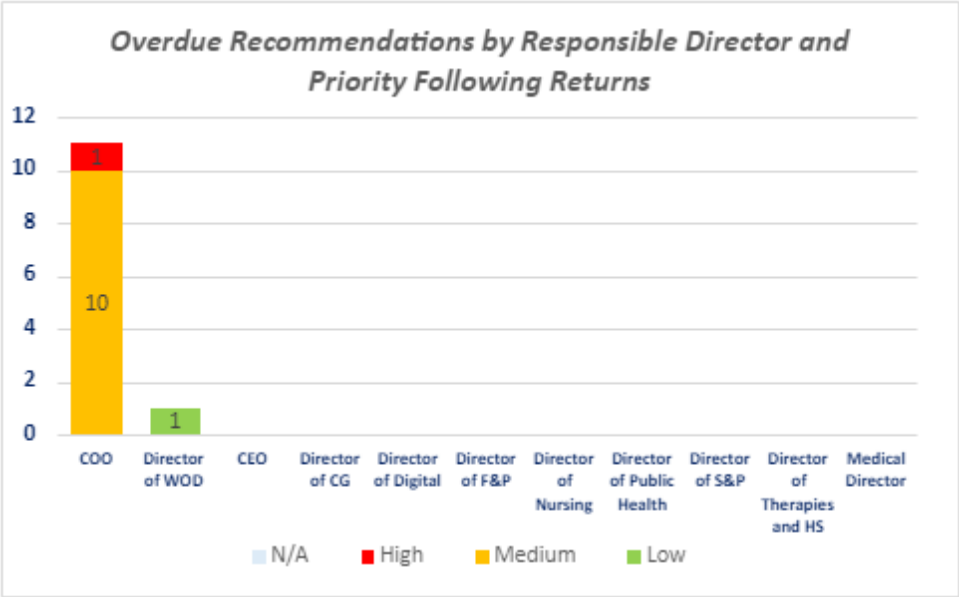
Gwybodaeth Ychwanegol: **Further Information:**

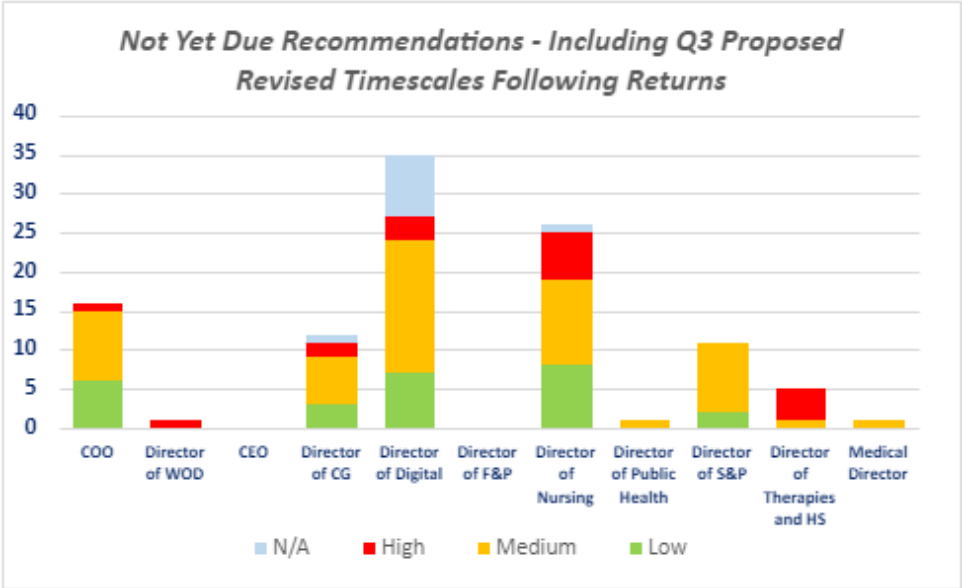
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	All terms are explained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

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









Overdue Recommednations by Priority	Low	Medium	High	N/A	Total
	1	10	1	0	12

Not Yet Due Recommendations by Priority	Low	Medium	High	N/A	Total
	26	55	17	10	108

Appendix 2 2017-21 Overdue Recommendations Pre-Updates

Audit Type	A&LUHB Ref No.	Report Title	Assurance Rating	Director	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by A&AC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmentin each ward and department, which should record relevant equipment details. The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-68.85	31/03/2024	3.02	Revised Timescale not approved by committee at 28.11.2023	Overdue	Overdue		Nov 2022- This recommendation is monitored regularly via the Medical Devices Committee. The deadline is proposed to be extended due to Health Board ability to get around all of the equipment. We would suggest that the system is in place to track the assets however, further work is required to physically tag the equipment and ensure compliance and traceability.	The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to bitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	Medical Electronics (E&ME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (E&ME) update the latest location on their database as equipment passes through the department. Capital Finance undertake walk about audits to tag and update locations of assets. All new assets are RFID tagged as part of our E&ME commissioning checks.	Whilst the aim is to tag all medical Equipment & devices throughout the Hb hospitals we are focused on completing one major site. This being the GLH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GLH. In total we have RFID tagged ever 4100 medical devices to date across our Hb sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a bitz approach to RFID tagging the remaining devices, starting at the GLH.	30/12/2023
External	2018.01EA	Structured Assessment 2018	Not Rated	Director of Digital	High	R3	R3 The Health Board should improve its information governance arrangements by: Improving compliance with the information governance training programme to reach the national rate of 95%.	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bimonthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020	-45.87				Overdue			• Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout A&LUHB.		Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress	Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non compliance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have difficulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	-23.90	30/12/2023	0.00	28.11.2023	Overdue	Overdue		• Strategic plan to incorporate cascade trainers into the training provision to increase compliance.					30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for Informatics division but Informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	-32.92				Overdue			Nov 23: The TOF has been reviewed and the structure and operational model for Digital is being finalised, due to the requirement of an OCP it is anticipated this will now be completed in approximately 6 months. August 2023: New governance group is under development to provide strategic oversight of digital initiatives, New Digital Service Request process is currently being finalised alongside a new Financial Control Procedure to provide governance and assurance over digital spend and initiatives. Business Partnership arrangements between Digital and the Divisions / Corporate Services is being planned. May 2023 - No additional TOF posts to be created pending new Director of Digital review March 2023- Director of Digital will be reviewing the Target Operating Model once in post January 2023 - Paper has been submitted to CEO and is under consideration. September 2022 - The proposal for TOF structures will be submitted October 22 with note at DDOB. August 2022 - Governance and Assurance Groups have commenced and include governance around procurement of departmental systems June 2022 - financial planning has been completed, CDO to meet with Executive Director NP on next steps July 22 March 2022 - Resource requirements have been identified as part of the Target Operating Framework, but are yet to be agreed. The aim is to resolve by end of Q1/23 November 2021 - The Templer Report has identified the resource requirements to achieve this strategic objective and as part of their engagement will ensure that this is progressed and a performance management framework established to provide oversight. The target date for setting up the Office of the SIRO is Quarter 4. June 2021 - not yet an agreed cost model to propose to Execs				30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for PMO Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	-26.93	30/12/2023	0.00	28.11.2023	Overdue	Overdue		Nov 23: The new digital service request process is nearing completion and will shortly be launched across the Health Board. The Digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained on all projects. Aug 23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. May 2023 - Benefits audit carried out and substantial assurance awarded. Funding to fully establish the PMO not yet secured however a portfolio view of all digital service requests and transoformation programmes has been developed along with a prioritisation and optimisation framework. DDOG has been stood down temporarily so prioritisation is done on an ad hoc basis with members of the exec team. Mar 23: Funding required for Head of PMO however, digital Portfolio manager recruitment underway in Programmes and benefits audit completed with substantial assurance. January 2023 - Awaiting funding for Head of PMO. Benefits management audit underway in programmes. September 2022 This is part of the TOF paper submission Oct 22. August 2022 - Funding requested to progress Head of PMO to further support the portfolio development and implementation of the Digital Strategy. Report on the progress against the strategy shared with Board in July. Further update on benefits required for Nov/Dec audit committee. June 2022 - Portfolio dashboard under development and quarterly portfolio review & update meeting scheduled. Head of PMO included in TOF funding requirements. Programmes looking to recruit Portfolio Managers to support the move to Portfolio Management. Standard milestones established in Programmes which will feed the portfolio register to support reporting. May 2022 - Significant work has been undertaken to develop an informatics wide portfolio register to determine LIVE and emerging project work. Further development underway to include dependencies and key project milestones dates. Some funding in place and posts filled, further investment detailed in Target Operating Framework cost model to support				30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	-26.92	30/12/2023	0.00	28.11.2023	Overdue	Overdue		Nov 23: Progress has been made on the request process, business partnering and governance and will be completed by the 31/12/2023. The Digital Champions Network has recently been relaunched. Aug 23: New Digital Service Request process, business partnering and new governance group is under development May 2023 - A divisional engagement model has been agreed for managing new service request and work in progress activities. A CSG meeting has been established. Urgent care to be established next and roll out to follow as resources allow. March 2023 - Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post January 2023 - Funded CNIO and Nursing Informatics lead. First Divisional meeting scheduled for December and await the outcome of the financial bid for the TOF September 2022 - Informatics have fully funded the Nursing Informatics Post and an increase in allocation for clinical leadership. The TOF paper being submitted in October 22 addresses the immediate priorities for more effective engagement with Informatics in the HB. August 2022 - WNCR rollout plans include a nurse on each ward being champions for digital systems and GAG's promoting the need for divisional champions to be identified by the SIAO's. June 2022 - agreement of co-funding informatics and Nursing, subject to financial strategy for TOF implementation; a review of stakeholder assets to be undertakent May 2022 - cost model submitted, seeking to deliver strategy end of Q1/23 November 2021- A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs. This includes the recommendation for Business partner roles to propogate a network of champions.				30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	-23.90				Overdue			Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. Aug 2023: Awaiting next HBOTS meeting. May 2023 - work to commence shortly under SIRO March 2023 - Part of work programme that will be commencing from May under Rani January 2023 - Part of the HBOTS work programme to be established with SIAOs September 2022 - Paper is drafted and will be submitted October 22. August 2022 - Pending financial strategy and TOF implementation June 2022 - subject to financial strategy for TOF implementation November 2021 - This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system				30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021	-23.90				Overdue			Nov 23: Aug 2023: Awaiting next HBOTS meeting.					30/12/2023
Internal	2021.00	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Chief Operating officer	Low	R3	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•Clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021	-26.92				Overdue			June 2023 - Remodelling of service and introduction of APP to FC so KPI to develop in line with new modelling	Quality of data and minimal guidance for reporting on performance	Fortnightly performance meetings, Divisional assurance meetings and triangulation with other governance processes.	ongoing		30/12/2023
External	2021.01EA	Audit of Accounts Report, 2020-21 - Addendum Issued December 2021	Not Rated	Director of Digital	Medium	R3	The HealthBoard should consider strengthening their IT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Welsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although aware currently investigating options for these.ii.A&LUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them too supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the finalised version will be released within the coming weeks.v.All user accounts are processedin line with NHS Wales standards.There is a current risk that unless a service request had been raised to the ICT Service Desk, staff who leave Pharmacy but remain within the organisation may still have access to WellSky. Further review of the staff leavers/policy may need to be undertaken.	31/12/2021	-23.90				Overdue			Nov 23: Critical Server refresh ongoing, KPI's being developed for presentation at Cyber Security Assurance Group Aug 23: No update - older servers are being replaced via critical server refresh project, updated figures to be provided by SC May 23: No further update Mar-23: Discussion with 3rd party is still ongoing Jan-23 i. Currently there are 2 remaining servers left on 2008. These rely on upgrades to the software applications to enable the move to a supported Windows Server version. The team will continue to liaise with the services to remove the last 2 remaining. ii. Currently we have 3 devices remaining. The team will continue to liaise with the services to remove the last remaining. iii. Confirmed this was completed. iv. Confirmed this was completed.				30/12/2023

Internal	2021.05	Pathology	Reasonable	Chief Operating Officer	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2022	-22.10	01/09/2023			Overdue	Overdue		All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP.	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.	Agency staff being utilised at a cost. Overtime being utilsed at a cost. Scrutiny forms and SBARS submitted to request additional staff that are urgently required prior to implementation of revised workforce plans.	Workforce plans to be completed as soon as is possible Following completion, business cases may need to be produced and submitted for approval to recruit the additional staff required which will ensure Pathollogy service requirements will be met over the next five years and beyond.	30/12/2023
Internal	2021.07	Occupational Health	Substantial	Director of Workforce & OD	Low	R1	The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately. b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st2022. Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st 2022.	31/03/2022	-20.95	06/10/2023		12/09/2023	Overdue	Overdue		Aug 2023: A new automated system OPASG2 is coming in on 20th September which will bring the following benefits in addition we are engaging with all Wales review and systems procurement. Applicants complete an online pre-employment health declaration – removal of paper forms! Integrated functionality between OPASG2 and the Trac recruitment system. Therefore, OH results update the applicant record directly in Trac. Transparency of applicant progress with timely updates visible in Trac such as an OH appointment booking. Reduced waiting times for Occupational Health Clearances	Aug 2023: Lessons learned from early implementers (Swansea)any any further potential dealys on an all Wales basis. Sep 2022 Awaiting decision regarding the new All Wales Occupational Health database. This has been put on hold until Spring 2023 . With regards OT implementation awaiting expressions of interest	Aug 2023: Executive team. Comprehensive training package Ongoing review of skill mix and resources to meet the deamands of the service .	Aug 2023: September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23. Autumn 2023 for full implementation following procurement and implementation of the new data base.	30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R1	R1 Clarity should be sought over the roles and responsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner. ABUHB Radiology internally request on service point if the department knows the server team need to undertake work. We will continue to do this.	01/03/2022	-21.93				Overdue					Targetted training is provided to teams in the meantime.		30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022	-19.97				Overdue			Nov 2023: WRIS backups with recent upgrade work proved to be reliable.				30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R2	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMB for an integrated electronic process cannot be delivered. The Health Board should carry out an analysis to fully identify its needs for a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	-20.95	30/09/2023	-2.98	12/09/2023	Overdue	Overdue		Aug 2023: The UAT has been passed and is with clincial apps and is being trialled in Primary Care on the 11/09/2023. There are discussion amonst informatics about integrating the WCP requesting within CWS and we have done early scoping exercises with a bussiness analysist revewing this currently. May 23: The UAT has been passed and is with clincial apps and Mr Rice to look at.	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5.1	R5.1 The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS.	Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	30/06/2022	-17.97				Overdue					Targetted training is provided to teams in the meantime.		30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R4	R4 The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed.	There is a backup regimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	-20.95				Overdue			A database that the alerts and notifications is on is not supported by RadIS.	RadIS will not support this with the alerts and notifications query on the server still.	The database has been backed up by the server team		30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	31/03/2022	-20.95				Overdue			Aug 2023: The UAT has been passed and this is currently being looked at by informatics	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R6	R6 Password controls should be improved with an increased minimum length and the Board should reduce the default maximum attempts available.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have 5 attempts.	01/03/2022	-21.93				Overdue			Nov 2023: currently trialling in primary care which has been succesful and is with software developments and informatics bussiness analysist to scope out as this is the selected solution from RISP.	Would need to staple in WCP ETR into CWS once the project has been scoped and timlined.	We have got checks for clinicians with similar names for obvious booking errors.		30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	-19.97				Overdue			Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.				30/12/2023

Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	-20.95				Overdue			Currently with DHCW to develop.	Time and resource in RadIS. As well as pending RISP program may not help development.			30/12/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	-19.97				Overdue			Aug 2023: The BC plans in radiology are quite extensive and well practiced	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.			30/12/2023
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	30/09/2022	-14.95	30/04/2023	-8.00	12/09/2023	Overdue	Overdue		November 2023 - new software was not procured due to cost implications. Work undertaken to cleanse database and ensure that relevant fields are completed to enable reports to be produced through Qlik. Work on reporting is currently underway. Update August 2023 - np new software procured by W&E. A meeting with informatics took place on 18/08 to discuss current database. Agreed Informatics do not have the expertise to make any significant changes to the system but have committed to maintain the system by best endeavours. Agreed that Qlik will be used to produce reports. Nov 2022 Alternative software solution has been procured via Symbiotix. Ongoing liaison between Symbiotix, IG & IT infrastructure teams to ensure all relevant safety aspects are mapped out. Further development work alongside Information Governance team to understand the barriers to uploading patient information is being undertaken.	IT Infrastructure Team resouce capacity may delay the implementation.	November 2023 - Meeting with IT and support has been put in place for basic maintence of database with reports being run through Qlik Mar 23 Ongoing liaison with Associate Director of Informatics Strategy & Planning	Q4 of 2022/23	30/12/2023
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Low	R4	R4 The Care after Death Team should: • develop call cascade lists to identify staff contact details in advance; • identify additional scenarios that may arise and detail action plans to overcome them; • test a range of continuity events regularly (at least once a year); and • identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.	The CaD Team accept this recommendation in full.	30/09/2022	-14.95				Overdue			November 2023 -fridge/freezer capacity is still available on the database and space can be identified in the event of unavailability. Work underway at RGH to install 56 further fridge/freezers (not completed December 2023). Deceased patient storage business contuity plan is currently being updated to identify/reflect new or additional scenarios. Update August 2023 - Fridge/freezer capacity available on the database and space can be identified in the event of unavailability. Mar 23 Being developed by CAD Manager. 24/03/2023 CAD Team have been sited within CSS Division since November 2022. Due to temporarily return to E&F in April; Facilities Manager to work with team to completion during Q1 of 2023/24.	28/07/23 Environment Act (Wales) increased recycling regulations to be enforced from Apr 24 (non-inpatient premises) and Oct 25 (inpatient premises). Requirements may change in the lead up to implementation of the Act		Q3 2022/23	30/12/2023

2017 Medical Equipment and Devices	**Assurance Rating** Limited	**Priority Rating** High
Executive Lead: Director of Therapies and Health Science		
Recommendation 1: 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.		
Management Response: The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.		
Final Report Agreed Implementation Date: 31/03/2018		
Revised Implementation Date: 31/03/2024		
Assurance Summary		

Recommendation 1:

Current situation and summary of work to date:

(a) Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details The Health Board is compliant with this part of the recommendation at a practicable minimum level. A centrally managed industry standard pan-organisation medical equipment register is in place and operational. The Health Board acquired and commissioned its Softpro Medusa medical equipment management database that is pertinent to national guidance for medical equipment management functionality. This database is managed by the Medical Electronics and Bio-Medical Engineering (EBME) service. Medical equipment management information on each item of equipment, including the location where each item is deployed, is recorded in Medusa. Reports can be produced filtered by ward/ department though the on-line Customer Portal. Medusa is used to manage work orders for life-cycle medical equipment management actions.
(b) The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed. The Health Board is fully compliant with this part of the recommendation. The Medusa database in use is industry standard in its structure and functionality for managing medical equipment within a UK health institution. Management of Medusa, including data accuracy checking, is overseen by the Health Board's EMBE service as part of their pan-organisation Medical Equipment Management and technical support
role.
(c) 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. The Health Board is partially compliant with this part of the recommendation. Ward and departmental managers can access a list of equipment in the register that is allocated to their work area from the centralised register. Ward and departmental

managers are familiar with the cohort of equipment used by their staff in their duties and understand their responsibilities around managing this equipment. EBME provide centralised control of the physical entry of records on individual items of equipment within the Medusa register database. Ward and departmental

Managers can access a list of equipment in the register that is allocated to their work area via the Customer Portal. Ward and departmental managers act according to their responsibilities detailed in the Management of Medical Equipment and Devices Policy linked to the equipment registered to their work area · There is an identified need to create a user guide for the Medusa Customer Portal so that ward and departmental managers can view and print reports on their allocated equipment so as to be better informed for their reporting of discrepancies and variations. Provision of appropriate training forward and departmental managers on using the Medusa Customer Portal would support them in this activity. · There is an identified need to support ward and departmental managers, though creation of a standard operating procedure, linked to the Health Board's Management of Medical Equipment and Devices Policy, to guide them in their responsibilities for nominating and delegating local day-to-day oversight of medical equipment and devices to ward/department equipment controllers (d) Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded The Health Board is fully compliant with this part of the recommendation. There is a programme of periodic register accuracy reviews and of auditing the review processes. A mechanism is in place for ward and departmental managers to audit the equipment deployed in their work areas against the register and to report discrepancies for correction action The Finance department has put in place a system for asset verification of deployed items that are classed as capital assets, including medical equipment and devices. EBME verify the records on individual equipment items at points of contact with it during its operational lifespan and from ad hoc updates received from ward and departmental managers. (e) Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues. The Health Board is compliant with this part of the recommendation at a practicable minimum level. The register captures equipment lifecycle stage events and changes to the departments to which equipment is allocated. Data accuracy of information held on individual items is managed under a rolling review programme and applied during EBME's routine planned preventative maintenance actions. Deployment location updates rely on manual

reporting by ward and departmental managers, by routine data verification by EMBE or under Finance's routine Asset Management activities. This will be automated once the RF tracking system is fully implemented. The temporary movement of equipment between departments with the flow of patients may go unrecorded prior to this. Consideration in the merit of adding temporary resource to support EBME in completing RF tagging of the remaining equipment would be advantageous in accelerating this project. Mitigating actions pending delivery of recommendation: The dominant risk factor related to this recommendation is of unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified:

Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate.

Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment. · Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually. · Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this. Barriers to compliance causing implementation Delay: The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle. EBME have not had the resources to create the Customer Portal instructions and disseminate them. Revised Timeline: Anticipate completion of the remaining mitigation actions by the end of March 2024.

2017 Medical Equipment and Devices				
Audit Recommendation Description	**Recommendation 1:** 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.			
Potential risks due to the outstanding recommendation	There is risk of unbalanced investment in portable medical equipment and devices owing to baseline purchasing of excess equipment in compensation for users having difficulty finding the equipment they need efficiently There is risk that ward and departmental managers have difficulty accessing the Medusa Customer Portal: ward and departmental managers require training on how to access and interrogate the Medusa database via the Customer Portal Ward and departmental managers need time allocation to oversee and to routinely verify their allocation of medical devices and equipment Assurance that ward and departmental managers are fully conversant with their responsibilities as stakeholders in the management of medical equipment and devices, intended by the Management of Medical Equipment and Devices policy, is weak			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	4 Likely	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*3 Moderate*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*12 High*	**15 - 25**	**Extreme**	Requires urgent action

2018 Structured Assessment	Assurance Rating *Not Rated*	Priority Rating *High*

Executive Lead: Director of Digital

Recommendation 3: The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.

Management Response: Information Governance training reviewed to include the legislation changes because of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bimonthly, and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.

Final Report Agreed Implementation Date: 01/03/2020

Revised Implementation Date(s): 30/06/2025

Assurance Summary

Recommendation 3

Training compliance is currently 83%. The additional national Cyber Security modules added to the Information Governance training has hindered progress in improving compliance due to the time required to complete the training package.

There is particularly low compliance amongst Clinicians and the Data Protection Officer has discussed this with the Medical Director. He will be reminding them of their responsibilities to complete the mandatory training.

Mandatory training compliance we will report to the Information Governance Sub-Committee and further plans will be put in place to improve compliance to the 95% target.

2018 Structured Assessment				
Audit Recommendation Description	**Recommendation 3:** The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.			
Potential risks due to the outstanding recommendation	There is a risk of an Information Governance breach leading to data loss and potential enforcement fines by the Information Commissioners office caused by the lack of understanding by staff across the organisation of keeping Information safe and secure.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	4	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*16*	**15 - 25**	**Extreme**	Requires urgent action

2020 IM&T Control and Risk Assessment	Assurance Rating *Advisory*	Priority Rating *N/A*
Executive Lead: Director of Digital		
Recommendation 4: The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.		
Management Response: A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.		
Final Report Agreed Implementation Date: 31/12/2021		
Revised Implementation Date(s) – 29/02/2024		
Recommendation 5: The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision-making process for all IM&T items.		
Management Response: The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division, but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.		
Final Report Agreed Implementation Date: 31/03/2021		
Revised Implementation Date(s) - 31/03/2024		
Recommendation 8: An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.		
Management Response: As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.		
Final Report Agreed Implementation Date: 30/06/2021		
Revised Implementation Date(s) – 29/02/2024		
Recommendation 9: A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.		
Management Response: The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Out with the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co-produced to manage all priority investments.		
Final Report Agreed Implementation Date: 30/09/2021		

Revised Implementation Date(s) – 31/07/2024
Recommendation 13: Critical assets should be identified within the asset and configuration management systems.
Management Response: This in part is due to the devolved nature of informatics. The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.
Final Report Agreed Implementation Date: 31/12/2021
Revised Implementation Date(s): 30/06/2024
Recommendation 14: The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.
Management Response: The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.
Final Report Agreed Implementation Date: 31/12/2021
Revised Implementation Date(s): 30/06/2025
Assurance Summary
Recommendation 4 Work is underway to align the directorates existing risk management framework with the updated Health Board framework and will be complete by the end of February. Any digital issue, events and problems are managed using well defined best practice and roles are in place within Digital Service Delivery to support this. The new directorate framework will outline how operational risks identified through day-to-day support activities are managed using Datix as the single source of information. **Recommendation 5** Regular Divisional engagement meetings have been expanded to include Urgent Care leaving Mental Health & Learning Disabilities and Medicine to be implemented before the end of March 2024. Each Division will be provided with a 'Digital Buddy,' a member of the Directorate Senior Leadership team who will chair the oversight meetings and will provide Divisions with a single point of contact for raising issues with the Directorate. As one of the key planning enablers the directorate participates actively in the annual planning process working with Planning to understand the needs of the service and align digital activities to those needs. The engagement and communication activities of the directorate will be summarised in a new Engagement & Communication Plan. Work is planned to restructure the directorate to enhance its strategic planning and engagement capability and new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requirements are understood, are properly documented, and have sufficient detail to enable prioritisation. The directorate recently had a substantial audit report from Internal Audit for its arrangements for stakeholder engagement. **Recommendation 8** A new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requests are understood, are properly documented, and have sufficient detail to enable prioritisation. A key component of this will be strategic alignment with the core local and national digital strategies. The Digital, Data & Technology sub-committee of the Finance & Performance Committee will provide an additional governance space for assurance of the work of the directorate by its Health Board stakeholders as well as the Executive.

Progress has been made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. Internal audit will shortly be undertaking an audit of our portfolio arrangements in line with best practice.
Currently the new Data Strategy is currently under development and associated strategies for ICT and Cyber Security are planned for the first quarter this year.
The Health Board has commissioned CGI to undertake consultancy of on the future of the Electronic Health & Care record across the organisation and we would expect a report for this in the summer. These strategies will be brought together as an overarching summary Digital Strategy following these developments.
Recommendation 9
The Digital Champions network for Microsoft 365 has been relaunched and there are plans to further develop this through networking events and lunch and learns.
Similar networks are being planned for Analytics and the refreshed Clinical Council.
Recommendation 13
New Cyber Security Assurance Group will be meeting in January 2024 and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group.
In addition, the Cyber Resilience Unit will be visiting the Health Board in late January to discuss progress against the Network & Information System Regulations.
In April 2024 work will commence on the Health Board's new security platform which will provide visibility of all assets connected to the network which will improve the visibility of critical assets which may not be managed by the directorate.
Recommendation 14
No progress, wider asset management approach and configuration management approach to be formalised during 2024/2025 financial year.

2020 IM&T Control and Risk Assessment				
Audit Recommendation Description	**Recommendation 4:** The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.			
Potential risks due to the outstanding recommendation	There is a risk of service or problem outages which would impact on service delivery being caused by unidentified risks that are being managed or mitigated			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	3	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*12*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 5:** The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision-making process for all IM&T items.			
Potential risks due to the outstanding recommendation	There is a risk that the benefits of Digital will not be realised leading to inefficient use of resources caused by the lack of Digital stakeholder engagement and service change that is not service driven.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*3*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*6*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 4:** The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.			
Potential risks due to the outstanding recommendation	There is a risk of service or problem outages which would impact on service delivery being caused by unidentified risks that are being managed or mitigated			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	3	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*12*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 5:** The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision-making process for all IM&T items.			
Potential risks due to the outstanding recommendation	There is a risk that the benefits of Digital will not be realised leading to inefficient use of resources caused by the lack of Digital stakeholder engagement and service change that is not service driven.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*3*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*6*	**15 - 25**	**Extreme**	Requires urgent action

2021 Mental Health and Learning Disabilities	Assurance Rating *Reasonable*	Priority Rating *Low*

Executive Lead: Chief Operating Officer

Recommendation 3: We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:

- the collection of baseline data;
- targets or success measures with which to compare what is actually achieved;
- the measurement and recording of the benefit metrics;
- responsible managers; and
- the oversight body of the benefits, to ensure these are achieved.

Management Response: Agreed and we acknowledge that a robust benefits realization plan needs to be developed and we are looking to commission external support to assist with this process for the SISU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.

Final Report Agreed Implementation Date: 30/09/2021

Revised Implementation Date: 31/01/2025

Assurance Summary

Robust benefits realization plan was developed in relation to SISU (commissioned externally by ABUHB (Aneurin Bevan University Health Board)) during process for the SISU Programme.

This BRP was included as part of the OBC submitted to WG & submitted to the Board for approval.

2021 Mental Health and Learning Disabilities				
Audit Recommendation Description	**Recommendation 3:** We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times. As this process is already underway, the Team should continue to identify other key performance indicators. This information should also link into individual performance within the Team, for training and improvement.			
Potential risks due to the outstanding recommendation				
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit

Likelihood		**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact		**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating		**15 - 25**	**Extreme**	Requires urgent action

2021 Pathology	Assurance Rating *Reasonable*	Priority Rating *Low*
Executive Lead: Chief Operating Officer		
Recommendation 8: The Health Board should complete a refresh of the latest workforce planning exercise (including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond. Where additional resourcing / facilities are required, these should be factored into the IMTP process.		
Management Response: To review and update workforce plans as appropriate. Workforce is factored into the IMTP		
Final Report Agreed Implementation Date: 24/02/2022		
Revised Implementation Date(s) - 01/09/2026		
Assurance Summary		
Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH (Royal Gwent Hospital) to provide suitable medium-term accommodation (ETA for accommodation plan 31/03/24). *Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25).* *Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent.*		

2021 Pathology				
Audit Recommendation Description	**Recommendation 8:** The Health Board should complete a refresh of the latest workforce planning exercise (including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond. Where additional resourcing / facilities are required, these should be factored into the IMTP process.			
Potential risks due to the outstanding recommendation	WFP for Microbiology in progress			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	1	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*8*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months

Risk rating	8	15 - 25	Extreme	Requires urgent action

2021 Audit of Accounts Report 2020-21	Assurance Rating *Not Rated*	Priority Rating *Medium*

Executive Lead: Director of Digital

Recommendation 3: The Health Board should consider strengthening their IT Controls as follows:

- All the Windows server 2008 operating system should be replaced with either Windows 2012 or higher where possible (this is almost completed with only twenty-three servers left);
- W7 and W8.1 desktop devices should be replaced as these are now de-supported;
- Ensure that the change management procedure is finalized;
  The IT Data Recovery Plan and Backup Policy should be updated and clearly defined;
- With regards to the Wellsky system, leavers and access changes should be formally recorded, and the Health Board should develop a suite of audit and security reports to run and monitor to ensure user access is appropriate.

Management Response:

- With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although we are currently investigating options for these.
- ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete. There is an active programme of work to remove these devices from the network or upgrade them to a supported version of Win10.
- We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change. The process has been widely socialized with all of Informatics and other Key Stake Holders and engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management. Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.
- The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated. A draft version has been shared within the team and the finalized version will be released within the coming weeks.
- All user accounts are processed in line with NHS Wales standards. There is a current risk that unless a service request has been raised to the ICT Service Desk, staff who leave Pharmacy but remain within the organization may still have access to WellSky. Further review of the staff leavers/policy may need to be undertaken.

Final Report Agreed Implementation Date: 31/12/2021

Revised Implementation Date(s): 30/06/2025

Assurance Summary

Recommendation 3

The work to remove legacy versions of Windows Server and Windows Desktop operating systems has gone well with no Windows 2008 servers remaining.

No further action is required on change management had a robust process is in place with strong engagement with stakeholders and assessments for clinical safety.

Further work is required to assess Backup and Recovery Policy and Starters, Leavers and Movers and will be part of the directorates workplan over the next two quarters.

2021 Audit of Accounts Report				
Audit Recommendation Description	**Recommendation 3:** The Health Board should consider strengthening their IT Controls as follows: I. All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty-three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv. The IT Data Recovery Plan and Backup Policy should be updated and clearly defined. v.With regards to the Wellsky system, leavers and accesses changes should be formally recorded, and the Health Board should develop a suite of audit and security reports to run and monitor to ensure user access is appropriate.			
Potential risks due to the outstanding recommendation	There is a risk of a cyber incident affecting critical clinical services leading to operational disruption, data loss and / or corruption caused by the continued use of legacy operating systems and applications which cannot be protected against the latest security threats.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	3	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*12*	**15 - 25**	**Extreme**	Requires urgent action

2021: IT System Controls (WRIS)	Assurance Rating *Reasonable*	Priority Rating *Medium*
Executive Lead: Chief Operating Officer		
Recommendation 2: The Health Board should seek clarity over why the requests made to DHCW (Digital Health and Care Wales) and the SMB for an integrated electronic process cannot be delivered. The Health Board should carry out an analysis to fully identify its needs for a Radiology system and seek to include these within WRIS or any future system.		
Management Response: We have tried to seek clarity and not had a full response. Request for CWS to include WCP for radiology reporting in the platform has been formally raised. We have raised the need for end to end requesting as a health board to the collaborative board for RISP project.		
Final Report Agreed Implementation Date: 31/03/2022		
Revised Implementation Date(s) - 30/09/2024		
Recommendation 10: The WRIS backups should be subject to regular testing / restore to ensure validity.		
Management Response: A request to ensure that a process for regular testing of the back-up to ensure their validity will be made.		
Final Report Agreed Implementation Date: 30/04/2022		
Revised Implementation Date(s) : 30/09/2024		
Assurance Summary		
We are working closely with DHCW and primary care to roll out the WCP Electronic Requesting system to allow true end to end electronic request from primary care. We are currently live in two GP practices and are working with another three, though the work required is on DHCW and the GP practice side not Radiology. There is a new digital service request in and is being reviewed by the business analysts in ABUHB informatics. There is a dependency on integrating the WCP Electronic Requesting module within CWS to get a true end to end electronic Radiology IT system, otherwise we will still be depending on request being manually inputted discussed in risk for recommendation 5 and 5.1. Leaving us still at a moderate to hight risk which is unchanged and likely one we will take until the RISP project is finished with WCP Electronic requesting is fully integrated into CWS. We are now fully compliant with recommendation 6 and all users have a maximum of 5 attempts to log into an account before it is locked. ABUHB carry out full SQL DB backups of the ABUHB WRIS weekly alongside daily incremental and Arcserve backups. There is no formal disaster recovery server for WRIS in ABUHB, though the PACS and RISP business continuity plans are well versed in ABUHB. This is unlikely to change with Solution being the national RIS with the RISP project. There is locally stored short-term storage of PACS images with full RIS and dictation functionality with the new RISP solution, but it will be predominantly cloud based. With any issue accessing this functionality in the external datacentre we will revert to the local short term image store with the full RIS and dictation functionality with limited to no clinical impact. Giving us a disaster recovery solution if the primary workflow is affected but this will be with the new national RISP solution. Currently we are still at a moderate to high risk which will be unchanged until we have the new solution. Logging functionality has been brought up but should be resolved in the new solution with Solitons enhanced audit trail. We will look to work alongside ABUHB ICT to feed any Soliton logs into SIEM, but the risk will remain until the new solution is in place.		

Audit Recommendation Description	**Recommendation 2:** The Health Board should seek clarity over why the requests made to DHCW (Digital Health and Care Wales) and the SMBfor an integrated electronic process cannot be delivered. The Health Board should carry out an analysis to fully identify its needs for a Radiology system and seek to include these within WRIS or any future system.			
Potential risks due to the outstanding recommendation	With the work entailed for DHCW within RISP there are not likely to be any agreed significant developments if wanted as Soliton will be the national RIS with the conclusion of the RISP project. This will then be covered with the contract we have with the national RIS/PACS solution for any developments we require. WCP Electronic requesting was chosen as the product of choice by RISP though confidence is low on the product within ABUHB and would require significant integration work within CWS.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*8*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 10:** The WRIS backups should be subject to regular testing / restore to ensure validity.			
Potential risks due to the outstanding recommendation	The database backups are taken by ABUHB, there is no formal validity testing in place, but the backups are maintained and monitored by ABUHB IT.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	1	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*4*	**15 - 25**	**Extreme**	Requires urgent action

2021 Facilities Care After Death	Assurance Rating *Reasonable*	Priority Rating *Medium*
Executive Lead: Chief Operating Officer		
Recommendation 3: R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements.		
Management Response: It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Division will now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.		
Final Report Agreed Implementation Date: 31/03/2022		
Revised Implementation Date(s) - 30/09/2024		
Recommendation 4: The Care after Death Team should: • develop call cascade lists to identify staff contact details in advance; • identify additional scenarios that may arise and detail action plans to overcome them; • test a range of continuity events regularly (at least once a year); and • identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.		
Management Response: The Care after Death Team accept this recommendation in full.		
Final Report Agreed Implementation Date: 31/03/2022		
Revised Implementation Date(s) - 30/09/2024		
Assurance Summary		

Recommendation 3 -Partially completed.

This risk has been resolved/removed by some minor changes to the current CAD (Care After Death) database and development work that will make the body store details available in Qlik. Awaiting final verification of Qlik data. Estimated date of completion 31/03/24

Recommendation 4 -Partially completed.

BCP has been developed and fridge and freezer plan in place to manage winter pressure. Additional capacity has been implemented. Cascade lists still to be added to BCP by 31/01/24

2021 Facilities Care After Death				
Audit Recommendation Description	**Recommendation 3:** R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements			
Potential risks due to the outstanding recommendation	Partially Completed. Awaiting verification of Qlik data.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*2*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*4*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 4:** The Care after Death Team should: • develop call cascade lists to identify staff contact details in advance; • identify additional scenarios that may arise and detail action plans to overcome them; • test a range of continuity events regularly (at least once a year); and • identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of Unavailability.			
Potential risks due to the outstanding recommendation	BCP has been developed and fridge and freezer plan in place to manage winter pressure. Additional capacity has been implemented. Cascade lists still to be added to BCP.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit

Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*2*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*4*	**15 - 25**	**Extreme**	Requires urgent action

2021 Occupational Health	**Assurance Rating** ***Substantial***	**Priority Rating** ***Low***

Executive Lead: Director of Workforce and OD

Recommendation 1: The Health Board should consider:

a) Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointments by staff or a self-directed referral to an appropriate professional
b) Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximize clinic availability, overtime options, re-focusing of service priorities and / or streamlining of processes to a bare minimum on a temporary basis etc.
c) Engaging in any future All-Wales reviews of occupational health services within the NHS.

Management Response:

a) It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All-Wales task and finish group developing this. Once implemented it should remove several administrative stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately.
b) occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand, for example Covid 19 PCR results and the annual Flu programme, additional administrative hours are sourced. This reduces any impact on routine Occupational Health function.
c) A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st of November and is planned to conclude on March 31st, 2022. Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st of November and is planned to conclude on March 31st, 2022.

Final Report Agreed Implementation Date: 31/03/2022

Revised Implementation Date(s) - 06/10/2023

Assurance Summary

Management Response 28/12/23:

a) In October 2023, following the introduction of a new clinical database (OPAS-G2), preplacement health questionnaires and management referrals both moved from paper-based systems to online. This has reduced the number of administrative stages.
b) Clinical work rosters have been merged and are no longer site-specific allowing for more flexibility in times of increased demand; the team are more agile in where and how they work. Occupational Health continues to review its skill mix and staffing resources to meet the demands of the service. Through periods of higher demand, the service has been supported in increasing clinical hours.
c) The service has been fully engaged when any All-Wales work has been undertaken. At present all NHS Wales Occupational Health departments are working to standardize occupational health provision, where possible, given the different configurations and staffing models. Some of the work includes the Heads of Service meeting quarterly, the introduction OPAS-G2 in all Health Boards and in 2024 we will look at standardizing job descriptions. In addition to this the dedicated Occupational Therapy provision for ABUHB staff was extended until March 2024.

*No Risk Assessment Provided

2021: IT System Controls (WRIS)	Assurance Rating *Reasonable*	Priority Rating *Medium*
Executive Lead: Chief Operating Officer		
Recommendation 1: Clarity should be sought over the roles and responsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.		
Management Response: We have had a recent upgrade, and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner. ABUHB Radiology internally request on service point if the department knows the server team need to undertake work. We will continue to do this.		
Final Report Agreed Implementation Date: 01/03/2022		
Revised Implementation Date:		
Recommendation 4: The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed.		
Management Response: There is a backup regimen in place, and DHCW has been notified of how this works. The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.		
Final Report Agreed Implementation Date: 30/06/2022		
Revised Implementation Date:		
Recommendation 5: The Board should investigate an electronic solution to uploading requests into WRIS.		
Management Response: Radiology have requested CWS to work with WCP for fully electronic requesting.		
Final Report Agreed Implementation Date: 31/03/2022		
Revised Implementation Date:		
Recommendation 5.1: The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS.		
Management Response: Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.		
Final Report Agreed Implementation Date: 31/06/2022		
Revised Implementation Date:		
Recommendation 6: Password controls should be improved with an increased minimum length and the Board should reduce the default maximum attempts available.		
Management Response: Since this audit, this has now been altered and note it was only one user with this many attempts all Administrators now have 5 attempts.		
Final Report Agreed Implementation Date: 01/03/2022		
Revised Implementation Date:		
Recommendation 7: The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.		
Management Response: We monitor this as much possible in Radiology. We have recently started receiving consultant leaver's lists from the Health Board and action these also. The success of the process will be tracked and evaluated to ensure it is working.		
Final Report Agreed Implementation Date: 30/04/2022		
Revised Implementation Date:		
Recommendation 8: The health Board should request that this logging function be developed. The Health Board should consider feeding WRIS events into the SIEM.		
Management Response: The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.		
Final Report Agreed Implementation Date: 31/03/2022		

Revised Implementation Date:
Recommendation 9: A formal disaster recovery plan for WRIS should be developed.
Management Response: The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB (Aneurin Bevan UHB) have a VMware environment where this is hosted. The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.
Final Report Agreed Implementation Date: 30/04/2022
Revised Implementation Date:
Assurance Summary
We are working closely with DHCW and primary care to roll out the WCP Electronic Requesting system to allow true end to end electronic request from primary care. We are currently live in two GP practices and are working with another three, though the work required is on DHCW and the GP practice side not Radiology. There is a new digital service request in and is being reviewed by the business analysts in ABUHB informatics. There is a dependency on integrating the WCP Electronic Requesting module within CWS to get a true end to end electronic Radiology IT system, otherwise we will still be depending on request being manually inputted discussed in risk for recommendation 5 and 5.1. Leaving us still at a moderate to hight risk which is unchanged and likely one we will take until the RISP project is finished with WCP Electronic requesting is fully integrated into CWS. We are now fully compliant with recommendation 6 and all users have a maximum of 5 attempts to log into an account before it is locked. ABUHB carry out full SQL DB backups of the ABUHB WRIS weekly alongside daily incremental and Arcserve backups. There is no formal disaster recovery server for WRIS in ABUHB, though the PACS and RISP business continuity plans are well versed in ABUHB. This is unlikely to change with Solution being the national RIS with the RISP project. There is locally stored short-term storage of PACS images with full RIS and dictation functionality with the new RISP solution, but it will be predominantly cloud based. With any issue accessing this functionality in the external datacentre we will revert to the local short term image store with the full RIS and dictation functionality with limited to no clinical impact. Giving us a disaster recovery solution if the primary workflow is affected but this will be with the new national RISP solution. Currently we are still at a moderate to high risk which will be unchanged until we have the new solution. Logging functionality has been brought up but should be resolved in the new solution with Solitons enhanced audit trail. We will look to work alongside ABUHB ICT to feed any Soliton logs into SIEM but the risk will remain until the new solution is in place.

2021: IT System Controls (WRIS)				
Audit Recommendation Description	**Recommendation 1:** Clarity should be sought over the roles and responsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.			
Potential risks due to the outstanding recommendation	There is an issue where the workflow for CWS calling for the Radiology images isn't supported by DHCW but they have been working collaboratively with us to resolve any issues that have arisen and supported updating the particular Database during the recent RadIS upgrade. All existing systems developed by DHCW are fully supported and documented with no concerns but the CWS integration I still unresolved in terms of defined roles, though support in troubleshooting has been generous from DHCW.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit

Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*8*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 4:** The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed			
Potential risks due to the outstanding recommendation	SQL Database backups are obtained weekly by ABUHB along with daily incremental and Arcserve backups. The maintenance and schedule around this is controlled by ABUHB IT and happens regularly for the risk to be minimal.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*2*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*4*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 5:** The Board should investigate an electronic solution to uploading requests into WRIS.			
Potential risks due to the outstanding recommendation	The national ETR solution is the one developed by DHCW for WCP and is also the chosen system within the new RIS/PACS solution. We are currently in the process alongside the business analysts in informatics of scoping the project. This would need to be integrated within CWS to have a true end to end electronic Radiology system in ABUHB. We won't progress further with this until WCP electronic requesting is fully rolled out within secondary and primary care in ABUHB.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*8*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 5.1:** The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS.			
Potential risks due to the outstanding recommendation	Without a true electronic requesting system such as the WCP solution that integrates fully with our RIS, we will still be at the risk of human error when creating request. When it comes to completeness checks on the data inputted into our RIS, we have got SOPs in place for this but is dependant on humans so there will always be a degree of errors which cannot be changed without a true end to end electronic requesting system.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**

Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*3*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*6*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 6:** Password controls should be improved with an increased minimum length and the Board should reduce the default maximum attempts available.			
Potential risks due to the outstanding recommendation	We are now fully compliant in this, there was a single user who was a system administrator with the maximum amount of password attempts higher than the recommended value. This has been rectified and every account now complies.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level 1**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	1	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*1*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*1*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 7:** The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.			
Potential risks due to the outstanding recommendation	We are developing a process of maintaining a list of active accounts of staff in Radiology and disabling those that leave. We do not receive those outsides of Radiology though there are very limited numbers of users outside of Radiology that have access to our PACS and RIS. The risk of this is low within radiology as we are aware of those who no longer work within Radiology but a greater risk outside as we are not informed of leavers and our access is not dictated to by active directory to control this. Though those who have left should have their Nadex accounts disabled and shouldn't be able to access the system. We will look to see if ICT or payroll can notify us of any leavers to disable any possible access within RadIS or PACS.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	3	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*2*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*6*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 8:** The health Board should request that this logging function be developed. The Health Board should consider feeding WRIS events into the SIEM.

Potential risks due to the outstanding recommendation	RadIS has limited logging functionality, and this has been raised many times in PACS/RIS SMB but is unlikely to be resolved before the RISP project comes to an end. The new national RIS solution will have full and comprehensive logging functionality. This risk is unchanged for now and staff should maintain their IG competence on ESR to ensure patient information isn't accessed inappropriately.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*5*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*10*	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 9:** A formal disaster recovery plan for WRIS should be developed.			
Potential risks due to the outstanding recommendation	We don't have a disaster recovery server in ABUHB. If the webserver is to go down, we have well documented and practiced business continuity plans to maintain the service.			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	2	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*4*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	*8*	**15 - 25**	**Extreme**	Requires urgent action

Appendix 3: 2022-23 Overdue Recommendations Pre Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	Low	R5	Implement robust communication mechanisms between the various partnership working forums (e.g., CC Development Group, Regional Integrated Complex Needs Panel, etc).Monitor the effectiveness of these forums and any new joint processes implemented.	Assistant Divisional Nurse / Division Lead QPS	30/11/2022	-12.95		-1484.92		Overdue			November 2023: interagency meetings now embedded with the most recent - CALDS/CAMHS cases interagency peer review / QA meeting now in place with agreed ToR, good engagement. Consultant Nurse plan now changed and not going ahead at the moment with development of other Divisional roles. Ongoing - Development of Complex Needs Pathway underway, Interagency collaborative meetings commenced, joint processes in draft form, Consultant Nurse JD in draft, expected to be advertised shortly	some concerns regarding differeing interpretations of the national framework and organisational responsibility between health and local authority	Vanguard training proposed by Welsh Government for Autumn 2023. UPDATE 6/11/23 Vanguard Training by Welsh Government rearranged from earlier in the year - now arranged for this month for interagency Senior Managers across Wales, with a view to resolve areas where agencies have conflicting understanding.		30/12/2023
Internal	2022.04	Agile Delivery	Not Rated	Director of Workforce & OD	High	R1	An overarching agile working plan should be developed. It should include:•An overarching vision (this could be taken from the already published Agile Working Framework).•A set of SMART goals/ milestonesto achieve this vision.•A list of Welsh Government targets which need to be achieved.•All relevant services areas should be included and engaged with.A benefits listshould be developedto sit alongside the planwhich details how the Health Board will measure its success against each of the goals. The listshould include quantifiable measurements which can be analysed to confirm the success of each goal.	Agreed, the overarching HBand WG visionwill be added to the developed Programme Plan. Overarching SMART goals will be articulated with more specific goals once the assessment and review of the estates has been undertaken.	30/11/2022	-12.95	30/11/2023	-0.98	12/09/2023	Overdue	Overdue		AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Nov 2022 Plan - will reconfirm the vision and SMART objectives in programme delivery board December 2022, then taken forward to executive Committee and Board for final endorsement	aug 2023: Estates review, accomdation group, ICT infrastructure, service change, impact of cost of living crisis on staff, capital availibility, financial review 22: Estates review, accomdation group, ICT infrastructure, service change, impact of cost of living crisis on staff, capital availibility, financial review	Aug 2023: Executive team 22: regular review through agile delivery programme board also the cost of living risk and estates risk is highlighted on the CRR	Request extension to November 23	30/12/2023
Internal	2022.04	Agile Delivery	Not Rated	Director of Workforce & OD	Low	R2	Confirm with the Executive Team that the agile working principles noted within the Agile WorkingFrameworkstill represent the current vision. If amendments are required, the Framework should be updated.	An agreed vision for agile working had been agreed by the Executive Team previously and had developed over the response to the COVID pandemic. There are agreed priorities in place for implementing this vision. However, to work beyond the agreed priorities and to embed agile working strategically into Health Board plans it is agreed that this is a good time to re-new the vision.	30/11/2022	-12.95	30/11/2023	-0.98	12/09/2023	Overdue	Overdue		AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Mar 23 Proposed agile vision presented to the Executive Committee on 09 February. Drivers and enablers were presented as well and hybrid working and setting up a network of hubs to facilitate the reduction in personal office/desk space.	Aug 2023: Redesigning vision following presentation and feedback from the Executive Committee and will progress this to Board 22: Redesigning vision following presentation and feedback from the Executive Committee and will progress this to Board	Executive team	Request extension to November 23	30/12/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Agree. We shall continue to review the roles required to implement the DAP objectives and ensure effective succession planning is in place.Directly relating to Initiative 9 – Facilities Division has recently appointed a dedicated Building Management System (BMS) Officer (due in post Jan23).Through an Academy Wales graduate developmentprogramme we shall be utilising a student placement to assist with decarbonisation metrics, reporting and engagement starting in 23/24.	01/11/2023	-1.93		-1484.92		Overdue			Nov 23: The new digital service request process is nearing completion and will be launched shortly across the Health Board. The digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained in all projects. Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls				30/12/2023
Internal	2022.05	Digital Benefits Realisation	Substantial	Director of Digital	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to programmes or Service Delivery. This will provide internal assurance of the process and ensures that options are presented to Digital Delivery Oversight Board (DDOB) with a clear assessment of priority and recommendations. DDOB is the body that will make informed decisions on the prioritisation of Informatics programmes and projects. New national programmes will be tracked through the same process allowing the Health Board to locally prioritise and feedback these priorities back to national. This draft process needs to be signed off and fully implemented.	01/06/2023	-6.95		-1484.92		Overdue			Nov 23: The new digital service request process is nearing completion and will be launched shortly across the Health Board. The digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained in all projects. Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls				30/12/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	Agree. Projects developed through the DAP shall be funded appropriately – ReFit, HSC, EFAB, revenue, discretionary capital.	01/11/2023	-1.93		-1484.92		Overdue							30/12/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	Agree. The DPB have requested suitable NWSSP Proc Serv. Representation at meetings to update and provide guidance and feedback on progress.Within the programme governance arrangements we have identified fourtask and finish working groups who will link with our local procurement team. In addition we also have a financial representative leading group 4 who directly links in with health board Director of NWSSP National initiatives which are reported at the Bimonthly board meetings within the health board.	01/11/2023	-1.93		-1484.92		Overdue							30/12/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Agree. The Decarbonisation Programme Board (DPB) within its structure has 4 subgroups each with national initiatives delegated to them. The DPB and subgroups each have ToR's and scheduled meeting frequencies.	01/11/2023	-1.93		-1484.92		Overdue							30/12/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	Agree. Funding submissions are suitably scrutinised by appropriate forums e.g. Pre-Investment Panel (PIP), Capital Programme Board or DPB.	01/11/2023	-1.93		-1484.92		Overdue						Letters returned to CEO	30/12/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agree. Projects shall be reported to the DPB with adequate metrics developed to measure carbon reduction potential. Such projects will also be reported to WG through the bi-annual qualitative reporting requirements.	01/11/2023	-1.93		-1484.92		Overdue						IMTP Process and Savings plans included as part of financial plan for 2023/24	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R2	R2 The role and responsibilities of the Primary Care & Community Estates Programme Board, in acting as the Project Board for major Primary Care projects, should be clearly defined in the Terms of Reference.	Agreed. The role of the Primary Care & Community Estates Programme Board, in acting as the Project Board will be defined and documented.	01/02/2023	-10.89	31/10/2023	-1.97	12/09/2023	Overdue	Overdue					Compendium and efficiency opportunities shared as part of a continuous process	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R3	R3 The Primary Care & Community Estates Programme Board should meet with the agreed frequency (6-weekly) as a minimum to ensure sufficiently regular oversight of the major projects within its remit.	Agreed	01/01/2023	-11.90	31/10/2023	-1.97	12/09/2023	Overdue	Overdue					Revised approach to Savings reporting and accountability established through financial reporting and recovery arrangements, inlcuding ABUHB Value & Sustainabilty Board	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R4	R4 The constitution and capacity of the Primary Care & Community Estates Programme Board to effectively execute the Project Board role for all the Primary Care projects within its remit should be reviewed and confirmed.	Agreed. The governance structure will be reviewed	01/02/2023	-10.89	31/10/2023	-1.97	12/09/2023	Overdue	Overdue					already in place as part of monhtly financial review and reporting	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R8	R8 A report should be tabled at the next Primary Care & Community Estates Programme Board meeting, presenting an update against each Gateway recommendation, and identifying any actions still outstanding.	Agreed	01/01/2023	-11.90	31/10/2023	-1.97	12/09/2023	Overdue	Overdue		Aug 2023: The Gateway Report was presented to a previous incarnation of the Project Board. It will be submitted again to the newly convened PB on 17th October. Remit of the Capital Planning Team	None	N/A	Papers and notes of newly convened PB	30/12/2023

Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R1	R1 Consideration should be given to making the supplementary courses mandatory and monitoring related training attendance	a.) The service is currently working with the national team on having a new online learning offering across Wales which includes a fully updated records management module which will be mandatory. b.) We will request, via the clinical information and professional leads, that attendance at the Health Records awareness sessions is compulsory for all ward based staff.At these sessions we will re-iterate the importance of good records management and highlight the issues that are impacting Health Records from the ward.	01/03/2023	-9.97		-1484.92		Overdue			Nov 23: IG are working with the Divisions to provide supplementary classroom training i'e. facilities. IG are looking to develop video modules as another alternative. Aug-23: The National online training incl: Cyber Security & Health Records modules has gone live. IG offer a blended approach to their training and supplementary courses provided are now included in the compliance rates if requested instead of the online version.				30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R4	R4 The management of ward clerks should be centralised, and consideration should be given to manage shortages through "bank arrangements".	a.) Local ward clerk shortages will be escalated to the Assistant Directors of Nursingand subsequently escalated to the Executive Director of Nursing. Action plan will be agreed how to solve them. b.) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing hierarchy to the ward staff.	31/07/2023	-4.98		-1484.92		Overdue			Nov 23: Will be discussed at Executive Committee and considered as part of the Digital Organisational Change Process				30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R3	R3 Records quality checks should be regularly carried out and formally evidenced. Consideration should be given to involve senior nursing staff in these checks.	The CNIO will monitor compliance with base line records management.	31/03/2023	-8.98		-1484.92		Overdue			Nov 23: Dashboard still being worked upon, national are also providing a standard one for compliance times across wales. DECI continue as buisness as usual. DNDG to discuss the way forward for nusing documentation Aug-23: Regular audits take place across the organisation such as DECCI audits. This is fed back via the senior nurses. The WNCR implementation will significantly improve some areas of compliance such dating and signing doucmentation and completion of risk assessments. The WNCR Business Change lead working with Information team to provide a dash board view of the completness and timeliness of assessment which can be provided to each ward				30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	High	R7	R7 Patient records security should be ensured at all times.	Nov 23: The development of this programme has been delayed due mainly to the recent ICO audit and the amount of work this created. However, there has been some audits undertaken by IG staff with the outcomes discussed the respective GAG's. IG will conduct security audits in remote areas to ensure compliance. The Governance Assurance Group agenda will be widened to include focused audits. The Health records service will work in partnership with this group and there will be a health records representative at Divisional GAG meetings from January 2023. Records management issues to be discussed in the divisional group meetings to create local action plans. Minutes are taken in these forums and progress monitored.	30/06/2023	-6.00		-1484.92		Overdue			Aug-23: An audit programme is under development in the IG team. The programme of work will commence in early October. Health Records are present in Divisional GAG meetings. Records management issues are discussed and a portfolio register is retained by IG and minutes are taken of the meetings.				30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.	31/03/2023	-8.98		-1484.92		Overdue			Nov 23: The promotion of good practice continues and the roll out of WNCR at NHH has commenced. Aug-23: Health Records have found significant amounts of loose filing on wards in RGH & St Woolos. This has been collected and scanned but has a negative impact as each sheet needs to be individually checked, barcoded and scanned rather than as a complete record. The rollout of WNCR has reduced paper generation on wards and the CNIO has been promoting good practice on wards as the system rolls out across RGH. Further implementations at YYF and NHH will further reduce the loose records situation.	Further rollout of WNCR in YYF, YAB, NHH will reduce the loose records and guidance will be provided to the staff on the wards in these areas.	Training of ward clerks where there are issues identified is ongoing and datix reports submitted where substantial breaches are identified.		30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R12	R12 Data recording in Datix should be improved to ensure a more accurate reporting on missing / lost records.	Reinforcement of reporting through Datix will be cascaded to ward staff in training sessions and Governance and Assurance Group meetings.	30/06/2023	-6.00		-1484.92		Overdue			Nov 23: There has been an increase in the number of breaches recorded since this work was undertaken and work will continue in these areas to get improvements. Aug 23 Work on completion and recording of breaches in DATIX has been covered in GAG's with additional training provided.				30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Nursing	Medium	R15	R15 We recommend the undated/ expired documents are reviewed, updated and ratified as a matter of priority.	Nurse Staffing Levels Wales (2016) Act Operational Framework and Escalation Process will now have approval date added and next review date.It is acknowledged that "The Protocol for requesting, authorising & booking bank and agency clinical workers Standard Operating Procedure" expired in 2017. The practice contained in the document remained the same up until the Covid Pandemic. During this time priority was to secure clinical staff to ensure our wards and our staff were safe. Subsequently, in 2022 the bank Rules have been reviewed and issued. This protocol will be reviewed in line with the implementation of safecare.	01/03/2023	-9.97		-1484.92		Overdue			Jun 23: Approval and review date added to NSLWA and updated protocol published.				30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transisition to service delivery	01/06/2023	-6.95	30/12/2023	0.00	28.11.2023	Overdue	Overdue		Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services				30/12/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	-6.95		-1484.92		Overdue			Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				30/12/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023	-0.95		-1484.92		Overdue							30/12/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R6	The Health Board should seek to align plans with other sources of digital projects.	Joint planning sessions with DHCW are now taking place and will be (following revised terms of reference and membership being agreed) considered by DDOB. DDOB will also receive escalations on funding/governance or priority issues whether local regional or national. The Programme Office will provide reporting against this	01/09/2023	-3.93		-1484.92		Overdue			Nov 23: Review of stratregy and governance arrangements has commenced.				30/12/2023
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Therapies and Health Science	Medium	R1	A SOP for how to manage and respond to HSE reports should be created. It should include, but not limited to: • how HSE reports are distributed to responsible staff within the Health Board; • who has designated responsibility for coordinating responses to HSE reports; • the escalation process for issues identified as part of HSE inspections; • who/which committee has responsibility for monitoring actions raised as part of the HSE reports and the process for doing this; and • when assurance reports should be produced and which committee should review them	The Health Board agrees with this recommendation. An SOP on the management of HSE reports will be developed and presented to the ABUHB Health and Safety Committee in May 2023	01/05/2023	-7.97	31/10/2023	-1.97	12/09/2023	Overdue	Overdue		August 2023: The development of an SOP on the management of HSE reports is being discussed at a national level via the All Wales Health and Safety Management Group. Following discussion at the natiional meeting in September 2023 an SOP will be prepared and shared with members of the Health and Safety Committee to share across the Health Board.				30/12/2023
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-7.97	31/10/2023	-1.97	12/09/2023	Overdue	Overdue		August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."				30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R1	The Discharge Policy is updated, approved and reissued, to be compliant with the All Wales policy, when issued.	The All Wales Discharge Policy is expected to be released imminently and will be intrinsic to the development of the new Health Board policy. We acknowledge that since the policy was published current practice has moved on so that the policy does not describe the working arrangements. A Task & Finish group will be established with cross divisional representation to redraft the policy and ensure the content reflects current and emerging practice once the new All Wales Policy has been made available. This work will be completed within three months of the introduction of the All-Wales Policy. In the meantime, and as noted above we will review the current Policy. We will report any ongoing risk and position to the QPSOG. The Health Board will ensure a process is in place for regular update and review of the new policy when reissued, reporting to the Clinical Standards Board.	01/10/2023	-2.95		-1484.92		Overdue							30/12/2023

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	Within the Health Board, training for discharge planning is delivered across existing induction and education programmes: Newly qualified and overseas nurses have an introduction to discharge planning through the Journey of excellence programme. The Health Boards practice educators provide ongoing education & training on discharge planning for nursing staff. The Head of Discharge has been working with the Universities to introduce a discharge planning session into student nurse training, ensuring awareness of the fundamentals before starting in their first post. Training for medical staff is currently ward based. The Assistant Medical Director for Planning will be working with a task and finish group to standardise training. Therapy staff receive discharge training throughout their undergraduate training. Much of their work is dedicated to preparing patients for discharge to their home environment or through referral to the provisions of rehabilitation or other support. Local discharge planning arrangements are disseminated through the site and ward teams.	01/10/2023	-2.95		-1484.92		Overdue								30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	01/10/2023	-2.95		-1484.92		Overdue								30/12/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	-6.95	31/10/2023	-1.97	12/09/2023	Overdue	Overdue		Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	None	N/A	Aug 2023: Agreed leases	30/12/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Low	R6	Quantified, measurable and achievable targets should be set to appraise project benefits.	The Benefits register will be updated to reflect quantified targets as at the end of March 2023.	01/06/2023	-6.95	31/10/2023	-1.97	12/09/2023	Overdue	Overdue		Aug 2023: This needs discussion at the newly constituted Project Board	None	N/A	Aug 2023: Updated BRP	30/12/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R6	User sign-off of the design and derogations should be formally recorded.	Agreed, Design & derogations will be formally and finally signed off by users to reflect very recent changes requested by the supplier of the Linear Accelerator medical devices	01/06/2023	-6.95		-1484.92		Overdue			November 2023: Awaiting Works and Estates sign off Aug 2023: Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts.	Aug 2023: Choice of Linac Supplier	This has not delayed project progress	Aug 2023: Final sign off by Varian and VT	30/12/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	The UHB should ensure that a Project Bank Account is established and operating in line with Welsh Government policy; or an application for this project to be exempt is confirmed.	It is now too late to implement a PBA at this project. WG were made aware of the absence of a PBA at the informal CRM meetings whilst a formal application for an exemption at this project was not submitted, we will ensure due process is applied at future developments.	01/12/2023	-0.95		-1484.92		Overdue				None	N/A	Board Papers	30/12/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Low	R7	There should be consistency between the capital procedures and the SFIs in terms of minimum competition levels	It is understood that Capital Procedures and SFIs are both currently being reviewed and updated. The need for consistency between the two has been highlighted.	01/09/2023	-3.93		-1484.92		Overdue			November 2023: Revised Capital Procedures have been prepared and are going through a formal approval process				30/12/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R7	An evaluation should be undertaken to determine that value for money was achieved, and why there was little interest from the market; this should inform future tendering exercises.	The tender evaluation report does explain the process that resulted in there being only 2 returned tenders. The reasons for companies not wishing to tender are also stated. The pre-tender estimate was shared with Shared Services and the returned tender scrutinised by all parties. Whilst no concerns were raised at this project, we will ensure at future projects, tenders are fully evaluated against the PTE and any significant variations and reasons for the same are highlighted at the tender report.	01/12/2023	-0.95		-1484.92		Overdue								30/12/2023
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25.	01/10/2023	-2.95		-1484.92	31/03/2025	Overdue			The IWN service was due to be evaluated by a process to consider the efficacy and impacy of all RIF funded programmes, due to conflicting priorities this has not taken place. We are therefore undertaking an internal evaluation to review the work of the IWNs to date and also undertaking a mapping exercise to see what resource exists at a community intervention level and there impacts. This also needs to be considered in the policy context of the new social prescribing fraemwork which will also inform delivery of community level interventions.	A larger piece of work is needed due to the new policy context.	The scoping of this work will be complete by end of March 2024 with a new service model designed and ready to be implemented by March 2025		30/12/2023
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	High	R1	We recommend that Health Board management ensure that a contract management policy and guidance is developed, approved, issued and communicated to all relevant staff. It should incorporate the following: 1. guidance over the operational management responsibilities associated with contracts, including the management / identification of contract risks, performance monitoring, escalation of matters arising etc.; 2. template documents to record details of how individual contracts are to be managed e.g. responsibility for oversight and delivery. This is particularly important where the responsibility lies across different functions within the Health Board; 3. the All Wales Procure to Pay e-Manual, issued by NWSSP Procurement includes a section on implementation and contract management processes and provides information that should be aligned to any position developed by the Health Board; and 4. the Procurement Policy and Financial Control Procedure is updated to incorporate any relevant references as a result of	A contract Management Policy is in the process of being developed and due to be drafted by the end of July 2023 for consideration and approval by end August 2023. The policy will make reference to standard documentation in order to standardise the approach to contract management across the Health Board, and form a FCP	01/08/2023	-4.95		-1484.92		Overdue								30/12/2023
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R1	The introduction of contract management guidance and policy should be supported by the roll out of an appropriate training programme to all relevant staff, to assist with the embedding of the agreed approach.	Once the Policy is finalised a training programme will commence for all contract managers delivered by the Head of Procurement and Assistant Head of Procurement, supported by the Divisional Finance Business Partners	01/12/2023	-0.95		-1484.92		Overdue							30/12/2023

Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R2	We recommend that Health Board management ensure that: a. A repository of all signed contractual documentation is established to include: all contract schedules, framework agreements, service level agreements, call off orders etc. b. The repository is placed on a shared platform such that it is accessible to all relevant staff / stakeholders.	This is difficult as Procurement services who maintain the bulk of any contract documentation sits under NWSSP who have their own architecture within SharePoint which is not readily accessible to Health Board staff. It is proposed in the contract management policy that a contract management plan will be drafted between procurement and the responsible division/contract manager with information to be issued back to procurement at regular intervals. This will ensure that all contract documentation is kept in one place and is accessible by contacting the procurement team.	01/12/2023	-0.95		-1484.92		Overdue								30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R2	Spot checks / audits should be regularly carried out to review compliance with the Enhanced Observation Framework.	The Enhanced Care Framework, although not specific to Dementia aims to guide staff through what to consider prior to securing additional support. The enhanced observation policies are different on all Mental Health and Learning Disabilities Units. We shall use this recommendation to review the enhanced care framework and associated policies. Workstream 4 leads will be asked to review the Enhanced Care Policy and determine how this can better align to VIPS monitoring for people with dementia.	01/10/2023	-2.95		-1484.92		Overdue								30/12/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The control and oversight of each individual mental health transformation project is formally allocated, documented and communicated to all interested parties to the project. This should include any third-party bodies engaged and ensure that any duplication or omission of effort is identified and addressed. There is a need to ensure that assurance mechanisms, including those provided by third-parties can be relied upon. b. Any such document should ensure that key aspects of a project's development and implementation are considered including time, cost, benefits, linkage of projects to strategic objectives, management of risk and ongoing monitoring of targets etc.	A review of the control and oversight of each of the individual mental health transformation projects will be undertaken to ensure it is appropriately allocated, documented and communicated to relevant stakeholders. The document will cover the areas outlined in recommendation 1.1b	01/10/2023	-2.95		-1484.92		Overdue								30/12/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board and the Mental Health Transformation Board established to provide oversight have Chairs appointed who are independent of divisional management to demonstrate and deliver the independence required of such bodies.	A review will be undertaken regarding the Chairs of both the WPWS Crisis Support Programme Board and Mental Health and Learning Disability Transformation Board.	01/09/2023	-3.93		-1484.92		Overdue			**Nov 2023.** Dr Kathryn Walters (Joint Head of Psychology, Counselling and Arts Therapies) has replaced the Divisional Director as the Chair of the Whole Person Whole System Crisis Support Programme Board. A more detailed update on progress will be provided in the next reporting cycle.					30/12/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board performs deep dives into projects to further scrutinise the information received in the Project Flash Reports.	Within the current structure of the Whole Person Whole System Crisis Support Programme Board there is currently the ability to focus on details regarding specific projects. However, a more formal approach to "deep dives" for individual projects will be introduced (12 monthly minimum) that will include comprehensive performance and benefits reporting.	01/09/2023	-3.93		-1484.92		Overdue			November 2023: The Board has agreed to carry out annual Board Planning and Development sessions where 'deep dives' will inform the onward planning for content. Dates in consideration for Jan/Feb 2024 being agreed at Nov 2023 Board	• Funding & locations of physical space to carry out sessions • Access to information with BAU teams for Operational Workstreams such as MH111p2 • Developments in systems to support in outcomes evidencing; eg Alt to inpatients theme. o Electronic PREMS/PREMS Programme have set up and manage collection of information. That information evidences qualitative & quantitative content for the services in the theme. The baseline comparators for BAU traditional services are not implemented electronically(EG Ward PROMS/PREMS) o The performance team priority has a request for virtual wards outstanding (2021) their focus has been with wider WCCIS issues.	• Funding - Looking at avaiblility rooms in wider HB estate & in discussion with partner stakeholders to ID any cost effective/neutral space in they may be able to offer as co hosts • Access to information from BAU leads (MH111p2) – SRO to meet with GM & AGM to discuss information requirements for Programme for benefits realization & whole system impact for all stakeholders. • Systems – o Programme Manager is able to support wards in 'spread & scale' to support them(on request from servcie leads) in implementing electronic PROMS/PREMS issue and reporting. o Performance team recognise the priority requirement for virtual wards set up, and requesting it is	Ongoing anticpating closure evidence Feb 2024	30/12/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	Consideration be given to the Whole Person Whole System Crisis Support Programme Board only receiving the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports	The Mental Health and Learning Disability Transformation Programmes (Whole Person Whole System Crisis Support Programme and Complex Needs Programme) will receive the Project Flash reports for all workstreams and those Boards will then report by exception to the Mental Health and Learning Disabilities Transformation Board.	01/09/2023	-3.93		-1484.92		Overdue								30/12/2023
Internal	2022.29	Bank Office and Temporary Workers	Reasonable	Director of Workforce & OD	Medium	R1	We recommend that outstanding tasks on the starter task checklist are completed at the earliest avaliable opportunity and that going forward, these checklists are fully completed before new workers are allowed to work their first full shift.	A progress review took place across internal and external appointments to bank with an implementation date of 24.04.2023 to ensure that all check lists are on the TRAC system. A plan is in place to quality check the older records in TRAC and ESR in priority order, oldest records first followed by those that have already started.	01/10/2023	-2.95		-1484.92		Overdue								30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R1	We recommend that the Clinical Coding Service Policy and Procedure document is reviewed, ratified, re dated and re issued.	The Clinical Coding Service Policy and Procedure Document will be reviewed by the end of December 2023	30/12/2023	0.00		-1484.92		Overdue							30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R2	We recommend that the Health Board issues guidance to clinicans coverning the accepted protocols, convetions and standards for the structure and content of patient records	Monthly meetings between the Medical Director and the clinical coding manager were re established in October 2023. These meetings will in part be used to formulate guidance to clinicians regardings the standards and content required in patient records.	30/12/2023	0.00		-1484.92		Overdue								30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R3	We recommend that where patient notes prose interpretatios challenges and the coder assigned requires furthereinformation to progress these e.eg diffucties wth clarity, content, form, structure, completness ect. - That these cases are processed as exceptions and logged to proide a record of the issue, how it was resolved and the time taken to close. Logs can then subsequently be used in clinician communications.	The content of clinical notes will be discussed in the monthly meeting between the medical Director and the Clinical coding manager. This will include detailing the volume of notes that have been diffucult to interpret and areaas of noteable concern.	30/12/2023	0.00		-1484.92		Overdue								30/12/2023

Appendix 4 2022-23 Overdue Recommendations Post Update

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	High	R1	We recommend that Health Board management ensure that a contract management policy and guidance is developed, approved, issued and communicated to all relevant staff. It should incorporate the following: 1. guidance over the operational management responsibilities associated with contracts, including the management / identification of contract risks, performance monitoring, escalation of matters arising etc.; 2. template documents to record details of how individual contracts are to be managed e.g. responsibility for oversight and delivery. This is particularly important where the responsibility lies across different functions within the Health Board; 3. the All Wales Procure to Pay e-Manual, issued by NWSSP Procurement includes a section on implementation and contract management processes and provides information that should be aligned to any position developed by the Health Board; and 4. the Procurement Policy and Financial Control Procedure is updated to incorporate any relevant references as a result of the above changes.	A contract Management Policy is in the process of being developed and due to be drafted by the end of July 2023 for consideration and approval by end August 2023. The policy will make reference to standard documentation in order to standardise the approach to contract management across the Health Board, and form a FCP	01/08/2023	-4.95		-1484.92		Overdue			January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				30/12/2023
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R1	The introduction of contract management guidance and policy should be supported by the roll out of an appropriate training programme to all relevant staff, to assist with the embedding of the agreed approach.	Once the Policy is finalised a training programme will commence for all contract managers delivered by the Head of Procurement and Assistant Head of Procurement, supported by the Divisional Finance Business Partners	01/12/2023	-0.95		-1484.92		Overdue			January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				30/12/2023
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R2	We recommend that Health Board management ensure that: a. A repository of all signed contractual documentation is established to include: all contract schedules, framework agreements, service level agreements, call off orders etc. b. The repository is placed on a shared platform such that it is accessible to all relevant staff / stakeholders.	This is difficult as Procurement services who maintain the bulk of any contract documentation sits under NWSSP who have their own architecture within SharePoint which is not readily accessible to Health Board staff. It is proposed in the contract management policy that a contract management plan will be drafted between procurement and the responsible division/contract manager with information to be issued back to procurement at regular intervals. This will ensure that all contract documentation is kept in one place and is accessible by contacting the procurement team.	01/12/2023	-0.95		-1484.92		Overdue			January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				30/12/2023

Appendix 6 Completed Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recom men-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2022	CYP Continuing Care	Reasonable	Chief Operating Officer	Low	R5	Implement robust communication mechanisms between the various partnership working forums (e.g., CC Development Group, Regional Integrated Complex Needs Panel, etc).Monitor the effectiveness of these forums and any new joint processes implemented.	Assistant Divisional Nurse / Division Lead QPS	30/11/2022	-12.95				Completed/ Closed	Completed/ Closed		January 2024: All Wales interagency Vanguard Training took place in November 2023 with attendance from ABUHB and some of the Local Authorities within region. Some good progress made, however, challenging situations continue to occur with cases being escalated to dispute. Assistant COO, has recently been scoping mechanisms within the UHB and the reconvening of local Complex Care Board. Interagency financial strains impacting on progress November 2023: interagency meetings now embedded with the most recent - CALDS/CAMHS cases interagency peer review / QA meeting now in place with agreed ToR, good engagement. Consultant Nurse plan now changed and not going ahead at the moment with development of other Divisional roles. Ongoing - Development of Complex Needs Pathway underway, Interagency collaborative meetings commenced, joint processes in draft form, Consultant Nurse JD in draft, expected to be advertised shortly	some concerns regarding differeing interpretations of the national framework and organisational responsibility between health and local authority	Vanguard training proposed by Welsh Government for Autumn 2023. UPDATE 6/11/23 Vanguard Training by Welsh Government rearranged from earlier in the year - now arranged for this month for interagency Senior Managers across Wales, with a view to resolve areas where agencies have conflicting understanding.	All Wales interagency Vanguard Training took place in November 2023 with attendance from ABUHB and some of the Local Authorities within region. Some good progress made, however, challenging situations continue to occur with cases being escalated to dispute. Assistant COO, has recently been scoping mechanisms within the UHB and the reconvening of local Complex Care Board. Interagency financial strains impacting on progress	30/12/2023
Internal	2022	Agile Delivery	Not Rated	Director of Workforce & OD	High	R1	An overarching agile working plan should be developed. It should include:•An overarching vision (this could be taken from the already published Agile Working Framework).•A set of SMART goals/ milestonesto achieve this vision.•A list of Welsh Government targets which need to be achieved.•All relevant services areas should be included and engaged with.A benefits listshould be developedto sit alongside the planwhich details how the Health Board will measure its success against each of the goals. The listshould include quantifiable measurements which can be analysed to confirm the success of each goal.	Agreed, the overarching HBand WG visionwill be added to the developed Programme Plan. Overarching SMART goals will be articulated with more specific goals once the assessment and review of the estates has been undertaken.	30/11/2022	-12.95				Completed/ Closed	Completed/ Closed		January 2024: The Agile Vision was presented and agreed with Executive Team on 12 October 2023 AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Nov 2022 Plan - will reconfirm the vision and SMART objectives in programme delivery board December 2022, then taken forward to executive Committee and Board for final endorsement	aug 2023: Estates review, accomdation group, ICT infrastructure, service change, impact of cost of living crisis on staff, capital availibility, financial review 22: Estates review, accomdation group, ICT infrastructure, service change, impact of cost of living crisis on staff, capital availibility, financial review	Aug 2023: Executive team 22: regular review through agile delivery programme board also the cost of living risk and estates risk is highlighted on the CRR	Agile Visioning documents signed off by Executive Team. A programme of work is being developed and measureable benefits defined to support implementation of the programme.	30/12/2023
Internal	2022	Agile Delivery	Not Rated	Director of Workforce & OD	Low	R2	Confirm with the Executive Team that the agile working principles noted within the Agile WorkingFrameworkstill represent the current vision. If amendments are required, the Framework should be updated.	An agreed vision for agile working had been agreed by the Executive Team previously and had developed over the response to the COVID pandemic. There are agreed priorities in place for implementing this vision. However, to work beyond the agreed priorities and to embed agile working strategically into Health Board plans it is agreed that this is a good time to re-new the vision.	30/11/2022	-12.95				Completed/ Closed	Completed/ Closed		January 2024: The Agile Vision and principles were presented and agreed with Executive Team on 12 October 2023 AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Mar 23 Proposed agile vision presented to the Executive Committee on 09 February. Drivers and enablers were presented as well and hybrid working and setting up a network of hubs to facilitate the reduction in personal office/desk space.	Aug 2023: Redesigning vision following presentation and feedback from the Executive Committee and will progress this to Board 22: Redesigning vision following presentation and feedback from the Executive Committee and will progress this to Board	Executive team	Agile Vision and Principles have been updated in the original Agile Working Framework.	30/12/2023
Internal	2022.1	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Agree. We shall continue to review the roles required to implement the DAP objectives and ensure effective succession planning is in place.Directly relating to Initiative 9 – Facilities Division has recently appointed a dedicated Building Management System (BMS) Officer (due in post Jan23).Through an Academy Wales graduate developmentprogramme we shall be utilising a student placement to assist with decarbonisation metrics, reporting and engagement starting in 23/24.	01/11/2023	-1.93				Completed/ Closed	Completed/ Closed		January 2024: The Decarbonisation programme is resourced through many divisions with the main facilities roles established. Additionally there are sub groups of the Board that provide the resources to progress actions under the DAP for ABUHB			Board reports present structure	30/12/2023
Internal	2022.1	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	Agree. Projects developed through the DAP shall be funded appropriately – ReFit, HSC, EFAB, revenue, discretionary capital.	01/11/2023	-1.93				Completed/ Closed	Completed/ Closed		January 2024: DAP schemes which require funding are included as part of the revenue or capital financial plan - significant capital expenditure is identified through the EFIT funding route			Board reports & financial plan & capital reports	30/12/2023
Internal	2022.1	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	Agree. The DPB have requested suitable NWSSP Proc Serv. Representation at meetings to update and provide guidance and feedback on progress.Within the programme governance arrangements we have identified fourtask and finish working groups who will link with our local procurement team. In addition we also have a financial representative leading group 4 who directly links in with health board Director of NWSSP National initiatives which are reported at the Bimonthly board meetings within the health board.	01/11/2023	-1.93				Completed/ Closed	Completed/ Closed		January 2024: ABUHB and SSP are in regular contact as part of reporting arrangements. Procurement lead is a member of the Decarb Board sub group.			Board Reporting mechanisms	30/12/2023
Internal	2022.1	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Agree. The Decarbonisation Programme Board (DPB) within its structure has 4 subgroups each with national initiatives delegated to them. The DPB and subgroups each have ToR's and scheduled meeting frequencies.	01/11/2023	-1.93				Completed/ Closed	Completed/ Closed		January 2024: complete			Board reports	30/12/2023

Internal	2022.1	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	Agree. Funding submissions are suitably scrutinised by appropriate forums e.g. Pre-Investment Panel (PIP), Capital Programme Board or DPB.	01/11/2023	-1.93				Completed/ Closed	Completed/ Closed		January 2024: complete			Board reports	30/12/2023
Internal	2022.1	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agree. Projects shall be reported to the DPB with adequate metrics developed to measure carbon reduction potential. Such projects will also be reported to WG through the bi-annual qualitative reporting requirements.	01/11/2023	-1.93				Completed/ Closed	Completed/ Closed		January 2024: complete			Board reports	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R2	R2 The role and responsibilities of the Primary Care & Community Estates Programme Board, in acting as the Project Board for major Primary Care projects, should be clearly defined in the Terms of Reference.	Agreed. The role of the Primary Care & Community Estates Programme Board, in acting as the Project Board will be defined and documented.	01/02/2023	-10.89	31/10/2023		12/09/2023	Completed/ Closed	Completed/ Closed		Jan 2024: Project Board in place since October 2023 August 23: The PC Programme Board did not meet after April 2023. A new SRO has been identified and a separate PB has been arranged for 17th October			New Project Board with new ToR	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R3	R3 The Primary Care & Community Estates Programme Board should meet with the agreed frequency (6-weekly) as a minimum to ensure sufficiently regular oversight of the major projects within its remit.	Agreed	01/01/2023	-11.90	31/10/2023		12/09/2023	Completed/ Closed	Completed/ Closed		Jan 2024: Project Board meets every 4 to 6 weeks			New Project Board frequenetly meeting	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R4	R4 The constitution and capacity of the Primary Care & Community Estates Programme Board to effectively execute the Project Board role for all the Primary Care projects within its remit should be reviewed and confirmed.	Agreed. The governance structure will be reviewed	01/02/2023	-10.89	31/10/2023		12/09/2023	Completed/ Closed	Completed/ Closed		Jan 2024: Separate Project Boards in place August 23: As above, the Primary Care and Estates Programme Board has been replaced by inividual project boards			Dedicated Project Board in place	30/12/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R8	R8 A report should be tabled at the next Primary Care & Community Estates Programme Board meeting, presenting an update against each Gateway recommendation, and identifying any actions still outstanding.	Agreed	01/01/2023	-11.90	31/10/2023		12/09/2023	Completed/ Closed	Completed/ Closed		Jan 2024: The Gateway Report was presented to a previous incarnation of the Project Board.	None	N/A	Gateway report shared	30/12/2023
Internal	2022.1	Records Managment	Limited	Director of Digital	Medium	R1	R1 Consideration should be given to making the supplementary courses mandatory and monitoring related training attendance	a.) The service is currently working with the national team on having a new online learning offering across Wales which includes a fully updated records management module which will be mandatory. b.) We will request, via the clinical information and professional leads, that attendance at the Health Records awareness sessions is compulsory for all ward based staff.At these sessions we will re-iterate the importance of good records management and highlight the issues that are impacting Health Records from the ward.	01/03/2023	-9.97				Completed/ Closed	Completed/ Closed		Jan-24: The Information Governance mandatory training includes records management and compliance will be monitored through the Information Governance Sub-Committee Nov 23: IG are working with the Divisions to provide supplementary classroom training i'e. facilities. IG are looking to develop video modules as another alternative. Aug-23: The National online training incl: Cyber Security & Health Records modules has gone live. IG offer a blended approach to their training and supplementary courses provided are now included in the compliance rates if requested instead of the online version.			New governance structure in place covering Information Governance and Health Records which will report into the Finance & Performance Committee.	30/12/2023

Internal	2022.1	Records Managment	Limited	Director of Digital	Medium	R3	R3 Records quality checks should be regularly carried out and formally evidenced. Consideration should be given to involve senior nursing staff in these checks.	The CNIO will monitor compliance with base line records management.	31/03/2023	-8.98				Completed/ Closed	Completed/ Closed		"Jan-24: Regular peer audits take place across the HB and are managed as part of the audit cycle. WNCR specific dashboard now in prototype. Health Records Assurance Group is being established which report into the Information Governance Sub-Committee (which reports to the Finance & Performance Committee)" Nov 23: Dashboard still being worked upon, national are also providing a standard one for compliance times across wales. DECI continue as buisness as usual. DNDG to discuss the way forward for nusing documentation Aug-23: Regular audits take place across the organisation such as DECCI audits. This is fed back via the senior nurses. The WNCR implementation will significantly improve some areas of compliance such dating and signing douc mentation and completion of risk assessments. The WNCR Business Change lead working with Information team to provide a dash board view of the completness and timeliness of assessment which can be provided to each ward			Audit cycles are in place and a dashboard to provide assurance for records management within WNCR. Health Records Assurance Group has a core role in provide assurance on the arrangements for creating, collecting, storing, safeguarding, disseminating, sharing, using and disposing of Health Records.	30/12/2023
Internal	2022.1	Records Managment	Limited	Director of Digital	High	R7	R7 Patient records security should be ensured at all times.	Nov 23: The development of this programme has been delayed due mainly to the recent ICO audit and the amount of work this created. However, there has been some audits undertaken by IG staff with the outcomes discussed the respective GAG's. IG will conduct security audits in remote areas to ensure compliance. The Governance Assurance Group agenda will be widened to include focused audits. The Health records service will work in partnership with this group and there will be a health records representative at Divisional GAG meetings from January 2023. Records management issues to be discussed in the divisional group meetings to create local action plans. Minutes are taken in these forums and progress monitored.	30/06/2023	-6.00				Completed/ Closed	Completed/ Closed		Jan-24: The Information Governance Sub-Committee and supporting groups are now in place and meetings are in the diary for the first quarter of this year. Aug-23: An audit programme is under development in the IG team. The programme of work will commence in early October. Health Records are present in Divisional GAG meetings. Records management issues are discussed and a portfolio register is retained by IG and minutes are taken of the meetings.			The Information Governance assurance structures are now in place and alongside the existing work of the divisional meetings and audit programme will provide assurance going forward.	30/12/2023
Internal	2022.1	Records Managment	Limited	Director of Digital	Medium	R12	R12 Data recording in Datix should be improved to ensure a more accurate reporting on missing / lost records.	Reinforcement of reporting through Datix will be cascaded to ward staff in training sessions and Governance and Assurance Group meetings.	30/06/2023	-6.00				Completed/ Closed	Completed/ Closed		Jan-24: The Information Governance Sub-Committee and supporting groups are now in place and meetings are in the diary for the first quarter of this year. Nov 23: There has been an increase in the number of breaches recorded since this work was undertaken and work will continue in these areas to get improvements. Aug 23 Work on completion and recording of breaches in DATIX has been covered in GAG's with additional training provided.			The Information Governance assurance structures are now in place and alongside the existing work of the divisional meetings to provide assurance going forward	30/12/2023
Internal	2022.1	Use of Off-contract Agency	Limited	Director of Nursing	Medium	R15	R15 We recommend the undated/ expired documents are reviewed, updated and ratified as a matter of priority.	Nurse Staffing Levels Wales (2016) Act Operational Framework and Escalation Process will now have approval date added and next review date.It is acknowledged that "The Protocol for requesting, authorising & booking bank and agency clinical workers Standard Operating Procedure" expired in 2017. The practice contained in the document remained the same up until the Covid Pandemic. During this time priority was to secure clinical staff to ensure our wards and our staff were safe. Subsequently, in 2022 the bank Rules have been reviewed and issued. This protocol will be reviewed in line with the implementation of safecare.	01/03/2023	-9.97				Completed/ Closed			Januray 2024: NSLWA was approved in January and is available on AB Pulse Policy Page along with the updated Protocol. Jun 23: Approval and review date added to NSLWA and updated protocol published.				30/12/2023
Internal	2022.2	IT Strategy	Reasonable	Director of Digital	Medium	R6	The Health Board should seek to align plans with other sources of digital projects.	Joint planning sessions with DHCW are now taking place and will be (following revised terms of reference and membership being agreed) considered by DDOB. DDOB will also receive escalations on funding/governance or priority issues whether local regional or national. The Programme Office will provide reporting against this	01/09/2023	-3.93				Completed/ Closed			Jan-24: Alignment meetings are held on a monthly basis with DHCW to align project plans, milestones and discuss and escalate risks and issues. Nov 23: Review of stratregy and governance arrangements has commenced.			Alignment meetings are held on a monthly basis with DHCW to align project plans, milestones and discuss and escalate risks and issues. The ABUHB PMO & DHCW PMO also meet regurlarly to align plans. This alignment plan is then used to facilitate 6-monthly exec to exec engagement meetings between the organisations to inform and drive more strategic & longer term plans.	30/12/2023
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	High	R1	The Discharge Policy is updated, approved and reissued, to be compliant with the All Wales policy, when issued.	The All Wales Discharge Policy is expected to be released imminently and will be intrinsic to the development of the new Health Board policy. We acknowledge that since the policy was published current practice has moved on so that the policy does not describe the working arrangements. A Task & Finish group will be established with cross divisional representation to redraft the policy and ensure the content reflects current and emerging practice once the new All Wales Policy has been made available. This work will be completed within three months of the introduction of the All-Wales Policy. In the meantime, and as noted above we will review the current Policy. We will report any ongoing risk and position to the QPSOG. The Health Board will ensure a process is in place for regular update and review of the new policy when reissued, reporting to the Clinical Standards Board.	01/10/2023	-2.95				Completed/ Closed	Completed/ Closed		January 2024: Completed				30/12/2023
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	Within the Health Board, training for discharge planning is delivered across existing induction and education programmes: Newly qualified and overseas nurses have an introduction to discharge planning through the Journey of excellence programme. The Health Boards practice educators provide ongoing education & training on discharge planning for nursing staff. The Head of Discharge has been working with the Universities to introduce a discharge planning session into student nurse training, ensuring awareness of the fundamentals before starting in their first post. Training for medical staff is currently ward based. The Assistant Medical Director for Planning will be working with a task and finish group to standardise training. Therapy staff receive discharge training throughout their undergraduate training. Much of their work is dedicated to preparing patients for discharge to their home environment or through referral to the provisions of rehabilitation or other support. Local discharge planning arrangements are disseminated through the site and ward	01/10/2023	-2.95				Completed/ Closed	Completed/ Closed		January 2024: Completed This is included on the Journey to Excellence Programme and the Patient Safety Events focus on learning and improvement.				30/12/2023

Internal	2022.2	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R6	User sign-off of the design and derogations should be formally recorded.	Agreed, Design & derogations will be formally and finally signed off by users to reflect very recent changes requested by the supplier of the Linear Accelerator medical devices	01/06/2023	-6.95				Completed/ Closed	Completed/ Closed		January 2024: Completed, Linac Bunker layouts have been signed off by the VT following a number of changes requested by them. November 2023: Awaiting Works and Estates sign off Aug 2023: Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts.	Aug 2023: Choice of Linac Supplier	This has not delayed project progress	Aug 2023: Final sign off by Varian and VT	30/12/2023
Internal	2022.2	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	The UHB should ensure that a Project Bank Account is established and operating in line with Welsh Government policy; or an application for this project to be exempt is confirmed.	It is now too late to implement a PBA at this project. WG were made aware of the absence of a PBA at the informal CRM meetings whilst a formal application for an exemption at this project was not submitted, we will ensure due process is applied at future developments.	01/12/2023	-0.95				Completed/ Closed	Completed/ Closed		January 2024: Closed, It is now too late to implement a PBA at this project. WG were made aware of the absence of a PBA at the informal CRM meetings whilst a formal application for an exemption at this project was not submitted, we will ensure due process is applied at future developments.	None	N/A	Board Papers	30/12/2023
Internal	2022.2	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Low	R7	There should be consistency between the capital procedures and the SFIs in terms of minimum competition levels	It is understood that Capital Procedures and SFIs are both currently being reviewed and updated. The need for consistency between the two has been highlighted.	01/09/2023	-3.93				Completed/ Closed	Completed/ Closed		January 2024: Completed, Capital procedures have been approved by Executive Committee. November 2023: Revised Capital Procedures have been prepared and are going through a formal approval process				30/12/2023
Internal	2022.2	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R7	An evaluation should be undertaken to determine that value for money was achieved, and why there was little interest from the market; this should inform future tendering exercises.	The tender evaluation report does explain the process that resulted in there being only 2 returned tenders. The reasons for companies not wishing to tender are also stated. The pre-tender estimate was shared with Shared Services and the returned tender scrutinised by all parties. Whilst no concerns were raised at this project, we will ensure at future projects, tenders are fully evaluated against the PTE and any significant variations and reasons for the same are highlighted at the tender report.	01/12/2023	-0.95				Completed/ Closed	Completed/ Closed		January 2024: Closed, The tender evaluation report does explain the process that resulted in there being only 2 returned tenders. The reasons for companies not wishing to tender are also stated. The pre-tender estimate was shared with Shared Services and the returned tender scrutinised by all parties. Whilst no concerns were raised at this project, we will ensure at future projects, tenders are fully evaluated against the PTE and any significant variations and reasons for the same are highlighted at the tender report.				30/12/2023
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Medium	R2	Spot checks / audits should be regularly carried out to review compliance with the Enhanced Observation Framework.	The Enhanced Care Framework, although not specific to Dementia aims to guide staff through what to consider prior to securing additional support. The enhanced observation policies are different on all Mental Health and Learning Disabilities Units. We shall use this recommendation to review the enhanced care framework and associated policies. Workstream 4 leads will be asked to review the Enhanced Care Policy and determine how this can better align to VIPS monitoring for people with dementia.	01/10/2023	-2.95				Completed/ Closed	Completed/ Closed		January 2024: Complete - Enhanced observational plan in place, senior nurse and dementia specialist nurse are undertaking enhanced observational reviews on all patients receiving cohorting and 121 care. Reports are fed back to the divisional team. This will be fedback to QPSOG/PQSOC				30/12/2023
Internal	2022.3	Bank Office and Temporary Workers	Reasonable	Director of Workforce & OD	Medium	R1	We recommend that outstanding tasks on the starter task checklist are completed at the earliest avaliable opportunity and that going forward, these checklists are fully completed before new workers are allowed to work their first full shift.	A progress review took place across internal and external appointments to bank with an implementation date of 24.04.2023 to ensure that all check lists are on the TRAC system. A plan is in place to quality check the older records in TRAC and ESR in priority order, oldest records first followed by those that have already started.	01/10/2023	-2.95				Completed/ Closed	Completed/ Closed		January 2024: Older records that had built up during Covid have all been quality checked and information added to ESR. Going forward, a new process is in place to quality check the file and as soon as all pre-employment checks and starter checks are complete before the person is able to start work.			New process in place	30/12/2023
Internal	2023	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R1	We recommend that the Clinical Coding Service Policy and Procedure document is reviewed, ratified, re dated and re issued.	The Clinical Coding Service Policy and Procedure Document will be reviewed by the end of December 2023	30/12/2023	0.00				Completed/ Closed			Jan 2024: Clinical coding policy reviwed, ratified, redated and re issues January 5th 2024.				30/12/2023

Internal	2023	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R2	We recommend that the Health Board issues guidance to clinicans covering the accepted protocols, convetions and standards for the structure and content of patient records	Monthly meetings between the Medical Director and the clinical coding manager were re established in October 2023. These meetings will in part be used to formulate guidance to clinicians regardings the standards and content required in patient records.	30/12/2023	0.00				Completed/ Closed			Jan 2024: Monthly meetings between the Medical Director and the Clinical Coding Manager were re-established in October 2023. These meetings will in part be used to formulate guidance to clinicians regarding the standards and content required in patient records. The Health Records Assurance Group will be convening in the first quarter of this year and reporting to the Information Governance Sub-Committee which will provide addition assurance on the standards, structure, and content of patient records.				30/12/2023
Internal	2023	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R3	We recommend that where patient notes prose interpretatios challenges and the coder assigned requires furthereinformation to progress these e.eg diffucties wth clarity, content, form, structure, completness ect. - That these cases are processed as exceptions and logged to proide a record of the issue, how it was resolved and the time taken to close. Logs can then subsequently be used in clinician communications.	The content of clinical notes will be discussed in the monthly meeting between the medical Director and the Clinical coding manager. This will include detailing the volume of notes that have been diffucult to interpret and areaas of noteable concern.	30/12/2023	0.00				Completed/ Closed			Jan 2024: Monthly meetings between the Medical Director and the Clinical Coding Manager were re-established in October 2023. These meetings will in part be used to formulate guidance to clinicians regarding the standards and content required in patient records. The Health Records Assurance Group will be convening in the first quarter of this year and reporting to the Information Governance Sub-Committee which will provide addition assurance on the standards, structure, and content of patient records.				30/12/2023

Appendix 5 2022-23 Revised Timescale Requests

Audit Type	ABLHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recom-men-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2022.05	Digital Benefits Realisation	Substantial	Director of Digital	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to programmes or Service Delivery. This will provide internal assurance of the process and ensures that options are presented to Digital Delivery Oversight Board (DDOB) with a clear assessment of priority and recommendations. DDOB is the body that will make informed decisions on the prioritisation of Informatics programmes and projects. New national programmes will be tracked through the same process allowing the Health Board to locally prioritise and feedback these priorities back to national.This draft processneeds to be signed off and fully implemented.	01/06/2023	-6.95	31/03/2024	3.02		Overdue			Jan 24: A new digital service request process will be implemented by March 2024 to funnel all new service requests using a request form in our Seren ICT portal through the DDaT senior leadership team with additional appraisal of requests undertaken by the business analysis team with requestors to ensure requests are understood, properly documented and managed and have sufficient detail to enable prioritisation and scaling to enable prioritisation and progression in alignment with Health Board priorities. Nov 23: The new digital service request process is nearing completion and will be launched shortly across the Health Board. The digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained in all projects. Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls				30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R4	R4 The management of ward clerks should be centralised, and consideration should be given to manage shortages through "bank arrangements".	a.) Local ward clerk shortages will be escalated to the Assistant Directors of Nursingand subsequently escalated to the Executive Director of Nursing. Action plan will be agreed how to solve them. b.) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing hierarchy to the ward staff.	31/07/2023	-4.98	30/06/2024	6.00		Overdue			Jan-24: First level of organisational process is underway and will commence in February. Nov 23: Will be discussed at Executive Committee and considered as part of the Digital Organisational Change Process				30/12/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.	31/03/2023	-8.98	30/06/2024	6.00		Overdue			Jan-24: Ward visits undertaken by records management staff to ensure loose notes colelcted from sites. As a part of the Digital Strategy, a review will be undertaken for a review of digitisation of the remaining health records, with a key requirement being eForms. With reference to R4, we can pick up any further improvements to be made to loose patient record filing. Nov 23: The promotion of good practice continues and the roll out of WNCR at NHH has commenced. Aug-23: Health Records have found significant amounts of loose filing on wards in RGH & St Woolos. This has been collected and scanned but has a negative impact as each sheet needs to be individually checked, barcoded and scanned rather than as a complete record. The rollout of WNCR has reduced paper generation on wards and the CNIO has been promoting good practice on wards as the system rolls out across RGH. Further implementations at YYF and NHH will further reduce the loose records situation.	Further rollout of WNCR in YYF, YAB, NHH will reduce the loose records and guidance will be provided to the staff on the wards in these areas.	Training of ward clerks where there are issues identified is ongoing and datix reports submitted where substantial breaches are identified.		30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transisition to service delivery	01/06/2023	-6.95	30/06/2024	6.00		Overdue	Overdue		Jan-24: RPA posts are in the Trac process for readvert and interview. A draft operational model has been developed. Completion remains dependent on successful team recruitment Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services				30/12/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	-6.95	31/03/2024	3.02		Overdue			Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Eeuctive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relauch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				30/12/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023	-0.95	30/09/2024	9.02		Overdue			"Jan-24: For Digital Specialist Procurement we have identified utilising Network 75, this combines a work placement and part time study as a route to a degree , the ethos of this scheme is for the directorate to grow their own talent for the future. •Analysis of current skills matched to Job Role has been largely completed and gap analysis is being undertaken. •Pre-requisite certification at Prince II foundation and ITIL v4 foundation desirable against all job roles. •Training Agreement has been implemented and is in use within the directorate but this needs consistency across all departments. •Budget restrictions have caused the removal of ring fenced training budget however many staff are taking advantage of non cost training (PLA etc) and being provided protected time for CPD. •Development of Learning & Develop Hub is making excellent progress •Need to agree on a skills management platform to implement "				30/12/2023

Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-7.97	30/04/2024	4.00		Overdue	Overdue		Januray 2024: In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."This will be implemented across the HB in April 2024. August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."				30/12/2023
Internal	2022.19	Dischage Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 5 Goals for Urgent & Emergency	01/10/2023	-2.95	31/03/2024	3.02		Overdue			January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review				30/12/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that thoy are in place well before the planned occupation of the building.	01/06/2023	-6.95	31/03/2024	3.02		Overdue	Overdue		Jan 2024: Still being progressed by Shared Services Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	None	N/A	Aug 2023: Agreed leases	30/12/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Low	R6	Quantified, measurable and achievable targets should be set to appraise project benefits.	The Benefits register will be updated to reflect quantified targets as at the end of March 2023.	01/06/2023	-6.95	31/03/2024	3.02		Overdue	Overdue		Jan 2024: Has been dicissed at Project Board but not finalised Aug 2023: This needs discussion at the newly constituted Project Board	None	N/A	Aug 2023: Updated BRP	30/12/2023
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25.	01/10/2023	-2.95	31/03/2025	14.98		Overdue			The IWN service was due to be evaluated by a process to consider the efficacy and impacy of all RIF funded programmes, due to conflicting priorities this has not taken place. We are therefore undertaking an internal evaluation to review the work of the IWN:s to date and also undertaking a mapping exercise to see what resource exists at a community intervention level and there impacts. This also needs to be considered in the policy context of the new social prescribing framework which will also inform delivery of community level interventions.	A larger piece of work is needed due to the new policy context.	The scoping of this work will be complete by end of March 2024 with a new service model designed and ready to be implemented by March 2025		30/12/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The control and oversight of each individual mental health transformation project is formally allocated, documented and communicated to all interested parties to the project. This should include any third-party bodies engaged and ensure that any duplication or omission of effort is identified and addressed. There is a need to ensure that assurance mechanisms, including those provided by third-parties can be relied upon. b. Any such document should ensure that key aspects of a project's development and implementation are considered including time, cost, benefits, linkage of projects to strategic objectives, management of risk and ongoing monitoring of targets etc.	A review of the control and oversight of each of the individual mental health transformation projects will be undertaken to ensure it is appropriately allocated, documented and communicated to relevant stakeholders. The document will cover the areas outlined in recommendation 1.1b	01/10/2023	-2.95	30/04/2024	4.00		Overdue			Januray 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.				30/12/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board and the Mental Health Transformation Board established to provide oversight have Chairs appointed who are independent of divisional management to demonstrate and deliver the independence required of such bodies.	A review will be undertaken regarding the Chairs of both the WPWS Crisis Support Programme Board and Mental Health and Learning Disability Transformation Board.	01/09/2023	-3.93	30/04/2024	4.00		Overdue			**January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. Nov 2023.** Dr Kathryn Walters (Joint Head of Psychology, Counselling and Arts Therapies) has replaced the Divisional Director as the Chair of the Whole Person Whole System Crisis Support Programme Board. A more detailed update on progress will be provided in the next reporting cycle.				30/12/2023

Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board performs deep dives into projects to further scrutinise the information received in the Project Flash Reports.	Within the current structure of the Whole Person Whole System Crisis Support Programme Board there is currently the ability to focus on details regarding specific projects. However, a more formal approach to "deep dives" for individual projects will be introduced (12 monthly minimum) that will include comprehensive performance and benefits reporting.	01/09/2023	-3.93	30/04/2024	4.00		Overdue			January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. November 2023: The Board has agreed to carry out annual Board Planning and Development sessions where 'deep dives' will inform the onward planning for content. Dates in consideration for Jan/Feb 2024 being agreed at Nov 2023 Board	• Funding & locations of physical space to carry out sessions • Access to information with BAU teams for Operational Workstreams such as MH111p2 • Developments in systems to support in outcomes evidencing; eg Alt to inpatients theme. o Electronic PREMS/PREMS Programme have set up and manage collection of information. That information evidences qualitative & quantitative content for the services in the theme. The baseline comparators for BAU traditional services are not implemented electronically(EG Ward PROMS/PREMS) o The performance team priority has a request for virtual wards outstanding (2021) their focus has been with wider WCCIS issues.	• Funding - Looking at availibility rooms in wider HB estate & in discussion with partner stakeholders to ID any cost effective/neutral space in they may be able to offer as co hosts • Access to information from BAU leads (MH111p2) – SRO to meet with GM & AGM to discuss information requirements for Programme for benefits realization & whole system impact for all stakeholders. • Systems – o Programme Manager is able to support wards in 'spread & scale' to support them(on request from servcie leads) in implementing electronic PROMS/PREMS issue and reporting. o Performance team recognise the priority requirement for virtual wards set up, and requesting it is reprioritised.	Ongoing anticpating closure evidence Feb 2024	30/12/2023
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	Consideration be given to the Whole Person Whole System Crisis Support Programme Board only receiving the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports	The Mental Health and Learning Disability Transformation Programmes (Whole Person Whole System Crisis Support Programme and Complex Needs Programme) will receive the Project Flash reports for all workstreams and those Boards will then report by exception to the Mental Health and Learning Disabilities Transformation Board.	01/09/2023	-3.93	30/04/2024	4.00		Overdue			January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.				30/12/2023
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Therapies and Health Science	Medium	R1	A SOP for how to manage and respond to HSE reports should be created. It should include, but not limited to: • how HSE reports are distributed to responsible staff within the Health Board; • who has designated responsibility for coordinating responses to HSE reports; • the escalation process for issues identified as part of HSE inspections; • who/which committee has responsibility for monitoring actions raised as part of the HSE reports and the process for doing this; and • when assurance reports should be produced and which committee should review them	The Health Board agrees with this recommendation. An SOP on the management of HSE reports will be developed and presented to the ABUHB Health and Safety Committee in May 2023	01/05/2023	-7.97	29/02/2024	2.00		Overdue	Overdue		January 2024: The development of an All Wales SOP on the management of HSE reports has stalled, therefore the Health Board have developed a Draft SOP which is currently awaiting approval August 2023: The development of an SOP on the management of HSE reports is being discussed at a national level via the All Wales Health and Safety Management Group. Following discussion at the natiional meeting in September 2023 an SOP will be prepared and shared with members of the Health and Safety Committee to share across the Health Board.				30/12/2023

Appendix 7 Not Yet Due Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: How service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	-67.87	31/03/2024	3.02	12/09/2023	Overdue	Not Yet Due		**March 2023** - A programme of respiratory protection equipment (RPE) inspections has been developed and commenced in October 2022. The plan to inspect all in-patient clinical areas by March 2023 is approximately 95% complete. The inspections conducted by the Corporate Health and Safety Department are recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. A programme of health and safety environmental inspections will commence in May 2023 and will target clinical areas. The programme will be carried out over a two-year cycle, commencing with the older estate or those that have been subject to significant change i.e. Royal Gwent Hospital and Nevill Hall Hospital. The inspections will be conducted by the Corporate Health and Safety Department and recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. The Corporate Health and Safety Department are also planning the development of self-assessment inspection tools for wards and departments to complete their own localised health and safety monitoring. This will support a programme of health and safety monitoring across the Health Board.	There are no identified barriers to implementing the revitalised plan of health and safety monitoring. Resources that were not previously available within the Corporate Health and Safety Department have now been established to ensure a sustainable system of monitoring.	The risk will reduce as the programme of health and safety monitoring is implemented.	August 2023: Notes of the Health and Safety Committee Inspection reports via AMaT	30/12/2023
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R2	R2 The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	-67.87	31/03/2024	3.02	12/09/2023	Overdue	Not Yet Due		**March 2023** - The Corporate Health and Safety Department have engaged with Divisions to ensure risks are recorded, monitoring and managed using the Datix system. This has improved the quality of health and safety risks on the system. The Corporate Health and Safety Department are reviewing all high risks (risk rating of 12 or above) recorded on the Datix system and where necessary support local managers to mitigate the risk. The programme of health and safety environmental inspections will support the identification and review of health and safety risks across the Health Board. Health and safety risks will be regularly reported to the ABUHB Health and Safety Committee to enable active monitoring. A revitalised education programme of health and safety risk assessment training has been approved and commenced in 2023. The register of risk assessors within the organisation has been reviewed and areas needing support will be prioritised for attendance at the risk assessment training.	The primary barrier to implementation would be lack of engagement from the areas / Divisions. Implementation of the new risk module in Datix Cymru could present a potential barrier.	The risk associated with the lack of health and safety risks will be reduced as areas engage with the risk assessment training and complete or update risks on the Datix system.	August 2023: Notes of the Health and Safety Committee Risk Assessment Training	30/12/2023
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	-68.85	30/04/2024	4.00	12/09/2023	Overdue	Not Yet Due		Nov 2022: An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised. • Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. • An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment. Aug 2023: • New infusion device service and training manager now in post. • New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard. • Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB. • Training sessions delivered and open to substantive and bank staff to book. • Strategic plan to incorporate cascade trainers into the training provision to increase compliance.		This risk is currently being partially mitigated by providing ad hoc training sessions in a seminar room in OSU to ensure new starter training for end users is being delivered as able. Fresenius reps helping with staff updates as able prior to finishing in post. Cascade sessions delivered to paediatric nurses as able, to enable them to support with delivery of paeds updates. Need for fixed infusion device training base escalated and venue being sought.	New QPS Infusion Device Service Training Manager now in post. Consolidation of the infusion device training records aim to be achieved by end of Sept 23 Development of a dashboard to indicate compliance levels aim to be achieved by December 2023. Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies.	30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Undermeath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1, and Board in Q2;	30/06/2021	-29.93	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		• Training sessions delivered and open to substantive and bank staff to book.				30/12/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	31/12/2022	-11.93	31/05/2024	5.02	28.11.2023	Overdue	Not Yet Due		Nov 23: The HIMSS maturity report has been excepted and it will be played into our Digital Strategy and IMTP planning. August 2023: The new Director of Digital is currently reviewing the TOF and will present findings and an action plan for the consideration by the Executive Committee in October 2023 November 2021 - This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				30/12/2023
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R1	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements. b.The policy and process documents will be updated to reflect the amendments.	31/10/2021	-25.90	31/03/2024	3.02	12/09/2023	Overdue	Not Yet Due		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				30/12/2023
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R2	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	-25.90	31/03/2024	3.02	12/09/2023	Overdue	Not Yet Due		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				30/12/2023
External	2021.01 EA	Audit of Accounts Report, 2020–21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	-19.97	31/03/2024	3.02	28.11.2023	Overdue	Not Yet Due		November 2023: Procurement completed. Draft Implementation plan being discussed with Divisional Directors. Roll out to commence in January 2024. Aug 2023: The roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress once purchased. Current technical issues with procurement. If resolved implementation will commence October 23. Nov 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress over the next 9 months.	Aug 2023: Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full. Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full.	Aug 2023: Executive Team. Legal and Procurement advice	September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23.	30/12/2023
Internal	2021.17	Corporate Governance: BAF	Reasonable	Director of Corporate Governance	Medium	R4	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	31/07/2022	-16.95	31/03/2024	3.02	12/09/2023	Overdue	Not Yet Due		August 2023: Risk Management Stratgey and Board Assurance Framework processes under review. Revised strategy due to Board in Q4, 2023/24.				30/12/2023
Internal	2021.20	Medicines Management	Reasonable	Medical Director	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	-8.98	31/12/2023	0.03		Overdue	Not Yet Due		Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics). The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy. The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational procedures are being implemented prior to introduction of the new policy and are expected to be completed by the end August 2023. A revised Management of Controlled Drugs Policy has been drafted and is being reviewed across the Divisions and will provided to the Clinical Standards and Policy Group in November 2023 for approval.	Delay due to HMRC licencing requirements		ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6	30/12/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-11.93	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dev to discuss scope and Digital will ensure this includes Information Asset Owners. Aug 23: CRU have provisionally provided a date for the next NIS CAF assessment process Oct 2023. As part of the engagement CRU have suggested a hybrid approach with onsite visits and interviews with systems owners. This is being piloted currently but is a process change from the previous assessment process undertaken in 2021				30/12/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	-11.93	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessemnt scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023 Aug 23:CRU are piloting process changes to their approach from their initial NIS assessment undertaken in 2021, Future NIS CAF assessments will include evidence gathering ,recording and reporting as part of the new format.				30/12/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022	-14.95	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process. AUG 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Office of he SIRO has been established, implementation of supporting governance and structures are in progress allowing costs to be fully assessed and actions prioritised. Aug 22: The creation of the TOM and creation of the HBOTS is ongoing This will provide the risk management framework to allow costs associated to improvements to be managed and prioritised."				30/12/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Low	R3	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre	30/09/2022	-14.95	31/12/2023	0.03	12/09/2023	Overdue	Not Yet Due		Mar 23•Some KPIs have been created, reviewed each week at SLR and will form the basis of the Flow Centre Review currently taking place	Mar 23 Review being undertaken currently			30/12/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Medium	R4	R4. We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	-17.97	31/12/2023	0.03	12/09/2023	Overdue	Not Yet Due		Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •The BCP has been created/updated and is due for a further review in light of recent IT risks and the joining of the Urgent Care Division	Mar 23 recent Divisional changes have meant that the BCP now requires further refinement however, original recommendation was implemented.			30/12/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Low	R4.1	R4.1 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	-13.97	31/12/2023	0.03	12/09/2023	Overdue	Not Yet Due		Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •This is on hold until we return to our call centre.				30/12/2023

Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security and the risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	-14.95	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established Sept 22. The reporting route is being established following the appointment of the new SIRO. Aug 22: Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that could be imposed."				30/12/2023
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	High	R1	CloseHealth Board monitoring ofthe key risks facing the CCNS to ensure:•appropriate action continues to be taken; and•support is provided to the CCNS as required	1)Engagement with families and staff in a review of service models –utilising co-production and with a compassionate leadership lens explore options of "out of family home" models of care, which may meet needs of child/young person more effectively, optimise management of scarce resources and support retention of staff.2)Workforce review to identify skill mixedworkforceresource required to deliver safe service across the various linesof commissioned service e.g.Continuing Care, Special Schools, Children's Out Patients, Clinical/Care closer to home3)Business Case/Service Review to establish options of further efficiency and priority with theidentification ofdiscrete financialbudgetlinesto meet assessed and agreed service priorities4)Developing new roles/skill mix within the Children's Community Nursing Service to enhance service provision5)Partnership Board/Welsh Governmentrecommendation required to determine the prudent delivery of care described as ancillary and incidental care needs, and multi-agency responsibilities initsdelivery.This will aid the alignment of Value-Basedhealth care and Value-Based social care	31/03/2023	-8.98	31/12/2023	0.03	12/09/2023	Overdue	Not Yet Due		Aug 2023: Awaiting sign off of Bridgeview before we can engage with our families to explore out of home model of care. 2. Workforce review completed and skill mixed model identified. Awaiting sign off of Band 4 before implementation. 3. Business case submitted detailing risks of service reduction in each area. New financial envelope was estimated from a period of high vacancies, high sickness and complaints from families due to a reduction in their statutory respite. 4. Currently no scope to develop new or additional roles within the CCNS due to financial constraints, however skills mix model has been developed through the workforce work to enhance the skills and allow a "grown our own" model for sustainability in the future of the service. 5. Ongoing discussions due to social care and health interperating the recommendations differently.	Aug 2023: Bridge view sign off. Agreement and sign off of Band 4 Senior Health Care Support Workers. Differing interperation of goevernmenet recommendations from health and social care			30/12/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	-3.02	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		November 2023: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues	November 2023: Any new policies are checked for embedded documents prior to publication		30/12/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-3.02	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/12/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-3.02	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/12/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this, escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-3.02	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		November 2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/12/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	-3.02	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		November 2023: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/12/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	-3.02	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		November 2023: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status.	November 2023: capacity to review policies given current operational and financial pressures.			30/12/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-8.98	31/01/2024	1.05	28.11.2023	Overdue	Not Yet Due		November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/12/2023
Internal	2022.12	Records Management	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023	0.03				Not yet due							30/12/2023
Internal	2022.12	Records Management	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	0.03				Not yet due							30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	-6.07	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	-8.98	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	-9.97	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.				30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-9.97	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits				30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-9.97	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deployed optimally to allow additional automations not dependent on in hours working to be undertaken.				30/12/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-9.97	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023				30/12/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	-6.95	31/03/2024	3.02	28.11.2023	Overdue	Not Yet Due		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			30/12/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	-6.95	31/03/2024	3.02	28.11.2023	Overdue	Not Yet Due		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				30/12/2023
Internal	2022.17	Risk Management	Reasonable	Director of Corporate Governance	Low	R2	The Health Board should clarify how Divisions will record risk in the meantime.	The Health Board is currently revising its Risk Management Policy which is expected to be presented for endorsement at the May 2023 Board meeting. Within the revised Strategy, refined guidance on capturing and recording of risks will be included.	01/05/2023	-7.97	31/03/2024	3.02	12/09/2023	Overdue	Not Yet Due						30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.	01/04/2024	3.05				Not yet due							30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024	3.05				Not yet due							30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.	01/04/2024	3.05				Not yet due							30/12/2023

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024	3.05				Not yet due								30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024	3.05				Not yet due								30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	3.05				Not yet due								30/12/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC	01/04/2024	3.05				Not yet due								30/12/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	At future projects Contracts should be executed prior to the commencement of works / duties.	Agreed -Future Projects Contracts will be signed prior to the commencement of works	01/03/2024	2.03				Not Yet Due			Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts.	Choice of Linac Supplier	This has not delayed project progress	Final sign off by Varian and VT	30/12/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Low	R5	At future projects All contracts should be dated	Agreed - Future Projects - Contracts will be dated.	01/03/2024	2.03				Not Yet Due			At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed	None	N/A	None, CWs have so far not been required	30/12/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	All contracts over £100k in value should be signed by both the Chief Executive & Chair in accordance with the UHB's Standing Orders (Scheme of Delegation)	Agreed - Future Projects Contract Values exceeding £100k will be signed by the Chief Executive & Chair in accordance with UHB Standing Orders.	01/03/2024	2.03				Not yet due							30/12/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R7	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity.	Agreed, the necessary collateral warranties will be obtained at the earliest opportunity.	01/06/2023	-6.95	28/02/2025	13.97	28.11.2023	Overdue	Not Yet Due		November 2023: there are numerous collateral warranties that occur at numerous points in the contract therefore this would not be completed until the end of the contract , i.e. February 2025. At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties. Aug 2023: At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties.	Aug 2023: None	N/A	Aug 2023: None, CWs have so far not been required	30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set formal deadlines for reporting. Auditors' comment on management response We agree with the current approach in the absence of mandatory deadlines. Therefore, whilst formal deadlines may not be the most suitable approach, we believe that the Health Board should continue to focus on the key principles of the Standards and the implementation of these. However, as this will be closely integrated with performance metrics and current monitoring arrangements, we recommend that exceptions are regularly escalated / reported following the commencement of workstream monitoring by the Dementia Programme	01/07/2024	6.03				Not yet due								30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	-6.95	31/01/2024	1.05	12/09/2023	Overdue	Not Yet Due		UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards.				30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R2	Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	-6.95	31/01/2024	1.05	12/09/2023	Overdue	Not Yet Due		Nov 2023: Review of the outcomes from the National Audit of Dementia there is a recommendation for a relaunch of information to raise awareness of the diagnostic Code for Dementia on Clinical Workstation (136). The information will be added to the Internal Pulse web pages and shared through ABUHB e mail communication network.			Michelle to confirm	30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff	01/07/2023	-5.97	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due						30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	-5.97	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.		30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	-4.95	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.				30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023	-3.93	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Language team.			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Language team who we collaborate with closely.	30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	-3.93	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due		Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvements in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.			Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvements in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.	30/12/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-3.93	28/02/2024	1.97	28.11.2023	Overdue	Not Yet Due						30/12/2023
External	2022.03 EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023	-3.93	31/03/2024	3.02	28.11.2023	Overdue	Not Yet Due		November 2023: The HOBB is undertaking a review of all board processes and procedures to secure greater consistency of approach and to ensure that all regulatory and statutory requirements are addressed though an action plan to improve board business. This will include the timeliness of meetings and scope of papers for consideration.				30/12/2023
External	2022.03 EA	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	-8.98	31/12/2023	0.03	12/09/2023	Overdue	Not Yet Due		June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital tookit. The CIVICA system is being rolled out with a specific focus on supporting teams with training to retrieve their own data. Patient verbal narratives are not yet on the system. The first CIVICA report will be presented at Executive Team in September 2023.				30/12/2023
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R1	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resources to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	3.02				Not Yet Due								30/12/2023

Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R2	All investigation evidence should be attached to the complaint Datix record for ease of referance in the event of queries.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	3.02				Not Yet Due							30/12/2023
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Low	R3	Complex complaint cases which under the regulations are permitted an investigation period of up to six months should be excluded from the 30 day breach statistics.	Welsh Government are currently reviewing PTR regulations.	31/01/2024	1.05				Not Yet Due							30/12/2023
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	R4	Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R5	Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require following OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability frameowrk between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	R6	Actions to address the circumstances that have led to individual complaints and those that have been identifed to address complaint themes through boarder learning pathways should be captired in actions plans. The delivery of the plans should be monitored by appropriate oversight groups.	Review all QPS resourses being undertaken via an OCP which will include learning.	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R7	Actions to review the current structure throughout the Health Board mapped to the end to end process. Where gaps in or additional resourse requirements are identified these should be implemented to meet the requirements of the Health Board.	Review of all QPS resourses being undertaken via an OCP.	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R1	We recommend that the Clinical Coding Service Policy and Procedure document is reviewed, ratified, re dated and re issued.	The Clinical Coding Service Policy and Procedure Document will be reviewed by the end of December 2023	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R2	We recommend that the Health Board issues guidance to clinicans covering the accepted protocols, conventions and standards for the structure and content of patient records	Monthly meetings between the Medical Director and the clinical coding manager were re established in October 2023. These meetings will in part be used to formulate guidance to clinicians regardings the standards and content required in patient records.	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Low	R3	We recommend that where patient notes prose interpretatios challenges and the coder assigned requires furthereinformation to progress these e.ng diffucties wth clarity, content, form, structure, completness ect. - That these cases are processed as exceptions and logged to proide a record of the issue, how it was resolved and the time taken to close. Logs can then subsequently be used in clinician communications.	The content of clinical notes will be discussed in the monthly meeting between the medical Director and the Clinical coding manager. This will include detailing the volume of notes that have been diffucult to interpret and areaas of noteable concern.	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	High	R4.1	we reccommend that the Health Board devise a plan to address the longstanding underperformance in the monthly coding of episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	The Executive Committee approved the restructing of the Clinical Coding department in August 2023, the agreed restructure when comlete wil deliver on the monthly coding of episodes target.	30/06/2024	6.00				Not Yet Due							30/12/2023
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	High	R4.2	We reccommend that the Health Board devise a plan to address the longstanding underperformance in claering the backlog of uncoded episodes. The performance of the plan should be reported regularly to the Board or an appropiriate forum.	Backlog of episodes will be systematically coded when the new Clincial Coding Structure in implemented. The new structure provides the workforce with he capability to deliver on the monthly coded episodes target and address backlog.	30/06/2024	6.00				Not Yet Due							30/12/2023
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R1.1	Business continuity plans and associated documentation should be completed for all service areas within the Health Board. The Health Board may wish to incorpoarte this process with the wider opeartional risk management processes. There needs to be an accountability and escalation routes if such plans/actions cards not completed.	Recommendation accepted - the requirement for business continuity plans is within the Policy and BG planing guidance. The emergency planning team have plans in place to further engage with specific service areas. The new intranet repository will provide further information and will provide further information and will be established to monitor the progress of plans. The newly established EPRR group will be well suited to be the forum for escalation.	31/01/2024	1.05				Not Yet Due							30/12/2023
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R1.2	Buisness continuity plans/action cards should be regularly tested, to ensure steps taken are the most effective. Following a continuity event test being completed, lessons learnt and updates to the documentation should be completed.	Reccomendation accepted - This is included within the policy and buisness continuity planning guidance. Outcome from exercises and tests can be added too the repository and monitored by the emergancy planning team and be available to share with others for learning and via the EPRR group.	31/01/2024	1.05				Not Yet Due							30/12/2023
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2	Buisness continuity should be promoted throughout the Health Board on a regular basis, to help raise awareness throughout all service areas	Recommendation accepted - Emergency planning promote buisness continuity on the intranet and to service leads, this wil be increased by quaterly updates on the intranet, using AB Pulse and with support from the communication team across other internal media platforms and through the EPRR group and the BC group.	31/01/2024	1.05				Not Yet Due							30/12/2023
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2.1	The training resourse on ABLHB Sharepoint should be clearly signposted so staff know what the team delivers and what training they will need either on buisness continuity or major incident.	Recommendation accepted - promote and signpost services to the guidance viw the intranet and using the EPRR and BCM group. The repository will be in place by Dec 2023, easily accessed via the front page of AB Pulse and agree a weekly promotion of teh link with the comms team for the first month, and then quaterly as per R2	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2.2	There should be regular monitoring of training delivery by the Emergency Planning Team to ensure staff have the appropriate knowledge.	This will be identified by through the tracker. The summary tracker will capture training, meetings, exersise and workshops, this wl sit within the repsoitory.	31/12/2023	0.03				Not Yet Due							30/12/2023
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Low	R3	The Emergency Planning Team should undertake a "deep dive" of the information received on the Buisness continuity Resilience Day and implement any improvement actions required.	Recommendation accepted - The emergency planning team, divisons and directorates will continue to undertake debriefs following exercises and events to identify learning. Plans and actions card will be ammended according following this process. These will be shared via the BCM nad EPRR group as appropriate. The EP will develop a bespoke BC debrief workshop for Spring 2024	31/03/2024	3.02				Not Yet Due							30/12/2023
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R4	The Health Board should ensure that operational areas incorporate best practice, learning, lessons and other experiences from the pandemic within their buisness continuity plans.	Recommendation accepted - The BC guidenace incorporates debrief requirement to identify lessons to inform planning, this will be ammended to incorporate learning from the pandemic. An updated version will be shared with BC leads highlighting this requirement to be incorporated in new plans and current plans to be reviewed to ensure learning is included. This will be highlighted in all training and at the BC group meetings. This will also be monitored on the summary tracker reported inot the BC and EPRR group as part of the planned monitoring process.	31/12/2023	0.03				Not Yet Due							30/12/2023

Internal Audit Progress Report

Audit, Risk and Assurance Committee

February 2024

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Gwasanaethau Archwilio a Sicrwydd | Shared Services Partnership Audit and Assurance Services

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

Contents

1. Introduction *3*

2. Progress against the 2023/24 Internal Audit Plan *3*

3. Summary of Findings *4*

4. Potential Audit Plan Changes *6*

5. Other Activity *6*

6. Recommendation *6*

Appendix A: Progress against 2023/24 Internal Audit Plan *7*

Appendix B: Audit Assurance Ratings *8*

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the February 2024 Audit, Risk and Assurance Committee (the 'Committee');
- discuss and seek approval for changes to the 2023/24 Internal Audit Plan, as listed within Section 4; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2023/24 Internal Audit Plan

There are 29 individual reviews in the 2023/24 Internal Audit Plan and an additional review included regarding Facilities. In addition, our Specialist Services Unit (SSU) undertake assurance work over major capital projects.

The table below details progress against the 2023/24 Internal Audit Plan.

Number of audits in plan:	29
Additional review: Facilities	1
Less: deferred audits	(3)
Revised total	27
Number of audits reported as final	9
Number of audits reported as draft	4
Number of audits work in progress	5
Number of audits at planning stage	5
Number of audits not started	4

The following 2023/24 final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 28th November 2023:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Integrated Performance Dashboard: Data Quality	Substantial
Stakeholder Engagement on IT Projects	Substantial
Facilities	Limited
Estates Assurance – Estates Condition	Limited

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

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reports issued since the last meeting on 28th November 2023.

Integrated Performance Dashboard: Data Quality (substantial assurance)

The audit reviewed source data used for the reporting of a sample of key metrics within the Integrated Performance Report (IPR). Overall, whilst we found that there were no data quality issues within the IPR, we did note that compilation is largely a process of transcription from monthly data values provided by teams within the Health Board or taken from national data tables.

Stakeholder Engagement on IT Projects (substantial assurance)

We undertook a review to provide assurance over the framework in place for stakeholder engagement on key IT projects.

Overall, we found guidance in place for programme and project management that includes stakeholder engagement and templates for stakeholder communication. Stakeholders are engaged with early in the process and their requirements incorporated into the specifications, accordingly.

We found appropriate stakeholder involvement within the governance structures, which enables ownership of projects and programmes, with users included within the testing stages and project and programme sign off.

Facilities (limited assurance)

The audit assessed whether appropriate stock processes are in place and whether applicable controls within the process for allocating / approving bank shifts are effective.

Overall, we provided limited assurance over this area, largely driven by the matters arising within the catering stock processes. The key matters identified include:

- a lack of procedures and reporting;
- incomplete or non-compliant stock management processes;
- the lack of management over the provision orders;
- insufficient waste management awareness;
- inconsistent and unknown stock levels;
- incorrect receipting of orders; and
- functionality within the bank system not being maximised to its potential.

Estates Assurance – Estates Condition (limited assurance)

This review sought to evaluate the arrangements put in place by the Health Board to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage / mitigate the risk.

A full survey of the estate was last undertaken in 2017 (a refresh now overdue, being beyond the recommended five-year interval). In the interim, the "high" risk backlog has increased from an assessed £200,000 to over £37m (based on the Health Board's estate department assessments and departmental funding requests etc).

A 2019 Estates Strategy targeted backlog reduction by 10% per annum. However, since that date, the reported total backlog has effectively doubled. At the time of the current review, there was no revised plan in place to fund the increased levels of backlog.

In the short to medium term, the Health Board has utilised a combination of all Wales capital funding, targeted EFAB funding, planned / reactive maintenance, and discretionary funding to address identified high-priority areas.

Since the 2017 survey, further assessment of estates backlog has been constrained by limited resource.

To effectively inform reporting, there was a need to ensure appropriate assessment methodologies, surveys, and accurate data, supported by an appropriately resourced maintenance team.

As noted, backlog data has been increasing over recent years with provisional data for 2022/23 increasing the backlog by circa £50m in one year. However, this may be in part due to survey and compilation methodologies.

However, backlog has been assessed within the Corporate Risk Register as being managed within acceptable tolerances. It was not therefore a focus for senior committees (and independent scrutiny).

There has therefore been a disparity between the backlog figures (being reported as increasing to some £100's of millions to Welsh Government), and a lack of profile internally (to drive investment).

The key matters requiring management attention included the need to review the corporate risk profile, based on the likely gap between available funding and investment needs.

It is recognised that by the conclusion of the audit, management were already reviewing governance reporting, and risk management arrangements. They were also engaging with NWSSP: Specialist Estates Services with a view to provide more cost-effective support for accurate and consistent data.

However, noting the issues at the time of audit, an overall limited assurance has been determined, notably due to the concerns that identified estate risks cannot be managed within existing funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales estate. At the UHB, RAAC had been identified at single story buildings at Nevil Hall hospital requiring urgent attention and the way forward was being discussed with NWSSP: SES.

4. Potential Audit Plan Changes

We have received a request from the Health Board to defer the 2023/24 Maternity Action Plan audit into 2024/25. This is due to the current work underway to consolidate, track and implement all outstanding actions identified regarding maternity. These include external reviews and the previous completed Health Board self-assessment.

A deferred audit will enable a review of the most recent position and the updated management process. However, this would delay a review of this key area for approximately six months.

Therefore, we are seeking a discussion and potential **approval** from the Audit, Risk and Assurance Committee for this amendment to the 2023/24 Internal Audit Plan.

5. Other Activity

The following meetings have been held/attended during the reporting period:

- monthly meetings with the Director of Corporate Governance;
- monthly meetings with the Director of Finance, Procurement and Value;
- Audit, Risk and Assurance Committee pre-meeting with the Audit, Risk and Assurance Committee Chair;
- review and advice over financial control procedures and workforce procedures; and
- liaison with senior management.

6. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and to **review** and **approve** the 2023/24 Internal Audit Plan change proposed within Section 4.

Appendix A: Progress against 2023/24 Internal Audit Plan

Audits	Status
Savings Programmes	Not started
Financial Controls	Planning
Decarbonisation	Planning
Asset Management	Draft report
Medical Equipment & Devices	Draft report
Risk Management & Assurance	Not started
Follow-up of High Priority Recommendations	Planning
The Health & Social Care (Quality & Engagement) (Wales) Act	Deferred
Integrated Medium Term Plan	Final report
Integrated Performance Dashboard - Data Quality	Final report
Business Continuity Planning	Final report
Safeguarding	Final report
Waiting List Management	WIP / Draft report
Directorate Review - Theatres	Not started
Job Planning	Deferred
Clinical Coding	Final report
Providing Care to Asylum Seekers & Refugees	Planning
Early Supported Discharge - Stroke	WIP
Intra-site Patient Transfers	WIP
Regional Partnership Board	Draft report
Long Term Sickness Absence Management	WIP
Maternity (Action Plan)	WIP
Flexible Working (advisory)	Planning
Allegations against Staff Policy	Deferred
Network Infrastructure (VPN)	Final report
Stakeholder Engagement on IT Projects	Final report
LINC Programme	Not started
Bevan Health & Wellbeing Centre	WIP
Estates Assurance - Estate Condition	Final report
Facilities Bank Approval Process	Final report

Appendix B: Audit Assurance Ratings

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

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

Facilities
Final Internal Audit Report

January 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Executive Summary 4
1. Introduction 5
2. Detailed Audit Findings 5
Stock ordering 6
Stock level and stock take 6
Stock receipting 7
Security 7
Food Waste 8
Management 9
Oracle and Synbiotix 9
Banking arrangements 10
Appendix A: Management Action Plan 12
Appendix B: Assurance opinion and action plan risk rating 24

Review reference:	AB-2324-23
Report status:	Final
Fieldwork commencement:	11th October 2023
Fieldwork completion:	6th November 2023
Debrief meeting:	6th November 2023
Draft report issued:	24th November & 15th December 2023
Management response received:	12th January 2024
Final report issued:	15th January 2024
Auditors:	Stephen Chaney, Acting Head of Internal Audit Laura Howells, Principal Auditor
Executive sign-off:	Leanne Watkins, Chief Operating Officer
Distribution:	Jamie Marchant, Divisional Director Estates & Facilities Rhys Shorney, Head of Facilities
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To provide assurance over whether appropriate stock processes are in place and whether applicable controls within the process for allocating / approving bank shifts are effective.

Overview

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

- lack of procedures and reporting;
- incomplete or non-compliant stock management process;
- lack of management of provision orders;
- insufficient waste management awareness;
- inconsistent and unknown stock levels;
- incorrect receipting of orders; and
- functionality within the bank system not being maximised to its potential.

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

Report Opinion

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	⇔ Facilities Stock Review 2017/18

Assurance summary[1]

Objectives	Assurance
1 Stock management	Unsatisfactory
2 Bank process	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Procedures and Reporting	1	Design	High
2	Stock Ordering	1	Design	High
3	Stock Take	1	Design	High
4	Stock Receipting	1	Design	Medium
5	Security	1	Design	Medium
6	Waste	1	Design	High
7	Systems	1 & 2	Design	Medium
8	Bank Shifts	2	Design	Medium

1. Introduction

1.1 This is an additional audit to the agreed 2023/24 Internal Audit Plan.

1.2 This review sought to provide the Health Board with assurance that there are appropriate stock management policies and procedures in place within the Facilities division and that they are adhered to.

1.3 Additionally, the Health Board was concerned over potential weaknesses within the Bank system for the provision and approval of bank shifts to staff. Therefore, we sought to provide the Health Board with assurance over the current process for checks and balances regarding bank shifts.

1.4 Where weaknesses have been identified we have provided recommendations to improve the applicable processes.

1.5 Risks associated with this review are:

- inadequate stock control leading to a misuse of / excess stock resulting in financial loss to the Health Board;
- inadequate IT systems / controls allowing for misuse of systems resulting in financial loss to the Health Board; and
- inadequate policies and procedures in place, which do not adequately cover the appropriate use of stock and bank systems and processes.

1.6 Testing was completed on a sample basis within the Facilities division.

1.7 During this audit we visited the following sites to review the stock management process:

- The Grange University Hospital (GUH);
- Royal Gwent Hospital (RGH); and
- Nevill Hall Hospital (NHH).

2. Detailed Audit Findings

Objective 1: Stock - Review of the updated stock practices / processes following the integration of the Grange University Hospital.

2.1 We found a lack of appropriate stock management procedures within the Facilities division. There is a Health Board financial control procedure (FCP) for stock that details an effective stock management process and should be utilised for developing local standard operating procedures (SOPs). No staff member interviewed during the audit, at any of the three sites visited, was aware if this FCP was being utilised within the Facilities division. Due to the lack of procedures, we walked through the stock management process and interviewed staff across GUH, RGH and Nevill Hall. We identified weaknesses within the local controls in place. **Matter arising 1**.

2.2 The stock management process is broken down into multiple stages, which are set out below. Several observations were consistent across all sites visited which have been grouped together. Any observations specific to individual sites have been separated out.

Stock ordering

2.3 All stock is ordered through Oracle, inconsistencies were identified when ordering across each site. All sites had issues with either ordering too many or too few provisions (in some instances significant variances).

2.4 All sites utilise recipe cards. However, staff interviewed on site did not believe the recipe cards were being accurately followed and there was a lack of portion control. However, we were unable to validate these comments as stock usage and wastage figures are not being recorded. We found that the comments received were consistent across each site.

2.5 There were issues across all sites with ordering 'off-catalogue' (purchasing stock on Oracle where products had not been approved by Procurement), although staff interviewed consistently noted there had been a reduction in using 'off-catalogue' as there had been an effort from management to reduce this. However, some staff were unable to confirm if certain items were on or off catalogue when completing the ordering sheet. Off catalogue orders should only be required if the approved supplier cannot provide what is required.

2.6 It was not possible to be provided with evidence that managers consistently and robustly challenge Oracle orders for their necessity as this, if done, is usually verbally. Staff on all sites consistently said the lack of challenge was an issue. There is a risk that stock may be ordered when it is unnecessary or vice versa. Uncontrolled quantities of stock may result in a potential financial loss to the Health Board. **Matter arising 2**.

Stock level and stock take

2.7 There was a lack of understanding of what a comprehensive stock take requires, by all staff and management across the three sites tested. Regular 'stock takes' were undertaken at both the RGH and GUH with just an annual 'stock take' being undertaken at Nevill Hall. However, not one stock take that we reviewed was completed correctly. Stock is simply counted on the shelf and then noted on a stock sheet.

2.8 The Health Board has a financial control procedure in place for Stores and Stocks which details the formula for a stock take:

- OPENING BALANCE OF ITEMS (quantities) = O
- Add receipts for a period = R
- Deduct issues made during the period = (I)
- Deduct any items scrapped or disposed of = (S)
- CLOSING BALANCE OF ITEMS = C

2.9 No staff member was aware of this procedure, except for the Head of Facilities and consequently, the procedure was not complied with. This allows for the manipulation / misappropriation and misuse of stock.

2.10 Stock levels across all sites varied. A multitude of staff informed us that stock levels changed depending on the staff member who ordered, with some ordering excessively and others not enough. However, due to the opening and closing stock balances not being recorded, we could not verify this.

2.11 Minimum and maximum stock levels of each product were meant to be in place, but staff at all sites confirmed this is not always adhered to. On review of the stock rooms at each site, we identified cases of non-compliance.

2.12 There was no evidence that the minimum and maximum levels set had robust data behind them, linked to footfall in the retail areas, and the varying levels of stock seen supported this. This is likely due to levels not being reviewed following the Covid-19 pandemic, which has affected footfall in the retail areas.

2.13 There is a risk that unnecessary amounts of stock are being stored, used and wasted resulting in a financial loss to the Health Board. **Matter arising 3**.

Stock receipting

2.14 There was anecdotal evidence that stock receipting was not completed effectively at any site with specific issues at each site.

2.15 RGH – order sheets are given to staff accepting deliveries to compare against the delivery note when checking stock. This is binned and no audit trail kept and as such, could not be reviewed.

2.16 GUH – ordering is completed within the General Office and stock is received by the Receipt and Distribution (R&D) department. Stock order sheets should be placed in the R&D pigeonhole before stock is received, to ensure stock delivered can always be compared to what is ordered. However, staff noted the stock order sheet is not always in the pigeonhole and sometimes deliveries arrive without delivery notes so stock can be accepted without being properly checked.

2.17 Nevill Hall – Staff informed us due to time constraints stock is not checked properly. Stock should be ticked off when checked. We reviewed order sheets and confirmed they had been ticked as checked but were informed a check is often not completed even though the sheet is ticked. However, other staff interviewed noted that despite this, errors in stock were less than once a month.

2.18 There is a risk that stock is consistently not being checked and received correctly. This allows any mistakes on delivery to potentially not be identified, resulting in a financial loss to the Health Board. There is a risk that if the required stock is not delivered patients will not receive their designated meals. **Matter arising 4**.

Security

2.19 There were CCTV cameras on all sites visited. However, there were specific observations noted at each site.

2.20 RGH – this was the only hospital where we were challenged by multiple staff when walking around the catering areas. This was an area of good practice. Stock rooms are not restricted and remain unlocked during the day. There are no cameras in this area.

2.21 GUH – all stock areas remain unlocked during the day except for the confectionery stock room. There are no cameras in the stock room area and staff agreed stock could be removed from the outside freezers without needing to take it back through the hospital.

2.22 We identified partially consumed stock in the stock room whilst the stock room was being replenished with the same product. We could not verify if this product had been bought and accidentally left in the stock room or if it had been taken from the stock within the room.

2.23 Nevill Hall – whilst on site, we observed a new stock delivery remained unattended for an extended period of time, in the loading bay, with easy access to remove stock and take it directly to the car park. There were no CCTV cameras in the loading bay area.

2.24 There is a risk that stock is misplaced, misused or stolen due to a lack of security measures across all sites, which may result in financial damage to the Health Board. **Matter arising 5**.

Food Waste

2.25 Food waste is not measured effectively at any site. There is considerable food wastage at all sites, but this could be for a number of legitimate reasons (e.g. patient waste). However, the Health Board does not have any current method of measuring food waste or the associated reasons – e.g. overordering, stock expiring, or lack of portion control.

2.26 GUH – Apetito (supplier) orders are measured on the Synbiotix system (food management software) and this identifies the inherent waste with the Apetito orders. Apetito meals are sent in set sizes called 'foils'. Foils are produced as small and large and vary in size. For example, a small foil could serve three patients and a large could serve six to eight patients. There is additional waste if only one patient on the ward orders a particular meal, as a small foil must still be used, thus wasting two portions (foils are sent to individual wards). Whilst there is an estimated cost to the total wastage of £80,316, this is largely a notional amount. The steps required to realise savings from reducing waste predominantly involve selecting a different approach to ordering foils – namely individual portions. However, ordering individual portions costs more than the current level of wastage. Nonetheless, there is a benefit to exploring stock waste reduction methods to maximise stock usage and continuing to regularly assess the cost position in case the cost differential becomes beneficial.

2.27 Nevill Hall – we observed 28 standard household wheelie bins that were filled with food waste. We informed that this is the total for the week that we visited (i.e. weekly waste). We were also informed by management on site that they had just started to implement a waste tracking sheet that required chefs to detail the

number of portions made and the number of portions used. The aim is to understand where the waste was being produced. This was in its infancy so we were unable to test it. However, if proven to help reduce waste the Health Board should consider rolling out the form across all sites.

2.28 There is a risk that due to the lack of management around food waste, more provisions than necessary may be purchased. This may lead to the current stock levels not being used effectively, resulting in financial damage to the Health Board. **Matter arising 6**.

Management

2.29 During our interviews with staff on site, consistent concerns were raised about the lack of management control around the stock management process and in particular, the lack of challenge to stock ordering.

2.30 There was a lack of understanding from management as to how to complete effective stock takes. If there was an understanding, management were not implementing the correct process.

2.31 Operational management on site were not historically required to formally report on stock usage, waste figures etc. to their monthly Facilities meeting. Senior management should consider how to implement the monitoring of stock either through data usage from systems such as Synbiotix or spot checking. This will provide operational management with guidance on what should be monitored and how. Support can then be put in place for any sites that need assistance with their processes.

Oracle and Synbiotix

2.32 We found several improvements which would assist in the stock management process. Currently, the Health Board does not utilise a specific stock management system. However, it was noted that there is a possibility to link Oracle and Synbiotix to function together. However, this would require the Health Board to better utilise the Synbiotix system, which has numerous functionalities they are not using.

2.33 We identified Oracle had no preferred supplier set up for specific products and detailed some products that are no longer used. A review of the capabilities of Oracle may also benefit the stock management process.

2.34 Overall, there is a risk that the Health Board does not fully utilise the functionality of the systems it has available, and the stock management process is not managed effectively. **Matter arising 7**.

Conclusion:

2.35 There are multiple areas of weak process, management and non-conformance to Health Board procedures that require improvement. Given the extent of the matters identified we have provided this objective with **unsatisfactory assurance**.

Objective 2: Bank system - specifically in relation to use within the Facilities Division

Banking arrangements

2.36 Facilities, as with other divisions, require additional shifts to be filled for a variety of reasons. For example, covering annual leave, sickness or a vacant post. These shifts should be filled in a particular order which is noted within the Health Board's Resource Bank – Booking Rules. In the three months from 15th August to 15th November there were 5,021 bank shifts within Facilities.

2.37 We undertook a walkthrough of the bank shift allocation process at both GUH and Nevill Hall. We identified a difference in approach across both sites.

2.38 The GUH's process involves a form provided to all staff to note their availability to fill any shifts still unresourced. This is then collated on a spreadsheet and used to fill open shifts. Our review of the spreadsheet showed that it is consistently used. Any shifts that are still unresourced or require covering at a short notice are added to a notice board and staff can add their names to the available shifts.

2.39 At Nevill Hall, an address book with contact details of staff is maintained. Staff are contacted to see if they can cover unfilled shifts. An availability form is also used, but only for hostess staff.

2.40 We confirmed, through our interviews, that many staff worked shifts via the Bank as opposed to being offered additional hours. This is in contravention to the Bank Rule Procedure. **Matter arising 8**.

2.41 We sought to test shift start and finish times for a sample of staff, however, no system is used to identify when staff start and end their shift. Whilst we were provided with examples of staff finishing shifts earlier, we were unable to verify this to determine the extent (if at all) of this practice. We identified that porters follow a process of logging into the Synbiotix system, to mark availability for ward duties during their shift. **Matter arising 7**.

2.42 The bank shifts are added to the Bank Staff system. The current system allows for staff with the necessary system permissions to either / or self-authorise shifts (create a bank shift), self-work (allocate the shift to themselves) and self-finalise (authorise the shift for payment). There is no default control within the system preventing users from completing all three steps. However, Workforce are currently in the process of updating each user account within the bank system to prevent staff from authorising their own shifts. This has not yet been fully set up but is in progress. **Matter arising 7.**

2.43 As the control is not yet fully implemented, we requested a report to identify if any staff members / users completed all three steps. During October, zero staff completed all three steps, but one staff member completed the first two steps neither of which is permitted. This latter exception was completed for five separate shifts.

2.44 There is no timeframe in which bank shifts are required to be added to the Bank, except adding shifts to the Bank after the shift has been completed (retrospective)

should not take place, unless there are exceptional circumstances. In March 2023 there were 264 retrospective bank shifts completed on the bank system (shifts allocated to staff and worked before appropriate sign off). Senior management raised this as an issue with operational management at each site and found a number of reasons why this occurs, including a lack of approvers (e.g. on the weekends), poor planning, or last minute notifications (e.g. sickness). There were 27 retrospective bank shifts in September 2023, which equates to 1.64% of all bank shifts during the month.

2.45 There is a risk the current process allows for the spend on the bank shift to occur (i.e. because the shift has already been worked) before the bank shift is actually approved by an appropriate person. When there are limited approvers, staff are able to contact the on-call Executive for approval of the shift. As approval is often verbal, we were unable to test whether this takes place.

Conclusion:

2.46 There has been an effort by management to reduce the number of retrospective bank shifts and action has been taken to stop staff completing all three steps within the bank process. There is room for improvement on the consistency of the approaches to the appointment of bank staff.

2.47 Although we did not note any areas of major non-compliance within our testing, the system is still open to misuse and there are only manual checks in place (i.e. the monthly reporting) and no automated controls in place to prevent any misuse. Progress is being made on this and so, we have provided this area with **reasonable assurance**. We recognise that the underlying issue (i.e. software change) is not the responsibility of the Facilities division to resolve, but there should be close monitoring over the validity of expenditure in the short term.

Appendix A: Management Action Plan

Matter Arising 1: Procedures and Reporting (Design)		**Impact**
Operational management are not required to formally report on stock usage, waste figures etc. to their monthly Facilities meeting. Senior management should consider how to implement monitoring of stock either through data usage from systems such as Synbiotix or spot checking. This will then provide operational management with guidance on what should be monitored and how. Support can then be put in place for any sites that need assistance with their processes.		Potential risk of: • Management being unaware of operational requirements • Risk of financial damage to the Health Board
Recommendations		**Priority**
1.1	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board and should be accessible to all staff. Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	**High**

Agreed Management Action		Target Date	Responsible Officer
	ACCEPTED. The following steps will be taken to address the issue:		
1.1	Standard Operating Procedures will be developed to detail each step of the new process. These processes will be shared with staff and be made accessible	**February 2024**	**Catering Service Improvement Manager**
1.2	Each member of staff involved in the management or delivery of stock takes will be provided with training detailing the correct methods to use	**March 2024**	**Facilities Managers**
1.3	Monthly stock takes will take place at each site following the process set out in the Health Board's Financial Control Procedure: Stores and Stocks	**March 2024**	**Facilities Managers**
1.4	Stock usage (patient orders and retail sales) will be monitored to track stock balances, and to ensure that provision orders align with all menus and match forecasted demand. Monthly Synbiotix data to be sent to senior FM managers of non-compliance with agreed provisions.	**February 2024**	**Facilities Managers**
1.5	Local management teams will report on stock levels, food waste (production, unserved, and damaged stock) at the monthly Facilities Management Team meeting (chaired by the Head of Facilities)	**March 2024**	**Head of Facilities**
1.6	Facilities Managers will provide assurance at monthly Facilities Management Team meetings that all provision orders match forecasted demand	**February 2024**	**Facilities Managers & Head of Facilities**
1.7	The Head of Facilities will consider the potential benefit of software to improve the efficiency, effectiveness and accuracy of stock management processes. Options to be presented to the Divisional Director for decision.	**March 2024**	**Head of Facilities**

Matter Arising 2: Stock ordering (Design)	**Impact**
We found that there was little to no challenge from the managers responsible for approving each Oracle order. We identified an excessive stock level of boxes of chicken breast strips at Grange University Hospital (GUH). We were also informed of incorrect orders being received including: • an excessive number of trifles ordered at the Royal Gwent Hospital (RGH); and • baby bottles and latex gloves incorrectly ordered at the RGH.	Potential risk of: • Excess waste of stock • Financial loss to the Health Board

Recommendations		**Priority**
2.1	Management should implement a consistent approach to stock ordering. This process should be based on current footfall and patient numbers, provisions already in stock and the quantities required per portion from the All-Wales recipes. Management should then complete monthly spot checks to ensure the process is being adhered to. Stock ordering should then be reported at the monthly Facilities meetings to ensure senior management have view of any issues.	**High**

Agreed Management Action		Target Date	Responsible Officer
	ACCEPTED. The following steps will be taken to address the issue: Actions set out in agreed management action for matter arising 1	As per matter arising 1	As per matter arising 1

Matter Arising 3: Stock take and stock levels (Design)	**Impact**
Regular 'stock takes' were undertaken at both the RGH and GUH with just an annual 'stock take' being undertaken at Nevill Hall. However, not one stock take is completed correctly or in accordance with the Financial Control Procedure: Stores and Stocks. Stock is counted, at a point in time, on the shelf and then the total noted onto a stock sheet, without any ongoing reconciliation or referencing to previous stock totals. Consequently, if stock were stolen or misplaced, it would not be identified as missing. Furthermore, there is no accurate information over current stock levels, to enable management analysis to take place.	Potential risk of: • Misappropriation of stock • Unknown stock levels • Financial loss to the Health Board.

Recommendations		**Priority**
3.1	Frequent stock takes should be undertaken, to ensure any stock discrepancies can be investigated, in accordance with the principles of the Financial Control Procedure: Stores and Stocks. Any discrepancies should be investigated immediately and where discrepancies cannot be resolved this should be raised with senior management. Where minimum and maximum stock levels are in place this should be reviewed to ensure they are still appropriate following the pandemic, alongside the reduction in footfall within the canteen and following pricing updates.	**High**

Agreed Management Action		Target Date	Responsible Officer
	ACCEPTED The following steps will be taken to address the issue:		
3.1	Agreed management action 1.2	**As per 1.2**	**As per 1.2**
3.2	A process for reporting, investigating and escalating discrepancies will be developed and implemented in 'flow chart' form	**February 2024**	**Senior Facilities Business Manager**
3.3	Initiate a review of current minimum and maximum stock levels to ensure that they remain accurate, then either: • Update the required minimum and maximum levels, alongside a process for regular review, or • Use software to determine stock levels/required orders	**February 2024**	**Senior Facilities Manager**

Matter Arising 4: Stock receipting (Design)			**Impact**
Stock receipting was not completed effectively at any site, with specific issues at each site identified. Furthermore, stock is not checked consistently when received. This may lead to delivery mistakes not being identified upon receipt, which may result in financial loss and / or insufficient food being delivered.			Potential risk of: • Ordering or delivery errors not being identified • Financial loss to the Health Board
Recommendations			**Priority**
4.1	Management should review the processes in place for receiving the delivery of stock and implement a consistent approach across each site. For example, a comparison between the delivery and the order sheet. Where the ordering and receipting process happens within different departments, management should ensure all staff are aware of their responsibilities. When stock is signed as accepted and correct, but stock errors continue to be accepted, management should investigate these occurrences and undertake appropriate action.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
	ACCEPTED. The following steps will be taken to address the issue:		
4.1	Review and update processes for the receiving and delivery of stock. A single process will be developed and implemented across each of the Health Board sites	**February 2024**	**Senior Facilities Managers**
4.2	The responsibilities of each person involved in the stock ordering, receipting, delivery and management process will be reviewed and clearly detailed. All people involved in the new process will be provided training	**February 2024**	**Facilities Managers**
4.3	Implement a system to monitor and review errors in the end-to-end process, including escalation and investigation in line with all stock ordering and control issues identified within this report.	**February 2024**	**Senior Facilities Managers**

Matter Arising 5: Security (Design)			**Impact**
There were CCTV cameras on all sites visited, however, the effectiveness of the camera coverage was low and in some stock areas there were no cameras present. Most stock was kept unsecured during the day with some rooms being locked.			Potential risk of: • Stock is stolen without detection • Lack of staff accountability, as there are no supporting processes in place to identify missing stock • Risk of financial loss to the Health Board
Recommendations			**Priority**
5.1	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
	ACCEPTED. The following steps will be taken to address the issue:		
5.1	Undertake a Privacy Impact Assessment in conjunction with Information Governance to assess the viability of CCTV cameras within stock areas	**Completed**	**Security Manager**
5.2	Review processes for staff access. To ensure that processes are in place to ensure all goods are secured and accessed in a controlled environment.	**February 2024**	**Senior Facilities Manager**
5.3	Ensure stock ordering, management and control processes easily identify stock anomalies and there is a robust process for investigation and escalation	**February 2024**	**Facilities Managers**

Matter Arising 6: Food Waste (Design)			**Impact**
Food waste is not measured effectively at any site. We found significant food wastage at all sites, but the underlying reasons or provision of assurance is not possible to identify why there is this level of wastage, as there is no effective management of stock across all aspects. For example, whether stock is over ordered, out of date or lack of portion control.			Potential risk of: • Insufficient food stock • Increased food wastage • Risk of financial loss to the Health Board
Recommendations			**Priority**
6.1	Management should review how they measure and monitor waste and ensure a consistent approach across all sites. There should also be consideration of the use of extended functionality within Synbiotix and / or the recording of food waste for management information. Waste levels should be monitored and reported to the monthly Facilities meetings and any anomalies investigated.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
	ACCEPTED The following steps will be taken to address the issue:		
6.1	Develop a process, in flow chart form, to effectively monitor food waste	**February 2024**	**Senior Facilities Managers & Catering Service Improvement Manager**
6.2	Food waste to be presented to and monitored by the Head of Facilities, as part of monthly performance highlight report at Facilities Management Team meetings	**March 2024**	**Head of Facilities**

Matter Arising 7: Systems (Design)	**Impact**
We found several improvements which would assist in the stock management process. Currently, the Health Board does not maintain a comprehensive stock management system, but it may be possible to link Oracle and Synbiotix to provide some of this functionality. However, this would require the Health Board to improve the utilisation of the Synbiotix system, which has numerous functionalities that are not in use. In addition, within the Bank Staff system a control to prevent the completion of the self-authorisation of shifts (create a bank shift), self-work (allocate the shift to themselves) and self-finalise (authorise the shift for payment) is absent. Whilst the Health Board is currently updating the controls for preventing staff approving shifts for themselves at each of the stages listed above, this has yet to be completed. However, we obtained a report for October 2023, to confirm that no member of staff / user had completed all three stages of the process for themselves.	Potential risk of: • Lack of stock management and stock levels • Financial loss to the Health Board • Increased risk of fraudulent activity

Recommendations		**Priority**
7.1	Management should investigate the following system improvements and implement if appropriate: a) <u>Stock Management System</u> • the functionality between Oracle and Synbiotix to create a functional and effective stock management system; and • the designation of preferred stock within Oracle, e.g. a particular brand of bread loaf and adding this to the ordering sheet that is sent to managers for approval, to assist with the selection of the lowest cost item. b) <u>Bank</u> • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
	ACCEPTED The following steps will be taken to address the issue:		
7.1	Explore the feasibility of using the stock control element of the Synbiotix system as it has the ability to record all goods received and track their usage and assess other stock management systems	**February 2024**	**Senior Facilities Business Manager**
7.2	Ad-hoc audits of all items ordered via oracle on a monthly basis to ensure all sites are adhering to the approved stock items.	**In place**	**Catering Service Improvement Manager**
7.3	**BANK** The division will be rolling out the AllocateMe function as part of the Health Roster payroll drop down project. (The Health Roster payroll drop down project is forecasted to take twelve months)	**Commenced. To be completed by 31/1/2025.**	**Business Support Manager**
7.4	Explore the use of safe care or alternative system to monitor staffs start and finish time this is part of the pre-enabling plan for the roll out Health Roster payroll drop down.	**February 2024**	**Business Support Manager**
7.5	As part of the Health Roster payroll drop down project and pre enabling plan a review of all staff's access levels will be undertaken	**Completed**	**Business Support Manager**
7.6	Managers to be responsible and accountable for reviewing and approving Health Rosters in line with Health Board policies. This will also include ensuring templates are accurate.	**February 2024**	**Facilities Managers**
7.7	All members of the management team to undergo formal Health Roster training with Workforce and Organisational Development	**January 2024**	**Head of Facilities**

Matter Arising 8: Bank shifts (Design)	**Impact**
In March 2023 there were 264 retrospective bank shifts completed on the bank system (shifts allocated to staff and worked before appropriate sign off). Senior management raised this as an issue with management at each site and consequently, there were 27 retrospective bank shifts in September 2023. However, the exceptions are still not in adherence with the Health Board's Resource Bank – Booking Rules.	Potential risk of: • Inconsistent approaches across the Health Board • Financial damage to the Health Board • Booking process not being adhered to.

Recommendations		**Priority**
8.1	Management should continue to monitor and inform staff of their responsibilities regarding bank shifts. Where individuals regularly do not comply with the Health Board's Resource Bank – Booking Rules this should be escalated and dealt with appropriately.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
	ACCEPTED The following steps will be taken to address the issue:		
8.1	Continue to monitor Bank Shift Booking Reports and address issues in accordance with Health Board policy	**Ongoing**	**Head of Facilities**
8.2	Implement a process that ensures All non-compliance reported to Head of Facilities, who will ensure that each occurrence is reviewed by the responsible manager in line with Health Board Policies, with findings presented back to the Head of Facilities.	**Completed**	**Senior Facilities Business 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.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

Estates Condition
Final Internal Audit Report

January 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Executive Summary 4
1. Introduction 6
2. Detailed Audit Findings 7
Appendix A: Management Action Plan 13
Appendix B: Estates Facilities Performance Management System (EFPMS) 27
Appendix C: Assurance opinion and action plan risk rating 29

Review reference:	AB-SSU-2324-02
Report status:	Final
Fieldwork completion:	13th October 2023
Draft report issued:	26th October 2023
Draft Report meeting:	17th November 2023
Updated Draft Report issued:	11th December 2023
Management response received:	18th January 2023
Final report issued:	19th January 2023
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Hannah Evans – Director of Strategy Planning & Partnerships
Distribution:	Leanne Watkins – Chief Operating Officer Robert Holcombe – Executive Director of Finance Jamie Marchant – Divisional Director of Estates & Facilities Mark Arscott - Head of Operations (Works & Estates) Kelly Jones – Head of Capital Finance Cara Tingle - Health, Safety & Statutory Compliance Manager (Facilities/Estates) Mike Ellery – Head of Capital Planning Rani Dash, Director of Corporate Governance
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging estate in Wales.

The latest nationally reported data (2021/22) confirmed a total backlog maintenance requirement of £149m for the UHB (University Health Board). This has subsequently increased further to an estimated £204m in 2022/23.

The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overview

Key to understanding the challenge is the quality and understanding of the baseline data.

A full survey of the estate was last undertaken in 2017 (a refresh now overdue, being beyond the recommended five-year interval). In the interim, "high" risk backlog has increased from an assessed £200,000 to over £37m (based on UHB estate department assessments and departmental funding requests etc).

A 2019 Estates Strategy targeted backlog reduction by 10% per annum. However, since that date, the reported total backlog has effectively doubled.

At the time of the current review, there was no revised plan in place to fund the increased levels of backlog.

In the short to medium term, the Health Board has utilised a combination of all Wales capital funding, targeted EFAB funding, planned / reactive maintenance, and discretionary funding to address identified high-priority areas as follows, including e.g.:

- Replacing old estate e.g. Bevan Health & Wellbeing Centre, Newport East Health & Wellbeing Centre, endoscopy upgrade at the Royal Gwent Hospital, and Nevill Hall Hospital upgrades – where the anti-natal clinic is to be demolished;
- The Health Board successfully secured Environmental Financial Advisory Board (EFAB) funding of £4.5m across 2022/23 & 2023/24 to tackle estate priorities;

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved

Assurance summary [1]

Assurance objectives		Assurance
1	Governance	Reasonable
2	Baseline information	Limited
3	Estates strategy	Limited
4	Funding strategy	Limited
5	Monitoring & reporting	Limited
6	Risk management	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	Priority
1	Management should initiate discussion with NWSSP: Specialist Estates Services prior to the next submission of the EFPMS to confirm methodologies for assessment and measurement.	2	High
2.1	Appropriate surveys should be undertaken following dialogue with NWSSP: SES.	2	High
2.2	Planned disposals approved by the Trust Board should be removed from backlog data in	2	Medium

- Discretionary funding of over £1m per annum was allocated to address statutory maintenance, and prioritised capital bids; and
- There were a further £157m of projects currently at the planning / business case stage, which would further up-grade the estate. However, funding for these in the current financial environment may be limited.

Since the 2017 survey, further assessment of estates backlog has been constrained by limited resource.

To effectively inform reporting, there was a need to ensure appropriate assessment methodologies, surveys, and accurate data, supported by an appropriately resourced maintenance team.

As noted, backlog data has been increasing over recent years with provisional data for 2022/23 increasing backlog by circa £50m in one year. However, this may be in part due to survey and compilation methodologies.

However, backlog has been assessed at the Corporate Risk Register as being managed within acceptable tolerances. It was not therefore a focus for senior committees (and independent scrutiny).

There has therefore been a disparity between the backlog figures (being reported as increasing to some £100's of millions to Welsh Government), and a lack of profile internally (to drive investment).

The matters requiring management attention included the need to review the corporate risk profile, based on the likely gap between available funding and investment needs.

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

It is recognised that by the conclusion of the audit, management were already reviewing governance reporting, and risk management arrangements. They were also engaging with NWSSP: Specialist Estates Services with a view to provide more cost-effective support for accurate and consistent data.

However, noting the issues at the time of audit, an overall **limited assurance** has been determined, notably due to the concerns that identified estate risks cannot be managed within existing funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales estate. At the UHB, RAAC had been identified at single story buildings at Nevil Hall hospital requiring urgent attention and the way forward was being discussed with NWSSP: SES.

	accordance with guidance.		
4.1	Management should review and implement effective reporting of estates condition/ backlog across the UHB's Committee structure e.g. outcomes against targets, funding risks, risk exposure etc.	*3,4,5*	High
4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	*3,4,5*	Medium
5	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) and to inform a financial model for required revenue support.	*4*	High
6	The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	*6*	High

1. Introduction

1.1 The audit formed a part of the 2023/24 operational plan agreed with Aneurin Bevan University Health Board (the UHB).

1.2 The effective and efficient management of the NHS Wales estate is essential for the delivery of quality health care services.

1.3 The audit was undertaken to evaluate the processes and procedures put in place by the UHB to support the management, condition, and performance of the estate.

1.4 The potential risks considered at this review were as follows:

- The Board may be unaware and / or may not be adequately informed to effectively assess and manage the risks associated with backlog maintenance (particularly statutory requirements);
- Appropriate funding may not be in place;
- The status and value of backlog maintenance may not be adequately defined, and the probability and impact may not be fully understood;
- Information may not be interrogated to ensure focus is prioritised on the key risks; and
- Performance in addressing identified priorities may not be monitored, potentially impacting organisational objectives.

1.5 The Estates and Facilities Performance Management System (EFPMS) enables the UHB to submit its annual declaration on key data to Welsh Government. The UHB reported position over the last three years, against NHS Wales averages, was as follows:

Table 1

	2019/20	2020/21	2021/22	2022/23
UHB Cost to eradicate High Risk Backlog (£)	204,000	200,572	37,754,428	61,258,480
UHB Cost to eradicate Significant Risk Backlog (£)	23,844,206	25,829,694	16,518,352	37,448,140
UHB Total Backlog Cost (£)	104,644,563	112,662,395	149,568,120	204,273,494
NHS Wales average: Total Backlog Cost (£)	78,098,898	97,385,329	113,007,158	
UHB Risk Adjusted Backlog Cost (£)	28,020,893	33,418,823	98,296,321	
UHB Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	22.77	25.03	21.47	
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77	

1.6 Note – backlog data published to the press (in response to a freedom of information request) in January 2023, included an additional £98,296,321 in error (caused by a double counting – as seen at **Appendix B**). This had not impacted the EFPMS data as published to Welsh Government e.g. the £204m referenced above.

1.7 Additional estate performance data across NHS Wales is presented at **Appendix B,** taken from the NHS Estate Dashboard Report for 2021/22 (as published by NWSSP: Specialist Estates Services).

1.8 Our audit work was reliant on the above information. We have not sought to provide assurance over the accuracy of supplied information; however, we have commented within the body of this report on the consistency in approach with other NHS Wales Organisations.

2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in **Appendix A**.

Governance: *To obtain assurance that robust governance arrangements were applied to ensure the organisation stays abreast of matters and associated risks relating to the Estates condition.*

2.2 The Estate Strategy was managed by the Director of Strategy, Planning & Partnerships with the operational estate being managed by the Divisional Director of Estates & Facilities.

2.3 Delivery was overseen by the Population Health, Planning and Partnerships (PHPP) Committee and the Executive Committee (both being committees of the Board).

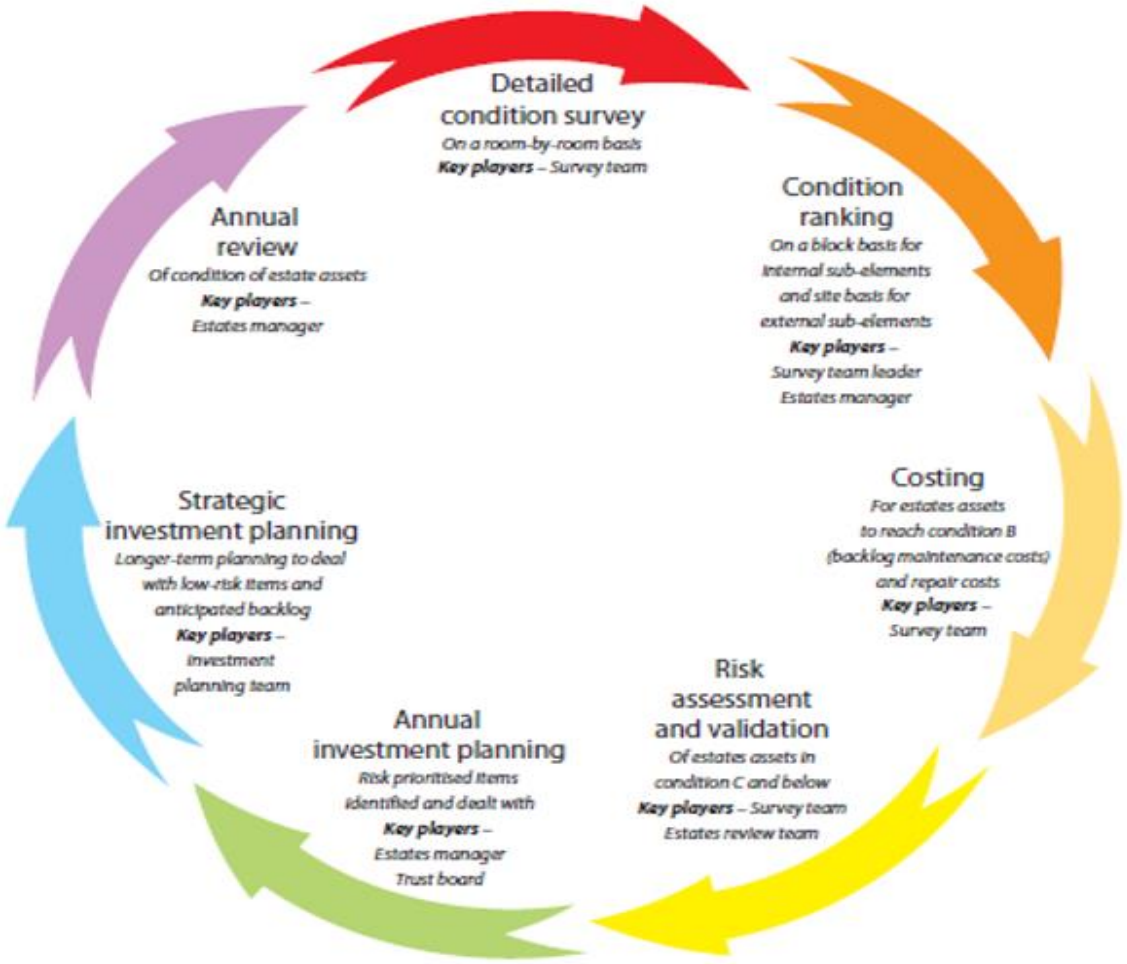
2.4 An independent member was also appropriately allocated for scrutiny and challenge of Estate matters.

2.5 The Divisional Director of Estates & Facilities had been newly appointed as the designated lead for Estates matters. While the officer is not a Board member, they are directly accountable to the Chief Operating Officer, facilitating appropriate reporting and escalation arrangements.

2.6 Whilst the governance arrangements in place were generally satisfactory, sound decision making is predicated upon the quality of management information. Accordingly, noting issues in subsequent sections of this report surrounding the management information, **reasonable assurance** has been presently determined.

Baseline information: *To ensure that the UHB had detailed assessments of the condition of the estate based on a combination of robust condition surveys and risk assessments. The information was managed and retained within robust management systems that were subject to regular review.*

2.7 The extant guidance in relation to assessing backlog: *'A risk-based methodology for establishing and managing backlog,'* (updated March 2013) describes the steps involved in establishing and managing backlog, as follows:



2.8 In respect of the detailed condition survey, the guidance recommends that[1]:

"NHS organisations carry out a detailed survey of their assets on a five-yearly basis[1]."

2.9 The most recent six-facet survey conducted in 2017, was non-invasive, limiting its overall reliability.

2.10 Subsequent to the survey, assessed backlog values changed significantly:

Table 2

	Pre-survey (£'m)	2017 Survey (£'m)
High & Significant risk	16.7	25.5
Low / Medium	22.3	82.5
Total backlog	**39**	**108**

[1] A risk-based methodology for establishing and managing backlog (publishing.service.gov.uk) (Applies in Wales)

2.11 To facilitate appropriate update, guidance also recommends that interim assessments should be conducted:

> *"You should update the findings of your detailed survey on an annual basis. This will inform your investment planning process and ensure your assets are safe and fit for purpose."*

2.12 The large change at the 2017 survey (as above), implies inaccuracy in interim assessments.

2.13 While "high" and "significant" sums were re-assessed, the £82.5m (above) was annually uplifted for inflation. Any "low and medium" backlog within this sum which has become higher risk may cause double counting (as it ages etc).

2.14 As noted, the 2017 survey also contained some key caveats, requiring more invasive surveys to better inform the backlog position. However, since that time further assessment had been constrained by limited resource, and refresh of the five-yearly (full) survey was also over-due.

2.15 Noting these matters, management was in active dialogue with NWSSP: Specialist Estates Services on the approach to undertaking both rolling / risk focussed, and also full surveys to ensure consistency in approach and accurate data (**MA 1** & **2**).

2.16 However, noting the current issues, including on-going use of an out-dated survey, **limited** assurance has presently been determined in relation to baseline information.

Estates strategy: *To obtain assurance that a tailored Estates strategy was in place including linkage to major investment, Estates condition, statutory compliance, decarbonisation requirements, service needs etc. The strategy also reflected emerging risks.*

2.17 An Estates Strategy was approved in 2019 covering the years 2018 – 2028. In accordance with good practice this supported the clinical strategy and included specific objectives and targets. Updates on the delivery of the strategy were routinely provided to the Partnerships, Population, Health & Planning Committee.

2.18 Together with an aim to reduce backlog by 10% per annum, a key objective (Objective 16) provided within the strategy was:

> *"to urgently assess the robustness of the calculation of high and significant risk backlog maintenance information contained within the Six Facet Survey and ensure that the reported backlog maintenance meets the risk definitions in appropriate guidance.*
>
> *Following this a prioritised action plan will be produced to address and reduce the high and significant risks."*

2.19 While associated action had been tracked, the Health Board also recognised the on-going nature of the work to better focus backlog expenditure (**MA 4**).

2.20 Whilst progress against the Strategy was observed, the Health Board have also recognised the need for periodic updates of the Strategy to ensure its continuing relevance. However, management have also highlighted that the timing of re-fresh is dependent upon a review of wider organisational strategies (**MA 4**).

2.21 Noting, the need for more effective understanding of backlog risks to direct investment focus, **limited assurance** has therefore been determined in this section. The funding risks are further discussed in the ***funding strategy*** section below.

Funding strategy: *To ensure there was a co-ordinated approach to the targeting of All-Wales, Estates Funding Advisory Board (EFAB) and Discretionary funding to implement the Estates Strategy.*

2.22 There has been historical under-investment across Wales in this area, resulting in a deterioration of the NHS estate condition.

2.23 The UHB published detailed funding plans within the 2019 Estate Strategy, utilising both Welsh Government and discretionary finance. However, as previously noted, the total funding secured from Welsh Government against the 2019 targets has not been reported (**MA 4**).

2.24 The 10-year capital plan submitted to Welsh Government identified a capital funding requirement of £220 million. Corresponding funding at this level had not been secured and no assurances had been received that funding would be made available. There remained therefore a material risk that the Estates Strategy and capital plan was unaffordable, particularly recognising the current financial climate and considering total funding requirements across Wales.

2.25 Noting the gap between available funding and targets to reduce backlog, there is a need for a more focussed plan (a Plan B) (in accordance with Objective 16 of the Estates Strategy) (**MA 4**).

2.26 Additional to All Wales funding of specific capital projects, the Health Board also receives discretionary and (from 2022-25) Estates Funding Advisory Board (EFAB) funding, though allocations are subject to competing bids.

2.27 Data showed the UHB expenditure on maintenance per square foot to have increasingly fallen below the Welsh average at the same time as backlog levels have doubled:

Table 3

Measure	2019/20	2020/21	2021/22
UHB Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	22.77	25.03	21.47
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

2.28 The current level of investment would therefore also be insufficient to effectively manage the condition of any new estate requirements identified within the Estates Strategy.

2.29 While recognising on-going dialogue with NWSSP: SES, there was also a need to confirm the adequacy/availability of a fully resourced specialist team to deliver ongoing assessment and management / rectification, with appropriate revenue support (**MA 5**).

2.30 It is concluded therefore that the UHB had utilised a range of funding options for the estate. However, noting the historical underinvestment in the estate and the material gap in approved levels of investment **limited assurance** had currently been determined in relation to the funding strategy.

Monitoring and reporting: *To ensure that appropriate management information was presented with regularity on key issues, including the estate condition and progress to implement the Estates / funding strategy. Monitoring and reporting included an assessment of the success of the combined strategies in improving Estates condition (and reducing risk exposure), and confirmation that expenditure of funding was in line with agreed conditions.*

2.31 The audit sought to determine the effective reporting and review of the Estates Strategy, including associated targets and actions and data as relating to backlog objectives.

2.32 Updates were reported against the Strategy to both the Partnerships, Population, Health & Planning Committee, and the Board. However, these did not include updates during 2022, when backlog increased by over £50m, and associated reporting of data was not included.

2.33 Management accepted that a full review of committee reporting was required to ensure effective scrutiny of backlog reporting including:

- progress to targets;
- key risks; and
- funding variances (**MA 4**).

2.34 Noting a need to refresh committee reporting in this area, **limited assurance** has currently been determined in relation to monitoring and reporting.

Risk management: *Assurance that risks were appropriately logged and escalated through the corporate risk reporting arrangements. The risk exposure of the UHB in relation to Estates condition was clearly reported.*

2.35 The UHBs Board Assurance Framework provides information on the structure of controls and assurances in place to manage and mitigate the significant risks which will impact upon the delivery of the UHBs Strategic Objectives.

2.36 The 2017 six-facet survey provided overall totals for each risk priority, as updated by the annual review of the Estates Risk Register. As previously indicated, this register formed part of the process to inform investment choices.

2.37 The Corporate risk register included two risks relating to backlog: RAAC, and general backlog. While the former was rated as high risk, the latter was identified as "green" – being managed within acceptable limits. However, the agenda of both committees and the Board was driven by top corporate risks - limiting associated reporting.

2.38 However, there has been limited effectiveness of actions to reduce the risk to date; coupled with continued deterioration of the estate condition and increasing pressures on the availability of capital resources. Accordingly the above should be reviewed to provide assurance to the Board that the actions are progressively achieving the desired risk mitigation (**MA 6**).

2.39 Accordingly, **limited assurance** has currently been determined in relation to risk management.

Appendix A: Management Action Plan

Matter Arising 1: Baseline - Data accuracy (Operation)	**Impact**
Backlog is defined as the value of estate falling below category "B" physical condition. Both values and percentages were published for overall compliance with physical condition. However, these were inconsistent, with the published percentage compliance indicating that backlog figures should be much lower (as published at the Estates and Facilities Performance Management System – returned to Welsh Government annually) e.g. ***Table 1***	Potential risk that: • Backlog is not appropriately recognised.

	2017/18 (£ m)	**2021/22 (£ m)**
Health Board Total Backlog Cost (£)	108.0	149.6
Acceptable physical condition %	87%	94%
Therefore: Deficient physical condition %	13%	6%
Value of buildings (UHB Accounts)	318	592
Implied deficient value	41	35

i.e., the declared percentages of defective estate would indicate much lower backlog values.

As noted above, the percentage of the estate deemed as meeting the criteria for acceptable physical condition has risen from 87% to 94%. This varies significantly from the published backlog figures which

have increased over the same period (backlog being defined as the value of the estate below acceptable physical condition). It is recognised that the Grange Hospital opened in November 2020, and contributed to the increase in value of the estate, and corresponding fall in the percentage of defective estate. No guidance was identified in relation to the percentage compliances, and varying approaches were identified across Wales in relation to their derivation e.g. inclusion of items as backlog that were past the end of their useful life, rather than exhibiting any deficiency. There was a need therefore to confirm both the methodology and accuracy of published data.	
Recommendations	**Priority**
1. Management should initiate discussion with NWSSP: Specialist Estates Services prior to the next submission of the EFPMS to confirm methodologies for assessment and measurement.	**High**

Agreed Management Action	Target Date	Responsible Officer
1. Agreed – the Divisional Director will ensure links with NWSSP prior to any submission of EFPMS data. The timing of this action will be subject to confirmed plans and timelines set by NWSSP for submission although at this point in time, the July 2024 date seems realistic.	July 2024	Divisional Director of Estates and Facilities

Matter Arising 2: Baseline – Surveys (Design)	**Impact**
In 2004, NHS Wales published *"A risk-based methodology for establishing and managing backlog"* (mandatory in Wales). This recommended a six-facet survey every five years, and that "y*ou should update the findings of your detailed survey on an annual basis."* The most recent six-facet survey was undertaken in 2017. No plans for a revised assessment were notified to audit by the UHB. Prioritised (departmental) capital requests were utilised to formulate the annual capital programme. These included only the highest need, with similar focus at the risk register on adding "high" risks. Subsequent to the 2017 survey, the UHB had therefore utilised its risk register together with prioritised capital requests to inform and update "high" and "significant" risks. The risk register is updated in this manner by Estates staff as they become aware of issues (rather than via structured surveys). "Low" and "medium" risks have been uplifted in value from those provided at the 2017 survey. This method was not therefore based on surveys of the estate to supplement caveats made at the full survey. Interim / annual surveys could therefore be scheduled on a rolling basis, focussed on priority / ageing estate. Guidance requires that backlog figures do not include estate for which there is a Trust Board approved plan for its disposal within five years. However, it is noted that although it is planned to dispose of the St Woolos site, as a time frame for this had yet to be approved, associated backlog remains included within reported figures. The guidance also requires prioritisation of single points of failure e.g., high voltage (HV) supply. It was not evident if any such un-mitigated issues existed (e.g. as would perhaps be identified within a business continuity or disaster recovery document). Noting limitations of resource, and the need for on-going assessment, management advised that they have been in active dialogue with NWSSP: Specialist Estates Services relating to surveys. This was	Potential risk that: • Backlog is not appropriately recognised.

intended to address issues of cost, accuracy, and usefulness, retention of funds, and to build local knowledge and expertise within the NHS.		
Recommendations		**Priority**
2.1 Appropriate surveys should be undertaken following dialogue with NWSSP: SES.		**High**
2.2 Planned disposals approved by the Trust Board should be removed from backlog data in accordance with guidance.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed – the Divisional Director has, since the fieldwork for this audit, been involve in two national level conversations with NWSSP about the future of facet surveys and how they should be done. There is no formal funding for regular surveys and these discussions are ongoing relating to most effective and cost-effective solutions with WG and NWSSP across NHS Wales and will dictate the final implementation of this action	August 2024	Divisional Director of Estates and Facilities
2.2 Agreed – guidance will be followed. This will be actioned for any future submissions for EFPMS and thus timeline will mirror that of **MA 1**.	July 2024	Divisional Director of Estates and Facilities

Matter Arising 3: Baseline – PFI Liabilities (Operation)	**Impact**
The Health Board also has certain assets financed under Public Finance Initiatives (PFI) as follows (as per the Health Board 2022/23 accounts):	Potential risk that: • Backlog is not appropriately recognised.

Asset	Remaining capital payments (excl. interest & service charges) £'m	Term (years)	Contract end date
Monnow Vale Health & Social Care facility	1.83	30	March 2036
Chepstow Community Hospital	1.054	25	February 2025
Nevill Hall Hospital Day Surgery Unit	0.388	25	September 2024
Nevill Hall lighting & heating (off balance sheet right to use asset)	3.413 (NPV of lease)	25	2025

Noting this, assessments should also include an appraisal of the sufficiency of reserve funds of the PFI partner to address backlog at handover, and any associated risks to the UHB.

Active monitoring of the above was in place via PFI expiry reviews. However, it remained to be confirmed that appropriate hand-back funds were in place.

Recommendations	**Priority**

3 The Health Board should assess the sufficiency of reserve funds to address backlog at the handover of PFI buildings.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
Agreed - The PFI agreements include a minimum level of expected condition for buildings &/or equipment to be maintained for operational capability. Regular management review ensures these contract terms are being met. When handover of PFI assets are expected escalated arrangements are put in place to assess the level of condition. The following PFI schemes exist: NHH LLanwenarth day surgery unit, which has now gone through a process of 'buy back' of the headlease. The operating lease will end in 2024, the process of negotiating a settlement figure has agreed the equipment and building condition expected at handover date. Chepstow Community Hospital PFI is in advanced discussions with the owner/provider relating to the PFI end in Feb 2025. Negotiations relate to the building being in a Condition B status at time of any handover, a condition review has been commissioned and the PFI provider has agreed to implement improvements to meet condition B. Energy PFI (Honeywell) in NHH which ends in December 2026. This PFI is about to undergo a readiness assessment through WG for PFI end but does not relate to buildings and only relates to plant. Monnow Vale – ends in March 2036	March 2024	Director of Strategy Planning & Partnerships in liaison with Director of Finance

Matter Arising 4: Estates Strategy - Delivery of estates objectives & targets (Operation)	**Impact**
The Welsh Health Building Note 08 2018 Estatecode stated that: *'An Estate Strategy should represent the vision …to provide a strategic framework ..reviewed annually using EFPMS data.'* In context, it is recognised that Welsh Government has not communicated a central, all-Wales long-term strategy. However, informed by the 2017 six-facet survey, the UHB published its Estates Strategy for 2018 - 28, in line with Estatecode guidance (and aligned to the Clinical Futures Strategy). This required: **Objective 15** *The Health Board to introduce a clear policy on the adoption of Agile Working principles .. as a means to assist in the reduction of .. office accommodation.* **Objective 16** (for immediate action) *(a) The Estates Department to urgently assess the robustness of the calculation of high and significant risk backlog maintenance information…* *(b) Following this a prioritised action plan will be produced to address and reduce the high and significant risks.* The Strategy also targeted capital investment of £220m by 2025 to upgrade the estate and enhance services (including £54.4m for rationalisation programmes). It also included targets to reduce "high" and "significant" backlog by 10% per annum. While reporting against the above objectives was found via both the Board, and the Partnerships, Health, Population & Planning Committee e.g. this did not include reporting during 2022 - when backlog increased by over £50m (being most recently reported in November 2021 & November 2023 respectively).	Potential risks that: • the Estates Strategy is not implemented. • the true levels of high and significant backlog are not appropriately understood, risk assessed, costed, and prioritised.

In the case of Objective 16, while this was reported as "actioned" to the Board in 2021, no associated paper was reported to clarify the revised understanding of backlog risks. The Health Board has subsequently experienced significant increases in "high" and "significant" risk backlog, alongside reporting at the corporate risk register that risks are at acceptable levels. A supporting paper would assist in reconciling these positions, including identification of any statutory maintenance that remains un-addressed. Committees could additionally be informed by variances between budgeted and approved funding e.g. including the impact of inflation.

In relation to Objective 15, action was recorded as being the introduction of an agile working policy. The UHB recorded only 91% space utilisation (in 2021/22) – ranking 6th among the Welsh Health Boards. It is recognised that EFPMS data serves as a means of benchmarking effective progress in this case.

Estates strategy update

Management have also recognised the need for periodic updates of the Estates Strategy to ensure its continuing relevance. Such re-set based on a revised and re-focused assessment of the estate would align with the above objectives by:

- confirming the need
- identifying key risks; and
- facilitating focused investment and workforce planning.

However, they have also highlighted that any re-fresh is dependent upon the review of wider organisational strategies.

Recommendations	Priority
4.1 Management should review and implement effective reporting of Estates condition/ backlog across the UHB's Committee structure e.g. outcomes against targets, funding risks, risk exposure etc.	**High**
4.2 Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
4.1 Agreed. The Board's Finance and Performance Committee has delegated responsibility to seek assurance that arrangements for the performance management of capital, estates and support services related standards and systems are sufficient, effective, and robust, including: • the monitoring of capital and estates related objectives and priorities as set out in the Board's IMTP and Annual Priorities; • the monitoring of compliance with Health Technical Memorandums; • the monitoring of progress in delivery Board-approved capital business cases and programmes of work. This is set out in the agreed Terms of Reference for the Committee abuhb.nhs.wales/files/key-documents/finance-and-performance-committee/finance-performance-committee-tors-march2022-pdf/ Work is ongoing to develop workplans for each Committee for the 2024/25 financial year and this will consider the role of each Committee and the work required to fulfil the respective Committee's obligations. In 2023/24, work was undertaken to revise the Capital and Capital Project governance arrangements which encompassed backlog maintenance within the discretionary capital programme. These governance arrangements were reported to the Board's Partnerships, Population Health and Planning Committee in July 2023 abuhb.nhs.wales/files/key-	March 2024	Director of Strategy Planning & Partnerships with Director of Corporate Governance

documents/partnerships-population-health-and-planning-committee/pphpc-agenda-and-papers-wednesday-12th-july-20231/ abuhb.nhs.wales/files/key-documents/partnerships-population-health-and-planning-committee/pphpc-agenda-and-papers-wednesday-12th-july-20231/		
4.2 Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	Pending wider refresh of clinical / other relevant strategies	Director of Strategy Planning & Partnerships

Matter Arising 5: Funding Strategy - Resource (Operation)	**Impact**
In April 2022 the Welsh Government Deputy Director of Estates and Capital Planning wrote to all Heads of Estates across Welsh health bodies to assess the adequacy of estates resource. This letter particularly referenced a desire to reduce outsourcing, stating: "*The central intention is to keep NHS Wales as a public service and to only outsource contracts and services when there is no in-house alternative or where there is a time limited job that requires specialist input to be completed*." Appropriate staffing is required to enable the on-going assessment and maintenance of the estate (in accordance with WG guidance). This would include adequately supporting and supplementing surveys undertaken by external advisers with local knowledge and enable follow-up (to minimise caveats and assumptions – ensuring more robust data). This would include not only an assessment of appropriate staffing numbers and grades, but of an adequate range of specialisms to assess and address the various aspects of backlog (e.g., Fire, Water, and medical gas safety, with an associated complement of trained Authorised Persons (AP's) to comply with regulatory requirements). At the UHB such specialist areas were subject to separate annual reports e.g. by NWSSP: Specialist Estates Services. Some of these identified the need to assign or train specialist officers in the various areas, and current need to conduct and assess inspections. This could avoid the categorisation of items as "high" risk pending appropriate survey. Some health bodies in Wales have re-based their resource needs by the forward assessment of suitability of the estates staffing. However, an assessment of future estates resource requirements and associated plans were not identified.	Potential risk that: • The programme is not appropriately resourced.

Best practice would therefore suggest that there is scope for a formal re-examination of Estates staffing, skills, and capacity, including in-house versus contracted out provisions (based on All Wales benchmarking).		
Recommendations		**Priority**
5 The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) and to inform a financial model for required revenue support.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
5 Agreed - the Divisional Director will review the operational workforce required to manage the current level of reactive work and also to ensure compliance with the appropriate level of Planned and Preventative Maintenance (PPM).	May 2024	Divisional Director of Estates & Facilities

Matter Arising 6: Risk Management - Assurance (Design)	**Impact**
Following the identification of prioritised areas of investment, reporting did not highlight or summarise the statutory "high" and "significant" risk backlog areas that remain unaddressed. To defer addressing statutory, "high" and "significant" backlog to future years should be an objective choice, with associated risks owned by management. It is also important that management understand potential single points of failure, and that key issues are reflected within the corporate risk register. The corporate risk register had assessed backlog as being maintained within acceptable limits (RAG rated "green"). Accordingly, backlog was not profiled as an issue at senior committees (in accordance with their Terms of Reference).	Potential risk that: • Management is not sighted on accepted risks. • Annual investment decisions are contrary to approved strategy. • The Board may not be assured that risk was appropriately managed.

Recommendations	**Priority**
6. The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	**High**

Agreed Management Action	**Target Date**	**Responsible Officer**
6. At its meeting in January 2024, the Board approved its Revised Risk Management Framework which set out the revised hierarchy for risk management within the organisation, alongside an agreed Risk Appetite Statement. In-line with this Framework, the Head of Risk and Assurance will work with the Divisional Director of Estates & Facilities to review the risk management arrangements in place,	January 2024	Director of Corporate Governance

ensuring appropriate escalation reporting from service to Board level.		

Appendix B: Estates Facilities Performance Management System (EFPMS)

NHS ESTATE DASHBOARD REPORT 2021/2022

HEALTH BOARD / TRUST ESTATE PERFORMANCE BREAKDOWN 2021/2022

National Key Performance Indicators

Percentage of the estate which is of reasonable standard and therefore falls within Estatecode category 'B'/'F' or above:

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	94	93	85	98	91
BETSI CADWALADR UNIVERSITY HEALTH BOARD	62	74	64	74	93
CARDIFF & VALE UNIVERSITY HEALTH BOARD	78	86	87	66	81
CWM TAF UNIVERSITY HEALTH BOARD	96	89	95	100	97
HYWEL DDA UNIVERSITY HEALTH BOARD	88	89	65	91	99
POWYS TEACHING LHB	67	80	72	71	86
SWANSEA BAY UNIVERSITY HEALTH BOARD	51	47	47	55	97
VELINDRE UNIVERSITY NHS TRUST	65	95	95	88	99
WELSH AMBULANCE SERVICES NHS TRUST	48	90	90	36	99

Backlog Maintenance Costs

*Target to be agreed

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	37,754,428	16,518,352	45,488,017	49,807,323	98,296,321
BETSI CADWALADR UNIVERSITY HEALTH BOARD	91,809,773	142,498,091	68,658,155	45,421,260	239,955,528
CARDIFF & VALE UNIVERSITY HEALTH BOARD	32,033,876	85,487,856	28,777,072	5,537,518	101,262,019
CWM TAF UNIVERSITY HEALTH BOARD	31,261,530	31,963,352	22,345,412	1,519,250	64,046,747
HYWEL DDA UNIVERSITY HEALTH BOARD	0	89,509,339	9,432,673	6,802,904	90,679,218
POWYS TEACHING LHB	5,075,437	23,998,187	12,931,568	10,039,954	30,117,985
SWANSEA BAY UNIVERSITY HEALTH BOARD	9,057,000	46,516,759	41,835,883	4,598,390	56,464,069
VELINDRE UNIVERSITY NHS TRUST	139,220	1,894,312	5,002,211	2,719,910	1,875,521
WELSH AMBULANCE SERVICES NHS TRUST	667,486	2,855,208	3,170,304	3,936,411	7,184,233

The complete dataset upon which this report is based is accessible from the NHS Wales Shared Services Partnership - Specialist Estates Services intranet and internet sites

Note – Risk Adjusted backlog = Non-critical backlog ("low" and "moderate") / Years remaining life of asset life + Safety critical backlog (i.e. "high" & "significant" risk)

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Integrated Performance Dashboard – Data Quality

Internal Audit Report

January 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Gwasanaethau Archwilio a Sicrwydd | Shared Services Partnership Audit and Assurance Services

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

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Findings 4
Appendix A: Management Action Plan 9
Appendix B: Assurance opinion and action plan risk rating 10

Review reference:	AB-2324-09
Report status:	Final
Fieldwork commencement:	17th November 2023
Fieldwork completion:	5th December 2023
Draft report issued:	12th December & 22nd December 2023
Debrief meeting:	13th December 2023
Management response received:	9th January 2024
Final report issued:	9th January 2024
Auditors:	Stephen Chaney, Acting Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Paul Solloway, Director of Digital Hannah Evans, Director of Strategy, Planning and Partnerships
Distribution:	Lloyd Bishop, Chief Digital Officer Lynne Wilde, Interim Assistant Director of Information Services Dilwyn Bull, Head of Information
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The overall objective of the audit was to assess the accuracy of data utilised within the Integrated Performance Report (IPR) dashboard. In particular, we focused on the accuracy of a sample of data used within the reporting of key metrics within the IPR dashboard i.e. that the source data utilised was consistent with the figures within the dashboard.

Overview

Whilst we found no data quality issues within the IPR dashboard, we did note that compilation is largely a process of transcription from monthly data values provided by teams within the Health Board or taken from national data tables. These are taken as provided within the dashboard compilation and the assessment and testing of controls that protect data integrity within the different source systems and their related databases were not in the scope of this audit.

We noted no significant issues in our review but identified one low priority recommendation within the detail of the report.

Matters arising are summarised in the table at the beginning of the next section, are referenced in the main body of the report and detailed further in the matters arising and management actions table in Appendix A.

Report Classification

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	No recent audit

Assurance summary[1]

Assurance objectives	Assurance
1 Governance arrangements	Substantial
2 Data validation	Substantial

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Operating procedure covering the production of the monthly dashboard	2	Design	Low

[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 Integrated Performance Reporting - Data Quality was completed in line with the 2023/2024 Internal Audit Plan.

1.2 The Integrated Performance Report (IPR) includes a performance measure dashboard (the 'dashboard'), covering a broad scope of Aneurin Bevan University Health Board's (the 'Health Board') activities. The dashboard is provided to a number of groups and committees (Executive Committee, Finance & Performance Committee, Board) where the areas on the performance measures and actions required to address adverse values are discussed.

1.3 The dashboard metrics are largely prescribed by the Welsh Government (WG), including where national targets have been set.

1.4 The audit assessed data accuracy and completeness by examining a sample of the performance measures in the dashboard and evaluating the processes used to capture and report data.

1.5 Assessment and testing of controls that protect data integrity in the source systems and their related databases were not in the scope of this audit.

1.6 The risks considered in this review included:

- Data used to report KPIs does not fit Welsh Government definitions resulting in mis-stated values.
- Data capture mechanisms allow data error, omission or duplication (i.e. double counting) impacting data quality.
- Poor data quality impacts the management decisions which are informed by it.
- Exposure to reputational issues for the Health Board, should reported data be found to be inaccurate or incomplete.

2. Detailed Findings

Objective 1: appropriate governance arrangements are in place to ensure effective reporting and oversight of the Health Board's Integrated Performance Report.

2.1 We sought to establish the governance arrangements that operate around the generation of performance data used by the health board's management teams to assess levels of compliance against Welsh Government KPIs and other measures, and the progress of the health board's IMTP developments and initiatives.

2.2 The audit focussed on the IPR dashboard, which is an element of the broader performance report.

2.3 The dashboard is made up of a range of metrics selected by the Executive Management Team. Core Welsh Government KPI metrics make up the majority of

the dashboard (e.g. RTT measures), but the wider mix of these changes over time to mirror current business priorities.

2.4 We noted the dashboard is not accompanied by definitions of the metrics within it nor does it include references to the National Framework of performance measures from which they are taken. We understand, however, that new metrics are defined and explained by the Executive responsible when these are first introduced to the dashboard and if required, that National frameworks in which they are defined are available for reference for clarity. The dashboard is included in published Board and sub-committee papers, which are then publicly available.

There were however instances of dashboard metric descriptions that did not reflect those provided in the National Framework and therefore could mislead readers. However, as the reports incorporate accompanying narrative and the availability of the descriptions from the Welsh Government, we consider the risk to be negligible. Examples are included below:

ABUHB dashboard description	National Framework measure description
4+ Weeks Waiting List	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)
Neurodevelopmental (iSCAN) Waiting List	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment

2.5 Dashboard metrics are captured monthly by the information team from the different data sources and compiled into a dashboard comprising around 40 metrics and presenting current and the prior 12 months.

2.6 The latter compares the metric values with established targets across a rolling 13 month period and uses colour coding, symbols and graphs to denote target compliance status and trend.

2.7 The dashboard is reviewed by the Executive Committee quarterly where it is used to assess compliance with and progress against KPI targets. The performance report and dashboard were reviewed at the Executive meetings held in July, August and November 2023.

2.8 The dashboard displays metrics for the quarterly Integrated Performance report (IPR) and more recently, the broader based Quarterly Outcome and Performance report that provides review and commentary on the Health Board's broader set of IMTP priorities.

2.9 Both IPR and Quarterly Outcome and Performance reports are also included in published Board and sub-committee papers which are then publicly available.

Conclusion:

2.10 We have recorded no matters arising under this objective, but an observation relating to dashboard metric descriptions has been documented. Therefore, we have provided **substantial assurance** over this area.

Objective 2: there are robust systems and processes to capture and validate the data required to produce the Integrated Performance Report.

2.11 We sought to establish the accuracy, completeness and quality of data used to create the IPR dashboard by examining a sample of the metrics it presents.

2.12 Metrics in the dashboard cover 22 sub-domains including the emergency department, stroke, cancer, and childhood immunisation. Excepting a few administrative based measures, all of the metrics in the dashboard provide information about Health Board related activity levels of patient treatment or care, but come from a variety of source databases.

2.13 These include internal systems (e.g. WPAS), populated by Health Board clinical or support staff, partners systems (e.g. WAST) collecting patient level data about the Health Board's patients and national all-Wales systems of other organisations (e.g. DHCW) that accumulate data from all of the Welsh health boards from the regular data submissions they make. Data values are then taken from these different sources for the IPR dashboard.

2.14 Other audits, both internal and external, periodically test the controls that operate to protect the integrity of data capture and storage in these individual systems and an assessment of the data quality controls in these systems was not in the scope of this audit.

2.15 Health Board operated systems databases

Patient level data is accumulated in systems that are directly accessed by Health Board staff as patients proceed along pathways of care and treatment including:

- arrival, assessment, treatment, admission/ discharge steps are keyed by clinical or support staff to the SYMPHONY system as patients flow along the urgent care pathway;
- details of patients' hospital visits, including waiting list management, medical records, inpatient treatment, outpatient appointments and emergency visits are captured by health board clinical or support staff in the Welsh Patient Administration System (WPAS); and
- details of stroke patients care across the entire stroke pathway are keyed into and captured by systems supporting the Sentinel Stroke National Audit Programme (SSNAP).

2.16 External data sources

By providing regular data submissions of patient activity to national organisations, the Health Board contributes its data to national databases which combine with data from other health boards, primary care provider's and other health care organisations to provide national statistics of a broad range of performance metrics.

2.17 DHCW and other national organisations then provide a range of aggregate and individual Health Board data tables and it is the latter that are accessed each month by the Health Board to populate sections of the KPIs in the IPR dashboard.

2.18 We noted that there is no local procedure document to support the monthly production of the IPR dashboard by the Health Board's Information Team, but rather the production relies on key staff who have knowledge of the detail of the data sources necessary to identify the appropriate numbers. Whilst this is not a complex process, it is good practice to document source and extraction processes to ensure that in the absence of the regular staff member, others would be able to perform the process avoiding an interruption to the dashboard production (see **Matter arising 1**).

2.19 We examined the metrics in the IPR dashboard reported to Board and sub-committees in quarter two 2023/24 and noted the points recorded in the following paragraphs.

2.20 Data for the dashboard metrics is accumulated within a range of computer systems, both Health Board and national, and is obtained from multiple sources to populate the IPR dashboard. These are set out for information in the table below:

Reporting Domain	Source System	Source of values for dashboard
RTT	WPAS	e-mail from corporate information
Follow-up waiting lists	WPAS	e-mail from corporate information
Health Risk Factors R1	WPAS	e-mail from corporate information
Stroke	SSNAP Database	e-mail from NHS Executive
Ambulance Response Times	WAST systems	e-mail from WAST
ED and Handovers	Symphony/WAST systems	ABUHB Patient Flow Performance Tracker
Cancer	Cancer Tracker	e-mail from – cancer services
LPMHSS	WCCIS	e-mail from corporate information
Adult psychology	WCCIS	e-mail from corporate information
CAMHS 4 Weeks Waits	WCCIS	e-mail from corporate information
Neurodevelopmental WL	WPAS	e-mail from corporate information
Health Care Acquired Infections (HCAI)	Public Health systems (infections)	Public Health Dashboard
Public Health	Public Health systems (immunisations)	Welsh Government Dashboard
MH Care Treatment Plan	WCCIS	e-mail from corporate information
% PADR/% Hours Lost/Core Skills	WG systems	Welsh Government Dashboard
Orthogeriatric Assessment	National Hip Fracture database	National Hip Fracture dashboard
Episodes clinically coded	WPAS (APC data submitted)	e-mail from DHCW
Agency spend % total pay bill	WG systems	Welsh Government Dashboard
Readmissions Rate Within 28 Days	WPAS (APC data submitted)	CHKS (healthcare intelligence and quality improvement service)

2.21 For Health Board operated systems, the teams draw from the large range of scheduled cyclic reports that take their data from the Health Board's data warehouse. The latter brings together and links information from various in-house systems. This information, which typically is available less than one month in

arrears, is shared in regular scheduled e-mails with a wide variety of different teams across the Health Board according to topic, for their information or use.

2.22 For other metrics, data for the performance dashboard is taken from the dashboards or data tables of Welsh Government and national bodies to whom the Health Board has submitted source data. With the latter metrics, Health Board data is recorded in the Health Board's dashboard only when it has been published by the Welsh Government, which can be several months later.

2.23 We obtained copies of the material to evidence each of the metric values in the September 2023 dashboard (and in some cases, earlier months, where values are recorded at a lower frequency) and noted no exceptions, other than occasional rounding of values.

Conclusion:

2.24 We have raised one matter arising relating to the need for written procedural documentation for preparation of the IPR dashboard and therefore have provided **substantial assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: operating procedure covering the production of the monthly dashboard (Design)	Impact
We noted that at present there is no documented procedure for the preparation of the Integrated Performance Report dashboard and this might create difficulties or delays in the absence of staff that regularly prepares this.	Potential risk that the dashboard would not be correctly and accurately prepared in the absence of the regular staff member assigned to its production

Recommendations	Priority
1.1 We recommend that the Health Board develops a procedure document covering the steps to compile the Integrated Performance Report dashboard for Executive Management Team, committees and the Public Board Meeting.	Low

Management Responses	Target Date	Responsible Officer
1.1 With the development of the new electronic Integrated Performance Dashboard now being complete, a standard operating procedure for updating the dashboard to reflect reported performance will be developed.	September 2024	Lloyd Bishop

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Ab-2324-25

Stakeholder Engagement on IT Projects

Final Internal Audit Report

January 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 4
Appendix A: Management Action Plan 8
Appendix B: Assurance opinion and action plan risk rating 10

Review reference:	ABUHB-2324-25
Report status:	Final
Fieldwork commencement:	1st November 2023
Fieldwork completion:	14th December 2023
Debrief meeting:	21st December 2023
Draft report issued:	19th December 2023
Management response received:	21st December 2023
Final report issued:	8th January 2024
Auditors:	Stephen Chaney, Acting Head of Internal Audit Martyn Lewis Senior I.T. Audit Manager Kevin Bridgman I.T. Audit Manager
Executive sign-off:	Paul Solloway, Director of Digital
Distribution:	Janice Jenkins, Assistant Director of Digital Programmes
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of 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.

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Executive Summary

Purpose

We reviewed the framework in place for stakeholder engagement on key IT projects.

Overview

We have issued substantial assurance on this area.

We found guidance in place for programme and project management that includes stakeholder engagement and templates for stakeholder communication. Stakeholders are engaged with at early stages with needs fed into requirement specifications.

There is appropriate stakeholder involvement in the governance structures, which enables ownership of projects and programmes and users are included within the testing stages and project and programme sign off.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure

Assurance summary[1]

	Objectives	Assurance
1	There is a process for identification of the relevant stakeholders.	Substantial
2	Stakeholders are engaged at an early stage.	Substantial
3	Stakeholders are included within programme.	Substantial
4	Stakeholders are included within testing stages	Substantial

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board' or 'organisation') a review of the process for stakeholder engagement within IT projects was completed.

1.2 In a programme and project management environment, a stakeholder is an individual or group that has an interest in the proposed change and can influence or impact the success of that change.

1.3 Stakeholder engagement involves building and maintaining relationships. It also involves preserving the active support and commitment of the people to the implementation of change, through programme or project delivery.

2. Detailed Audit Findings

Objective 1: There is a process for identification of the relevant stakeholders for IT programmes and projects.

2.1 The Health Board has developed a comprehensive project management framework / guidance, encompassing stakeholder management that is committed to carrying out its business openly and transparently. This is done in a manner that encourages the active engagement of its citizens, community partners and other stakeholders.

2.2 The guidance requires that the Project Manager conducts a stakeholder analysis at the project / programme start up stage, and updates this throughout the project lifecycle. There is a departmental Stakeholder Analysis Template that details the required information to ensure the relevant stakeholders are identified for each programme / project. The stakeholder analysis captures key information including decision authority, level of influence / interest and stakeholder status, which allows for the definition of varying levels of engagement required, including:

- the key player;
- active consultation;
- maintenance of interest; and
- keeping informed.

2.3 Following on from the stakeholder analysis, the guidance requires that an Engagement and Communications Plan (the 'Plan') is defined which sets out how the different stakeholders will be engaged with, including the type of engagement activities.

2.4 The Plan is an integral part of all projects and contains the means and frequency of communication with parties, both internal and external to the project. There is guidance on how communications are to be undertaken within the departmental Communication Management Approach, which outlines standard communication requirements for projects and programmes. The stakeholder engagement approach is embedded within the Plan and so identifies the role of stakeholders in the engagement activities and the nature and frequency of these activities.

Conclusion:

2.5 There is a formal requirement within project and programme documentation for the identification of stakeholders within programmes and projects, the analysis of these and the development of a structured communications and engagement plan to meet the appropriate engagement needs. Templates are provided for stakeholder analysis and communication along with guidance on the communication approach to be used. Accordingly, we have provided **substantial assurance** over this objective.

Objective 2: Stakeholders are engaged at an early stage and requirements and opinions are included within specifications.

2.6 The Project Management Framework outlines the requirement for early engagement of stakeholders. This is achieved via the Communication Management Approach, which is created at the start of the project by the project manager. This is then used as a guideline on how to communicate with stakeholders (both internal and external) during the project. The Communication Management Approach facilitates engagement with stakeholders through the establishment of a controlled and bi-directional flow of information. The Plan details how and when stakeholders will be communicated and engaged with throughout the project lifecycle.

2.7 Early engagement is achieved with the use of workshops, which are effective for establishing stakeholder requirements, identifying risks, working through issues, benefits identification and lessons learned. We note that the Framework allows for the use of surveys to collect project data, but also to obtain valuable points of view and feedback from stakeholders and groups.

2.8 There are various channels of communication open to stakeholders providing them with the relevant information on the progress of the projects and from our testing. It is apparent that the level of engagement with the stakeholders is at the appropriate level and using workshops, the concerns of the stakeholders are considered.

2.9 If stakeholders are unable to attend workshops, the Framework identifies a number of alternative methods of communication in order to collect opinions. The alternative methods include:

a. emails;

b. file sharing;

c. intranet; and

d. project plans.

2.10 At present there is no formal template to capture workshop and steering groups attendance or feedback, although we note that individual projects keep records of who attended the workshops. **Matter Arising 1.**

2.11 The Health Board also complete process maps to fully understand the 'as is' and 'to be' processes. This allows the Health Board to ensure that the implementation fully considers all the needs of the users. The documents are used to inform the

process flows in the system and support the development of the guidance produced in support of the implementation / training. Any concerns that are identified, that require further pieces of business change work, are included within the Change Readiness Assessment.

2.12 Our testing confirmed that stakeholder analysis was undertaken, and communications plans developed. We also note that requirements and concerns were obtained, and these were added to the specifications.

Conclusion:

2.13 The guidance requires engagement with stakeholders at an early stage, to identify the requirements, with templates provided for defining the communication processes and engagement. Our testing confirmed that processes are being followed and stakeholder opinions are appropriately captured. Accordingly, we have provided **substantial assurance** over this objective.

Objective 3: Stakeholders are included within programme and project governance structures.

2.14 The Project Board comprising of the project manager, project owner, senior users and other stakeholders is the decision-making authority for the project and provides overall direction and management. The Project Board has a duty (amongst others); to ensure effective communication within the project team and with internal and external stakeholders. This is achieved by the inclusion of stakeholders as part of the project board and project teams, where deemed appropriate in accordance with the Framework. From the testing conducted on the stakeholder analysis document, stakeholder involvement on the project board at the appropriate level is identified.

2.15 The broad remit of the organisation's Project Board is to support the project owner in providing overall direction and management for the project. The project owner is ultimately accountable for the project's success. To maximise the chances of success, the interests of both the senior project users (those who specify the business requirement) and the project suppliers (those providing the products or services to meet the business requirement) should be represented on the Project Board.

2.16 The Project Board represents three areas of interest:

a. Project Owner: taking ultimate responsibility and accountability for the successful completion of the project.

b. Senior User: representing the end users of the products from the project.

c. Senior Supplier: representing those designing, facilitating, building, procuring, and implementing the project's product.

2.17 While there are other various stakeholders, the project owner can be considered the key stakeholder in the project and therefore they ensure that the project meets its objectives and delivers the project benefits. From the documentation provided, it is evident that stakeholders are included in the project's initiation and throughout the project.

2.18 We reviewed the composition of project boards / teams and we confirmed that there was appropriate stakeholder inclusion in these, which enabled ownership of the projects and programmes.

2.19 Our testing confirmed that attendance at project governance meetings was appropriate, and where there was no attendance there were separate, specific meetings with the relevant individuals.

2.20 Attendance of key stakeholders at project board meetings are recorded in the minutes of the meeting. However, there is no process to record the attendees in a central datasheet which would help highlight repeated non-attendance. **Matter Arising 2**

Conclusion.

2.21 There is appropriate stakeholder inclusion within programme and project governance structures, with stakeholder representation on project boards and project teams. Accordingly, we have provided **substantial assurance** over this objective.

Objective 4: Stakeholders are included within testing stages and programme and project closure.

2.22 We note that the Framework requires stakeholder engagement during the user acceptance testing (UAT) stage. From our testing we confirmed that UAT is being conducted, which includes a range of stakeholders and with the inclusion of the relevant individual department, thus providing a wide spectrum of UAT testing.

2.23 As part of the Framework the Health Board maximises use of the Project Closure Report and sign off process, which has stakeholder inclusion. We confirmed that key users and stakeholders are included in the sign off stages of projects.

2.24 The Health Board has recognised that additional data needs to be captured regarding UAT and to this end they have established a working group to develop a standardised UAT script template and report. This will be used by all projects and is an ongoing development, which enhances the current Framework.

2.25 The project closure documentation, which forms part of the Framework, aims to provide the foundation for a formal and clear closure of the project. This results in the project and responsibility being properly handed over to service delivery, as confirmed in our testing. The report is circulated to the project board/owner/stakeholders for approval so that the project can be disbanded.

Conclusion:

2.26 Guidance requires that users are involved at the testing stage. Our testing confirmed that this is the case and we note further improvements are being made in documenting and defining the UAT. Stakeholders are also included in the project sign off and closure. Accordingly, we have provided **substantial assurance** over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Workshop Template (Operation)			**Impact**
At present there is no formal template to capture workshop and steering groups attendance or feedback, although we note that individual projects keep records of who attended the workshops.			Potential risk of: • Stakeholder needs not fully defined.
Recommendations			**Priority**
1.1	A template should be developed in order to record all workshop attendance.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Standardised templates for Steering Groups and Workshops will be developed by the Business Change Team and will be incorporated into the Project Management Framework.	31/03/2024	Assistant Director of Digital Programmes

Matter Arising 2: Project Attendance (Operation)			**Impact**
Attendance of key stakeholders at project board meetings are recorded in the minutes of the meeting. However, there is no process to record the attendees in a central datasheet, which would help highlight repeated non-attendance.			Potential risk of: • Stakeholder involvement is incomplete.
Recommendations			**Priority**
2.1	Consideration should be given for a single record to track attendance at project and programme boards.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	A meeting attendance tracker will be created and will be implemented for use by all Project Boards.	31/03/2024	Assistant Director of Digital Programmes

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: February 2024

Document reference: 3997A2024

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed / to be performed in accordance with statutory functions.

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Contents

Audit, Risk and Assurance Committee update

About this document 4

Accounts audit update 5

Performance audit update 7

Other relevant publications 10

Additional information 10

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the health board.	Complete	Audit of Accounts report presented to committee at July 2023 Audit. Risk and Assurance Committee
Charitable Funds: • Planning • Audit of Charitable Fund	Rob Holcombe – Director of Finance and Procurement	• This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and	Complete	Reported to Charitable Funds Committee 22 January 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Financial Statements		performance of our audit approach will be responsive to each assessed risk. • We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.		

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Deep dive	Nicola Prygodzics – Chief Executive Officer	In addition to the core structured assessment work, we will also undertake "deeper dive" work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.	Planning	To be confirmed
Annual Audit Report	Nicola Prygodzics – Chief Executive Officer	This report summarises the findings from the 2023 audit work at Aneurin Bevan University Health Board.	Report finalised and included in today's committee papers	February 2024
Follow-Up of Primary Care Services	Leanne Watkins – Chief Operating Officer	Follow-up of recommendations made in our Primary Care services review	Report finalised and included in today's committee papers	February 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic on workforce planning arrangements	Sarah Simmonds – Executive Director of Workforce and Organisational Development	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	Report finalised and included in today's committee papers	February 2024
Unscheduled Care Arrangements	Leanne Watkins – Chief Operating Officer	This work has been carried forward from the 2020 Audit Plan, after having initially been postponed due to the pandemic. Our phase one work has examined discharge planning arrangements and patient flow. We will assess the Health Board's progress against the 2017 audit recommendations we made on discharge planning. We are also producing a report for the Health Board and its partners on the Regional Partnership Board that describes progress being made in developing whole system solutions to delayed discharges.	Reporting	To be confirmed
Quality Governance	Jennifer Winslade – Executive	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review Follow up	Director of Nursing James Calvert – Medical Director Peter Carr – Executive Director of Therapies and Health Sciences	Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.		
Tackling NHS Waiting Lists	Leanne Watkins – Chief Operating Officer	This work will be completed across all health boards and follows on from our national overview report on the planned care backlog in May 2022. Although we are still in the scoping phase, we intend to consider waiting list performance and arrangements to improve elective waits.	Planning	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
Corporate Joint Committees – commentary on their progress	November 2023

Additional information

7 Audit Wales recently completed a survey on stakeholder perceptions across all public sector bodies. The closure for response was June 2023. A copy of the report is available in the February 2024 Audit, Risk and Assurance committee meeting papers.

Audit Wales
1 Capital Quarter, Tyndall Street,
Cardiff CF10 4BZ
Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Annual Audit Report 2023 – Aneurin Bevan University Health Board

Audit year: 2022-23

Date issued: January 2024

Document reference: 3988A2024

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report 4

Key messages 5

Detailed report

Audit of accounts 7

Arrangements for securing efficiency, effectiveness, and economy in the use of resources 9

Appendices

Appendix 1 – reports issued since my last annual audit report 16

Appendix 2 – audit fee 18

Appendix 3 – audit of accounts risks 19

Summary report

About this report

1 This report summarises the findings from my 2023 audit work at Aneurin Bevan University Health Board undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources.

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 28 July 2023, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have commented on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments. I have also published an NHS Workforce Data Briefing

that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit, Risk and Assurance Committee on 8 February 2024. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however I brought some issues to the attention of officers and the Audit and Risk Assurance Committee for improvement.

13 However, I qualified the regularity opinion because the Health Board did not meet its revenue resource allocation over the three-year period ending 31 March 2023.

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

14 Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the regularity issues.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- Urgent and sustainable action is needed to tackle the long waiting times for orthopaedic services. There's a clear commitment to improve waiting times, however, it could take three years or more to return the orthopaedic waiting list to pre-pandemic levels.
- Given its financial and performance challenges, the Health Board needs a clear plan to set out how it will achieve financially sustainable service models. In general, Board and committee governance arrangements and the corporate arrangements for developing plans are reasonably effective. However, there is scope to provide clarity on both the impacts of actions set out in plans and actions taken to improve performance.
- From an all-Wales perspective, despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.
- The Health Board has set clear workforce priorities based on a good understanding of its significant risks. It is working hard to address its immediate workforce challenges and its key actions are appropriately aligned to its agreed People Plan. However, the approach is over-emphasising the short term and operational fixes. There is a clear need to revisit Clinical Futures implementation plans so that they enable the development of financially affordable, efficient, and sustainable service workforce models.
- The Health Board has made reasonable progress in addressing our previous recommendations, particularly in relation to public engagement and Neighbourhood Care Network development and activity. However, the sustainability of some primary care services remains a concern and there needs to be a more co-ordinated, unified, and strategic approach to primary care planning, resourcing, and reporting on outcomes.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

20 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however I brought some issues to the attention of officers and the Audit and Risk Assurance Committee for improvement.

21 I must report issues arising from my work to those charged with governance (the Audit, Risk and Assurance Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues on 18 July 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit, Risk and Assurance Committee

Issue	Auditors' comments
Uncorrected misstatements	There were no uncorrected misstatements.
Corrected misstatements	There were a number of adjustments made to the draft accounts, none of which impacted on the reported deficit.
Other significant issues	I qualified my regularity opinion and issued a substantive report because the Health Board did not achieve its financial duty to achieve financial balance for the three-year period 2020-23.

Issue	Auditors' comments
	I also reported improvements which could be made to the verification process for the property, plant and equipment assets and in the production of the remuneration report.

22 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2023 and the return was prepared in accordance with the Treasury's instructions.

23 My separate audit of the charitable funds accounts will be completed by 22 January 2024. No issues have arisen to date, and I will report my opinion to the Charitable Funds Committee.

Regularity of financial transactions

24 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

25 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

26 For 2022-23, the Health Board failed to meet the first financial duty, which gives additional flexibility to LHBs by allowing them to balance their income with their expenditure over a three-year rolling period. The three-year period being measured under this duty this year is 2020-21 to 2022-23.

27 The Health Board did not achieve financial balance for the three-year period ending 31 March 2023, exceeding its cumulative revenue resource limit of £4,789.223 million by £36.348 million, which I deem to be outside its powers to spend, so I have issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2022-23 accounts.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

28 I have a statutory requirement to satisfy myself that the Health Board proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- commenting on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments.
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.
- publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally.
- reviewing the effectiveness of the Health Board's workforce planning arrangements.
- assessing the extent to which the Health Board has implemented my 2019 recommendations on primary care, as well as the extent to which there is appropriate capacity and capability to deliver priorities as well as the extent to which the Board and/or its committees consider matters relating to primary care.

29 My conclusions based on this work are set out below.

Orthopaedic Services in Wales

30 In March 2023, I commented on orthopaedic services across Wales. My national report 'Orthopaedic Services in Wales – Tackling the Waiting List Backlog' sets out the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the nationally co-ordinated work to modernise services. My report also set out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services.

31 My work found that securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with the COVID-19 pandemic making this significantly worse. Previous monies allocated by Welsh Government have resulted in short term improvements but have not achieved the sustainable changes to services that were necessary with orthopaedic waiting list targets not met since they were first established in 2009.

32 Since the impact of the pandemic has lessened, orthopaedic services have been slow to restart, and while necessary infection control regimes will continue to have

an impact on throughput, there is scope for current capacity to be used more efficiently. My scenario modelling indicates that it could take between three to five years to return orthopaedic waits to pre-pandemic levels across Wales. This is based on both a significant drive on community-based prevention and an increase in capacity and activity. Without this, services may never return to pre-pandemic levels.

33 My work found that there is a clear commitment to improve orthopaedic services. NHS Wales commissioned efficiency and effectiveness reviews both nationally and locally, which set out a suite of recommendations. A national clinical strategy for orthopaedics was also commissioned which sets out service options and a clear clinical voice on what needs to be done. However, urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

34 In addition to my national report, my team set out how the Health Board's orthopaedic services compare to other health boards across Wales. My comparative report highlighted that the Health Board has:

- some of the highest waits, including patients waiting longer than a year for a first outpatient appointment, although the proportion of patients on the waiting list for longer than two years is below the all-Wales average;
- the highest level of potential latent 'lost' demand as an impact of patients not going to their GP during the pandemic;
- the lowest levels of orthopaedic bed and medical workforce capacity;
- some of the shortest waits for radiology services, and physiotherapy; and
- good uptake of 'see on symptom' pathways to reduce unnecessary follow-up outpatient demand, but lower uptake of the use of patient-initiated follow-up.

35 My scenario modelling indicates that optimistically the waiting list for the Health Board could return to pre-pandemic levels by 2026, and realistically by 2029 but without concerted effort may take many years to return to pre-pandemic levels, if at all. My local report also sets out a series of prompts and questions for Board members to inform debate and obtain assurance that improvement actions at a local level are having the desired effect.

Structured assessment

36 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

37 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations. At the time of my structured assessment work, the Health Board was subject to "enhanced monitoring" by the Welsh Government for its planning and finance arrangements and for aspects of its service performance.'

Board transparency, effectiveness, and cohesion

38 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- Public transparency of Board business;
- Arrangements to support the conduct of Board business;
- Board and committee structure, business, meetings, and flows of assurance;
- Board commitment to hearing from staff, users, other stakeholders; and
- Board skills, experiences, cohesiveness, and commitment to improvement.

39 My work found that Board and Committee arrangements are reasonably effective; however, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.

40 Board and committees operate transparently, with appropriate discussions on key financial, performance, and quality challenges. The Health Board's committee structure is well-established, and meetings are well chaired. There are reasonably effective arrangements to support flows of assurance from the committees to the Board; however, the quality and timeliness of the information the Board and committees receive requires improvement. The Board demonstrates a commitment to continuous improvement.

Corporate systems of assurance

41 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- Overseeing strategic and corporate risks;
- Overseeing organisational performance;
- Overseeing the quality and safety of services; and
- Tracking recommendations.

42 My work found that the Health Board is making good progress in developing and refining its systems of assurance. Work is also progressing to strengthen arrangements for monitoring risk, performance and the quality and safety of services. However, it will need to effectively embed these new arrangements across the organisation to manage the finance, performance, and quality risks it faces.

43 The Health Board is implementing a new Performance Management and Accountability Framework, but it needs ensure that performance reports set out clearly the actions required to address underperformance and, where relevant, the impact of past actions taken. Its arrangements for tracking and monitoring outstanding audit and inspection recommendations are improving but will require more focus to close overdue recommendations.

Corporate approach to planning

44 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- Producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and
- Overseeing the delivery of corporate strategies and plans.

45 My work found that the Health Board's approach for developing its strategic and corporate plans is generally effective. However, the Health Board is facing increasing challenges, including growing demand for care with need becoming more complex, continued 'legacy' from the COVID-19 pandemic and substantial financial pressures. The Board will need to give careful consideration to sustainable clinical service models to ensure improved efficiency and productivity as part of the strategy development. Its arrangements for developing the Integrated Medium-Term Plan and corporate strategies are reasonably effective. However, reports setting out the progress to deliver plans need strengthening.

Corporate approach to managing financial resources

46 My work considered whether the Health Board's has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- Achieving its financial objectives;
- Overseeing financial planning;
- Overseeing financial management; and
- Overseeing financial performance.

47 My work found that the Health Board is facing significant financial challenges. It did not achieve financial balance for 2022-23. Until the announcement of an additional allocation of £89 million in October 2023, it was forecasting a deteriorating position for 2023-24. The current year-end forecast, including the non-recurring additional Welsh Government allocation, is a deficit of £57 million.

48 While it has a reasonable approach to financial planning, several factors are impacting its ability to achieve the plan, including blocked beds, prescribing spend, Continuing Healthcare costs, service demand and wider inflation-related cost increases. The Health Board has established an ambitious savings plan but the risks to its ability to deliver these savings are already apparent. Finance savings reports should be clearer on the extent that actions that it is taking to address the risks are having the desired impact. Board finance reports are open and transparent about the Health Board's financial challenges and the potential impact on service quality and safety when making difficult decisions with the aim of improving the financial position.

NHS workforce data briefing

49 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that in some instances, the growth in staff levels, particularly in nursing and some medical specialties hasn't kept up with increasing demand.

50 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23. Wales is growing its own workforce, with increased nurses and doctors in training.

51 Despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies are able to recruit sufficient graduates, once they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer.

Workforce planning arrangements

52 My review examined whether the Health Board has effective arrangements to support workforce planning. It focussed on the strategic and operational workforce planning, how it uses workforce information and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.

53 My work found that the Health Board has a good understanding of its strategic workforce challenges and has set clear workforce priorities based on a good understanding of the significant risks it faces. Actions are appropriately aligned to the agreed People Plan and the Health Board is improving data to support workforce planning and is engaging well with its key stakeholders.

54 However, there is a clear need for it to develop workforce plans that support long-term financially sustainable service models. The Health Board is working hard to address the immediate workforce challenges but is not giving sufficient attention to workforce redesign and service transformation.

55 There is appropriate Board, Committee and Executive level scrutiny of delivery of the Health Board's People Plan, but the reports which are produced to inform oversight need to better describe the progress that is being made and the impact the Plan is achieving.

Primary care follow-up review

56 My review examined the extent to which the Health Board has implemented my previous 2019 recommendations relating to primary care. I also assessed the extent to which the Board and/or its committees regularly consider matters relating to primary care, and whether the Health Board's central primary care services team has the appropriate capacity and capability.

57 My work found that the Health Board has made reasonable progress in addressing our previous recommendations, particularly in relation to public engagement and Neighbourhood Care Network development and activity. However, the sustainability of some primary care services remains a concern and there needs to be a more co-ordinated, unified, and strategic approach to primary care planning, resourcing, and reporting on outcomes.

58 The Health Board has strengthened public engagement and key aspects of Neighbourhood Care Network activity and development. It is also beginning to improve its approach to evaluating new ways of working. However, it is yet to establish a clear financial baseline to support the shift in resources from secondary to primary care. Primary care services are appropriately reflected in the Health Board's Clinical Futures strategic plans, Integrated Medium-Term Plan (IMTP), and 11 underpinning Neighbourhood Care Networks IMTPs. Between them, they set out a high-level ambition and some detailed improvement actions to transform services. Primary care reporting to the Board and its committees has improved,

however, there is scope to provide greater coverage on primary care challenges, opportunities, and risks. There remain a very limited number of corporately reported performance indicators for primary care and there needs to be clearer outcome-based measures and reporting to help to understand what is being achieved.

59 The work of primary care support and contracting teams has grown significantly, however, they are increasingly crisis-driven. The Health Board recognises a need to review the function of the Primary Care Operational Support Team to provide 'upstream support' rather than crisis response and consider team resourcing levels. At present though, resources supporting transformation are separate to core primary care practice support which may mean that overall capacity is not best utilised.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2023.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2023
Opinion on the Financial Statements	July 2023
Audit of Charitable Funds Financial Statements Report and Opinion on the Charitable Funds Financial Statements	January 2024
Performance audit reports	
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog: A comparative picture for Aneurin Bevan University Health Board	March 2023
NHS Workforce Data Briefing	September 2023
Structured Assessment 2023	November 2023
Review of Workforce Planning Arrangements	December 2023

Report	Date
Primary Care Follow Up Review	December 2023
Other	
2023 Audit Plan	April 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Unscheduled Care: Flow out of Hospital	February 2024
Review of Financial Efficiencies	March 2024
Quality Governance Follow up	May 2024
Review of Planned Care Services Recovery	July 2024
Managing demand for urgent and emergency care	July 2024

Appendix 2

Audit fee

The 2023 Audit Plan set out the proposed audit fee of £420,682 (excluding VAT). My latest estimate of the actual fee, on the basis that some works remains in progress, is in keeping with the fee set out in the outline.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2023 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and evaluate the rationale for any significant transactions outside the normal course of business.	My audit team: • tested journal entries; • reviewed accounting estimates, particular primary care payments; and • did not identify any transactions outside of the normal course of business. No material issues arose from the work carried out
The risk of failing to meet your first financial duty to break even over a three-year period has now crystalised. The position at month 12 shows year-end surplus/deficit of £37 million. This, combined with the outturns for 2020-21 and 2021-22, predicts a three-year deficit of £36.5 million. We will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion. Your current financial pressures increase the risk that management	My audit team will focus our testing on areas of the financial statements which could contain reporting bias.	My audit team reviewed year-end transactions, in particular accruals and cut-off. No matters arose from the work carried out. I chose to place a substantive report on the financial statements explaining the failure to break even over a three period and the circumstances under which it arose.

Audit risk	Proposed audit response	Work done and outcome
judgements and estimates could be biased in an effort to achieve a sustainable financial position in future years.		
There is a risk that the disclosures within the Remuneration Report will be incorrect. My work identified a number of amendments to the draft 2021-22 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. I understand that for 2022-23, the Health Board has continued to experience a significant number of changes at Senior Management level.	My audit team will review the completeness and accuracy of the Remuneration Report.	Our work in this area identified some issues which we reported to those charged with governance in the Audit report prior to sign off – there was no material impact on the accounts.
There is a risk that the Gross Book Value (GBV) of assets will be materially mis-stated. 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 2022. As part of my audit team's review of asset lives, my testing of assets recorded as having a Net Book Value (NBV) of 'nil' as at 31 March 2022 found that all of our sample tested were no longer in use and therefore the GBV of these assets	My audit team will review the process for asset impairment review and verifying asset existence and sample test assets recorded as having a NBV of 'nil' to gain assurance that there are no material misstatements in accounting and reporting.	Our work in this area identified a number of issues which we reported to those charged with governance in the Audit report prior to sign off – there was no material impact on the accounts.

Audit risk	Proposed audit response	Work done and outcome
was potentially materially overstated.		
Accounting for Property, Plant and Equipment and Intangible Assets continues to be one of the most challenging areas of the accounts and there is a risk that the revaluation of the Health Board's estate is not accounted for correctly. The quinquennial revaluation of the NHS Estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert. • test the appropriateness of asset valuation bases. • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts. consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	My audit team: • considered the appropriateness of the work of the Valuation Office as a management expert; • tested the appropriateness of the asset valuation base; • reviewed a sample of movements in carrying values; and • considered whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions. No material issues arose from the work carried out.

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Primary Care Follow-up Review – Aneurin Bevan University Health Board

Audit year: 2022

Date issued: December 2023

Document reference: 3654A2023

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Contents

Summary report

Introduction 4

Key messages 6

Recommendations 8

Detailed report

Implementation of previous audit recommendations 9

Board-level visibility and focus on primary care 14

Capacity and capability to deliver local and national priorities 16

Appendices

Appendix 1 – Audit methods 19

Appendix 2 – 2019 audit recommendations 20

Appendix 3 – Organisational response 23

Summary report

Introduction

1 Primary care is the first point of contact for most people who use health services in Wales. It encompasses a wide range of services, delivered in the community by a range of providers, including General Practitioners (GPs), Pharmacists, Dentists, Optometrists, as well as other professionals from the health, social care, and voluntary sectors.

2 In 2018-19, the Auditor General reviewed primary care across all Health Boards in Wales, with a particular focus on general practice. That work focussed on strategic planning, investment, workforce, oversight and leadership, and performance.

3 Our 2019 Review of Primary Care at Aneurin Bevan University Health Board (the Health Board) found that it had comprehensive plans for primary and community care and was making steady progress towards implementing the key elements of the national vision. While performance levels were above average for many indicators, growing workforce pressures were challenging the sustainability of core GP services in some areas.

4 The Health Board had assessed the workforce challenges in some practices and was in the early stages of testing solutions. Primary care plans were informed by Neighbourhood Care Network plans, but the networks were not fully mature.

5 There were some examples of resources shifting closer to home and the aim was to increase investment in primary care. A lack of data made it difficult to accurately calculate the overall investment in primary care and the shift in investment from secondary care to primary care.

6 Despite strong leadership arrangements, limited performance indicators did not allow oversight of all areas of primary care and there was scope for greater focus on primary care at Board-level.

7 The landscape for primary care in Wales has changed since our original review in 2019:

- Welsh Government has published its long-term plan for health and social care - A Healthier Wales. The plan highlights primary care's crucial role in helping to realise the ambition of creating a seamless whole system approach with services designed around people, based on their needs, supporting them to stay well and not just providing treatment when they become ill. This means that more services traditionally provided in a hospital setting are shifted into the community to provide care at home or closer to home to take pressure off hospitals and reduce the time people wait to be treated.
- the Strategic Programme for Primary Care is the all-Wales primary care response and contribution to 'A Healthier Wales'. It set out six workstreams:
  - focussing on 'ill-health' prevention and wellbeing;
  - developing 24/7 access to services;

- exploiting data and digital technologies;
- strengthening workforce and organisational development;
- improving communications and engagement; and
- developing 'cluster-level' vision and enabling service transformation.

- in February 2023, the National Primary Care Board, which oversees the Strategic Programme for Primary Care, identified that work is progressing at a varying pace within each Health Board area. Aligned to this, there are wider concerns around the capacity of central Primary Care Services Teams within Health Boards to deliver organisational priorities, as well as Board-level visibility and focus on primary care.
- Welsh Government has embarked on an ambitious programme of contract reform across General Medical Services, Dentistry, Community Pharmacy, and Optometry to:
  - ensure primary care services are sustainable;
  - improve patient access to primary care services;
  - reinforce the focus on quality and prevention;
  - enable cluster working to plan and deliver services; and
  - strengthening the workforce.
- primary care services were severely impacted by the COVID-19 pandemic. Whilst the immediate public health emergency has subsided, primary care providers continue to face challenges as they recover and reconfigure their services with the aim of responding to the needs and expectations of the public in a post-pandemic world.

8 Our review has focussed primarily on assessing the extent to which the Health Board has implemented our 2019 recommendations. However, we have also undertaken some additional work to consider the extent that:

- the Health Board's central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs; and
- the Board and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board's primary care services.

9 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

10 Overall, we found that **the Health Board has made reasonable progress in addressing our previous recommendations, particularly in relation to public engagement and Neighbourhood Care Network development and activity. However, the sustainability of some primary care services remains a concern and there needs to be a more co-ordinated, unified, and strategic approach to primary care planning, resourcing, and reporting on outcomes.**

Implementation of previous audit recommendations

11 We found that **the Health Board has strengthened public engagement and key aspects of Neighbourhood Care Network activity and development. It is also beginning to improve its approach to evaluating new ways of working. However, it is yet to establish a clear financial baseline to support the shift in resources from secondary to primary care**.

12 The Health Board has strengthened key aspects of Neighbourhood Care Network activity and development. Whilst there remains some variation in Neighbourhood Care Network membership, representation at meetings has improved and there are clear plans to develop arrangements further. The Health Board has clearly defined the role of the Neighbourhood Care Networks as part of the Primary Care and Community Services Division, the five Integrated Service Partnership Boards, and the Public Service Boards. The Health Board continues to invest in leadership development, and all Neighbourhood Care Networks Leads have completed the Confident Primary Care Leaders course. However, there is no specific locum Neighbourhood Care Network Lead post to provide additional capacity and backfill for absences and share learning.

13 The Health Board is strengthening it approach to public engagement and this is helping both to highlight pressures facing the primary care system and signpost alternative services as they become embedded. But the Health Board needs to become better at determining the extent that its investment in primary care improvement is delivering the intended impact. At present, the Health Board does not have a baseline to assess the extent to which services are shifting to more preventative and community-based models. There also isn't a truly evaluative approach to determine the impact Neighbourhood Care Network initiatives, although the Health Board is strengthening its evaluation approaches during 2023. Where there is evidence of evaluation, the Health Board does not always allocate mainstream funding to new ways of working. This could mean that impactful approaches to manage health conditions in the community may not be embedded.

Board-level visibility and focus on primary care

14 We found that **primary care is appropriately reflected in Health Board strategies and plans. However, there is a need for a more integrated, unified, and strategic approach to primary care planning and resource utilisation. Whilst primary care reporting to the Board and its committees has improved, opportunities remain to provide greater coverage on primary care challenges, opportunities, improvements, and risks**.

15 Primary care services are appropriately reflected in the Health Board's clinical futures strategic plans, Integrated Medium-Term Plan (IMTP), and 11 underpinning Neighbourhood Care Networks IMTPs. Between them, they set out a high-level ambition and some detailed improvement actions to transform services. The Health Board has a Primary Care and Community Services Integrated Medium Term Plan for the 2023-26 period. This incorporates both service modernisation and the sustainability of primary care services and integrates enabling requirements including digital, estates, communications, workforce and quality. The Health Board is intending to move away from a solely community service focussed plan, from 2024, to integrate primary and community services with acute services aligned to wider clinical futures strategy and plans.

16 There is improving primary care reporting to the Board and committees, but it is fragmented which makes is hard to form a collective view on the primary care challenges, opportunities, improvements, and risks. There remain a very limited number of corporately reported performance indicators for primary care. There needs to be clearer outcome-based measures and reporting to help to understand what impact or difference is being achieved.

Capacity and capability to deliver local and national priorities

17 We found that **the work of primary care support and contracting teams has broadened and increased significantly. But it has also become increasingly crisis-driven, and this needs to be addressed as a priority**.

18 The work of primary care support and contracting teams has grown significantly; however, they are increasingly crisis-driven. The Health Board recognises a need to review the function of the Primary Care Operational Support Team to provide 'upstream support' rather than crisis response and consider team resourcing levels. At present though, resources supporting transformation are separate to core primary care practice support which may mean that overall capacity is not best utilised.

Recommendations

Implementation of previous audit recommendations

19 Based on our findings above and in the detail of this report, the status of our 2019 audit recommendations is summarised in **Exhibit 1**. We have provided the progress and status against each recommendation in more detail in **Appendix 2**.

20 The Health Board has provided an update to the open recommendations, setting out proposed action for improvement (**Appendix 3**).

Exhibit 1: status of our 2019 recommendations

Implemented	Ongoing	No action	Superseded	Total
5	9	0	1	15

Detailed report

Implementation of previous audit recommendations

21 We considered the Health Board's progress in implementing our 2019 audit recommendations. These focus on:

- investment in primary care (2019 Recommendations 1a and b);
- new ways of working (2019 Recommendations 4a, b, c, and d); and
- Neighbourhood Care Networks (2019 Recommendations 5a, b, c, d, and e).

22 Recommendations relating to oversight of primary care at Board and committees (2019 Recommendation 2 and 2019 Recommendations 3a, b, and c) are discussed later in this report.

23 Overall, we found that **the Health Board has strengthened public engagement and key aspects of Neighbourhood Care Network activity and development. It is also beginning to improve its approach to evaluating new ways of working. However, it is yet to establish a clear financial baseline to support the shift in resources from secondary to primary care**.

Investment in primary care

24 We considered whether the Health Board has:

- calculated a baseline position for its current investment and resource use in primary and community care (2019 Recommendation 1a); and
- reviewed and reported, at least annually, its investment in primary and community care to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care (2019 Recommendation 1b).

25 We found **that the Health Board has not yet established a clear financial baseline. As a result, it has been unable to monitor the full extent to which resources and services are being shifted from secondary to primary care.**

26 The Health Board has not yet established a clear financial baseline from which to measure resource shift towards primary care. However, it implemented a different approach to budget setting for the 2023-24 financial year based on forecast spend within divisions rather than based on historical budgets. This is intended to address the historical issue of funding not being transferred between divisions and is to be accompanied by greater focus on baselines to help facilitate activity and resource shift in the future. **We therefore consider Recommendation 1a to be ongoing**.

27 'A Healthier Wales' clearly seeks a shift in resources to community services, but at present the Health Board cannot evidence sufficient progress. There are some examples of service delivery being moved to primary care (we discuss this further in **paragraph 32**). At present though, there has been no comprehensive examination of the value and impact of the Health Board investments in

modernising and improve primary care services. **We therefore consider Recommendation 1b to be ongoing**.

New ways of working

28 We considered whether the Health Board has:

- worked with the Neighbourhood Care Networks (NCNs) to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes, and to inform decisions on whether to expand these models (2019 Recommendation 4a);
- centrally collated evaluations of new ways of working and shared the learning by publicising the key messages across all NCNs (2019 Recommendation 4b);
- begun to fund these new models from mainstream funding, subject to positive evaluation, rather than from the Primary Care Development Fund (2019 Recommendation 4c); and
- worked with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments (2019 Recommendation 4d).

29 We found that the Health Board **has appropriately strengthened its arrangements for promoting new ways of working amongst the public and signposting them to alternative points of contact. However, given growing funding constraints, it needs to become better at systematically evaluating the outcomes from new models and initiatives to inform decisions on continued investment**.

30 The Health Board started its new Neighbourhood Care Network[1] funded project evaluation process in January 2023. Its aim is to assess projects systematically and objectively to improve accountability, measurement, and increased transparency of project outcomes. The work is being led by Neighbourhood Care Network Office Service Improvement Managers who are providing support to locality teams. Through these new approaches, the Health Board is expecting to strengthen its evidence base for projects, inform decision making, help to identify key organisational learning, and establish unmet need and demand. The Health Board is planning to prepare evaluation outcomes in time to inform the 2024-25 Neighbourhood Care Network Plan development process. The Primary Care and Community Services Division performance dashboard is also under review, and the Health Board currently plans to update this to reflect the agreed measurement

[1] A Neighbourhood Care Network (also known as a GP cluster) is a 'place-based' partnership network whose aim is to shape services at a neighbourhood level (typically supporting populations of 40,000 to 60,000). The Health Board has 11 Neighbourhood Care Networks in total.

strategy across the Neighbourhood Care Network funded projects. **We therefore consider Recommendations 4a and 4b to be ongoing**.

31 There are some examples where new models and initiatives have become mainstream in primary care. These include the Ophthalmology Diagnostic Treatment Centre for Glaucoma and Wet AMD (age-related macular degeneration), the extended Minor Skin Surgery Service, and the introduction of an Integrated Primary and Community Care Academy. However, the Health Board faces risks when implementing new primary care services as many sources of funding are non-recurrent. If the funding stops, this could either affect the sustainability of new models and initiatives or result in unfunded service cost pressures within the Primary Care and Community Services Division. The Health Board's central Neighbourhood Care Network Office is working with the Value-Based[2] Health Care Team to evaluate new models that are clearly demonstrating impact. This will then be used to support business case proposals to begin mainstreaming some models of care that are proven to be effective. The Neighbourhood Care Network Office is also strengthening financial governance to ensure there is an Award Letter and Project Initiation Document or Service Level Agreement in place for all Neighbourhood Care Network funded projects. These agreements will specify the outcome data to be collected to inform decisions about scaling-up and mainstreaming effective models. **We therefore consider Recommendation 4c to be ongoing**.

32 The Health Board appointed a Communication and Engagement Officer in October 2022 to help ensure that the public are aware of pressures and alternative services which can help to reduce the pressure on GPs. This has resulted in stronger and more coordinated communication programme that is aligned to the wider corporate Health Board approach. Furthermore, the Health Board is appropriately promoting several alternative points of contact including the:

- Community Pharmacy Common Ailment Service;
- Eye Health Examination Wales Service;
- Urgent Dental Hotline; and
- NHS 111 Option 2 for Mental Health Crisis support.

33 In support of the new arrangements above, the Health Board requires that all existing patient-facing staff undertake the national care navigation training package as part of the national GMS Contract access commitment. All new patient-facing staff complete the national care navigation training package within three months of their start date. The Health Board has recently produced and shared videos on its social media channels featuring Neighbourhood Care Network Leads as part of a wider social media campaigns to help manage patient expectations during periods of peak demand. Part of that work included the production of video stories to raise public awareness of extended roles within primary care such as associate nurse

[2] Value-based healthcare is the equitable, sustainable, and transparent use of available resources to achieve better outcomes and experiences.

practitioners, clinical pharmacists, and psychological health practitioners. **We therefore consider Recommendation 4d as implemented**.

Neighbourhood Care Networks

34 We considered whether the Health Board has:

- reviewed the relative maturity of clusters, and targeted and strengthened its support for clusters where necessary (2019 Recommendation 5a);
- reviewed the membership of NCNs and attendance at NCN meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups (2019 Recommendation 5b);
- clarified and publicised governance and leadership arrangements for NCNs, to ensure better understanding of the responsibilities for decision making (2019 Recommendation 5c);
- ensured that all NCN leads have attended the Confident Primary Care Leaders Course (2019 Recommendation 5d); and
- considered introducing a locum NCN lead post, to work across all NCNs providing additional capacity and backfill for leads. The post could also be valuable in sharing learning across NCNs (2019 Recommendation 5e).

35 We found that **the Health Board has made good progress in implementing new Neighbourhood Care Networks and wider governance structures, as well as supporting individuals to develop their leadership skills**.

36 Internal Audit's report on Neighbourhood Care Networks, issued in December 2022, concluded that they were not fully mature, drawing attention to complex primary care structures. Since then, Welsh Government has set 2022-23 as a transition year for introducing new local authority footprint-based partnership governance structures and has awarded £0.56 million of additional funding to the Health Board to support their development[3]. Throughout 2022-23, the Health Board has utilised the funds to create an Accelerated Cluster Development Hub project to strengthen governance structures, and to support pan-cluster planning and local Neighbourhood Care Network delivery and distributed leadership. The Strategic Programme for Primary Care Fund is also supporting additional capacity and capability to:

- enhance health intelligence,
- promote service improvement, communication, and engagement,
- and strengthen workforce planning, organisational development, and business support across the networks.

[3] Aneurin Bevan University Health Board Strategic Programme for Primary Care year 1 funding proposals

The Accelerated Cluster Development Hub Project and associated programme has made good progress in supporting the Neighbourhood Care Networks and creating the local authority footprint-based (pan-cluster) Integrated Services Partnership Boards. **We therefore consider Recommendation 5a as implemented**.

37 Neighbourhood Care Network governance is guided by nationally agreed Terms of Reference for NHS Wales Clusters. This sets out the responsibility of individual cluster members and the role of the Health Board in leadership. The membership and structure of the Health Board's Neighbourhood Care Networks have developed over the last year, resulting in strengthened representation from local authorities and the third sector in all Neighbourhood Care Networks. Furthermore, the 'Professional Collaboratives' are also starting to provide a mechanism for GP Practices, Dental Practices, Community Pharmacies, Optometry Practices, Community Nurses, and Allied Health Professionals to together. Over time, these collaboratives should support development within their profession specific groups and facilitate working across a Neighbourhood Care Network to design solutions that meet the needs of local people. **We therefore consider Recommendation 5a as implemented**.

38 The Health Board agreed its Neighbourhood Care Networks governance and leadership arrangements at its public Board meeting on 30 November 2022. This set out the structure, roles, interrelationships between the Accelerated Cluster Development Programme Board, the Supporting Neighbourhood Care Networks Office, and local government and health board corporate leadership structures and scrutiny committees. The Board also agreed the partnership governance structure for planning and delivery under the Regional Partnership Board, which included the 5 Integrated Services Partnership Boards, the role of the Neighbourhood Care Networks, and the underpinning role of professional collaboratives. During the first three months of 2023-24, the Health Board has published its first newsletter "Neighbourhood Care Network News", which signposts to progress of the work of the networks and provides links to updated website information on the form and function of the networks. **We therefore consider Recommendation 5c as implemented**.

39 The Health Board is investing in corporate support for individuals to develop their leadership skills. All Neighbourhood Care Networks Leads have completed the confident primary care leaders course. In addition, neighbourhood care network leads are encouraged to pursue other leadership development opportunities. This includes, for example, the Health Education and Improvement Wales leadership training platform and also pairing some leads with those in other health boards. The newly appointed workforce transformation manager has developed a bespoke leadership development programme for Neighbourhood Care Networks and Professional Collaborative lead roles. **We therefore consider Recommendation 5d as implemented**.

40 There is no specific 'locum' Neighbourhood Care Network Lead post to provide additional capacity and backfill for absences and share learning as we previously recommended. However, the Health Board's investment in its Accelerated Cluster

Development Hub, including its supporting development programme, is improving the resilience of delivery arrangements. **We therefore consider recommendation 5e as superseded**.

Board-level oversight of primary care

41 We considered the extent to which the Board and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board's primary care services. In doing so, we specifically considered whether the Health Board has:

- reflected primary care in its strategies and plans in line with the ambitions of 'A Healthier Wales';
- developed an action plan for raising the profile of primary care in the Health Board (2019 Recommendation 2); and
- ensured the contents of Board and committee performance reports adequately cover primary care (2019 Recommendations 3a, b, and c).

42 We found that **primary care is appropriately reflected in Health Board strategies and plans. However, there is a need for a more centralised, unified, and strategic approach to primary care planning and resource utilisation. Whilst primary care reporting to the Board and its committees has improved, opportunities remain to provide greater coverage of primary care challenges, opportunities, improvements, and risks**.

43 Welsh Government is encouraging localised planning at a cluster level and strengthening co-ordination at a local authority footprint level through the creation of pan-Cluster Planning Groups, known as Integrated Services Partnership Boards. The Health Board's primary care improvements are developed 'bottom up' by the Health Board's Neighbourhood Care Networks. All Neighbourhood Care Networks have developed their own Integrated Medium-Term Plans for the period 2020-23. Some have also recently prepared Annual Plans for 2023-24. The two published 2023-24 Neighbourhood Care Network 'cluster plans' link appropriately to national strategy, policy, and legislation. They also both effectively align to the priorities of the Health Board and relevant local authorities. The Health Board's Integrated Medium-Term Plan provides a reasonable approach for consolidating some quite detailed short-term primary care actions to be delivered during 2023-24.

44 However, the many plans that cover primary care services do not sufficiently allow the Health Board to collectively understand the totality of its resource requirements. Whilst the Neighbourhood Care Network Plans appropriately identify delivery actions, they do not effectively identify the totality of the resource requirements needed to deliver them. This is particularly notable in terms of digital, workforce, capital, and estate resource requirements.

45 The regional and place-based Neighbourhood Care Network planning is supported by national and often short-term funding streams. The Health Board is utilising

national Strategic Programme for Primary Care Funds to support area-based planning and enhance obesity services.

46 Furthermore, whilst the Health Board's IMTP identifies primary care improvements, it is difficult to see the totality of the capital and revenue resource required to deliver the plans. As a result, we cannot determine whether there is sufficient resource allocated to deliver the Health Board's primary care aims and ambition. Nor can we determine whether the Health Board is planning to utilise the totality of its current £276 million primary care and community revenue spend to best effect.

47 The Health Board has a Primary Care and Community Services Integrated Medium Term Plan from 2023-26. This incorporates both service modernisation and the sustainability of primary care services and integrates enabling requirements including digital, estates, communications, workforce and quality. The Health Board is intending to move away from a solely community service focussed plan, from 2024, to integrate primary and community services with acute services aligned to wider clinical futures strategy and plans. This should assist the Health Board in developing new integrate care pathways.

48 Our review of Board papers over the year to August 2023 found that whilst the Health Board is increasing and improving Board and committee oversight of primary care services, it remains very fragmented:

- core primary care divisional spend against budget is included in the finance update to Finance and Performance Committee and the Board. However, this doesn't give a sense of whether primary care services are financially efficient, nor does it report on shifting resources to primary care as required in 'A Healthier Wales'.
- information on the funding of wider Neighbourhood Care Network improvement work is not routinely reported. The report on Accelerated Cluster Development (Neighbourhood Care Network development) programme report prepared for the July 2023 Partnerships, Population Health, and Planning Committee, provided a good overview on actions and improvement activity but little information on costs or quantified outcomes.
- Primary Care Sustainability updates to the Board (including Board briefings) and the Partnerships, Population Health and Planning Committee over the last year frequently refer to failing practices, practice closures and managed practices. This helps the Board react to increased primary care risk, but because it is not reported alongside wider cluster improvement plans it makes it difficult to see a joined-up sustainable solutions.
- Board IMTP updates include frequent references to primary care although these are on a relatively narrow range of primary care issues/initiatives.
- the Board Assurance Framework (BAF) does not identify any risks regarding the achievement of strategic aims for primary care. For example, it does not include:

- a strategic risk relating to the Health Board's ability to achieve a shift in resources to primary care to fulfil the goals set out in 'A Healthier Wales'.
- a strategic risk relating to corporate primary care resources to support transformation and change.

- the Integrated Performance Report contains some primary care indicators, but these do not effectively reflect either the primary care sustainability risks or wider Neighbourhood Community Network plans. Furthermore, they do not focus on outcomes, the impact achieved from improvement initiatives, or measures that may help to indicate primary care service sustainability risk.
- the 2021-22 Annual Report on Primary Care provides a good overview of developments and risks across general medical services, general dental services, general ophthalmic services, and community pharmacy services. However, there is limited information on finances, performance reporting, and links to wider Neighbourhood Care Network activities. Evidence suggests that the annual report did not go to a committee or the Board, and we have not seen any evidence to indicate that a 2022-23 Annual Report in primary care services has been prepared and reported to committee or the Board.

49 As a result of the above, Board members are unable to form a strategic view on the totality of the primary care services and whether actions will lead to sustainability of services in the longer term. **We therefore consider Recommendation 2 and Recommendations 3a, b, and c to be ongoing**.

Capacity and capability to deliver local and national priorities

50 We considered whether the Health Board's central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs. In doing so, we considered whether the central Primary Care Services Team has:

- an appropriately resourced structure, which is kept under review, with clear lines of accountability; and
- arrangements for identifying and supporting learning and development needs, and succession planning on an ongoing basis.

51 We found **the work of primary care support and contracting teams has broadened and increased significantly. It has also become increasingly crisis-driven, and this needs to be addressed as a priority.**

52 The Primary Care Operational Support Team (the Support Team) was established to provide support for GP practices working closely with the Urgent Primary Care Team (UPTC). The Support Team resides in the Chief Operating Officer's portfolio and comprises three nurses, one pharmacist and two administrators. It supports GP practices in several areas, including:

- recruitment challenges;
- early practice interventions;
- assisting managed practices;
- the Merger Incentive Scheme[4]; and
- addressing vacant practice outcomes.

53 Several practices have required crisis support in recent years, which has limited the capacity of the Support Team to work on the prevention agenda and support early interventions. The Primary Care Contracting Team was originally developed as a back-office function to manage primary care contracts. It too has become increasingly involved in managing the Health Board's response to contract resignations and branch surgery closures. This includes responding to the resultant patient and service provider concerns and helping to support multi-disciplinary team-based solutions for primary care.

54 Because of increasing concerns about the sustainability of some primary care services, the Health Board re-established the Primary Care Sustainability Board in October 2022. Its remit is to oversee and direct a programme of work to improve the sustainability of primary care services. This includes a strong focus on training, staff retention, and a public communications strategy. The Primary and Community Care Academy was also re-established in 2023. Its remit includes workforce planning and succession planning, identifying training needs and developing an education and training programme, workforce development, communications, and engagement with primary care providers.

55 The Health Board recognises the need to review the function of the Support Team to provide 'upstream support' rather than crisis response and to consider team resourcing levels. Alongside the capacity to support the day-to-day operation of services, the Health Board is also investing in strengthening its support for Neighbourhood Care Network development. The Neighbourhood Care Network office, coordinated by a Senior Programme Manager includes a Commissioning Manager, leads for organisational development, communications and engagement, a business management, and data analysis capacity. The office also includes, dental, optometry and pharmacy clinical advisory capacity. Neighbourhood Care Network Office capacity is supported by funding from the Strategic Programme for Primary Care and supports Neighbourhood Care Network development and related clinical service design.

56 At present and as identified above, resources supporting primary care transformation are separate to core primary care practice support which may mean that overall capacity is not being used to full effect. In reviewing the function and resource levels of the Support Team, the Primary Care Sustainability Board should

[4] The Health Board introduced the Merger Incentive Scheme in 2018 in order to support practices with smaller population list sizes to reach the necessary critical mass required to deliver the most effective and sustainable services.

consider opportunities to bring operational and transformational resources together in a more integrated way to strengthen resilience and optimise resources.

Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Neighbourhood Care Network's plans from 2020 onwards. • Health Board Integrated Medium Term Plans. • Cluster Annual Plans. • Relevant primary care focussed Board and Committee papers. • Papers relating to the April 2023 Board Development Session. • Patient Quality Safety and Outcomes Committee agenda and papers. • Relevant Internal Audit Reports including reports on NCNs, and Tredegar and Newport Health and Wellbeing Centres. • Self-Assessment. • Collaborative leadership development resources. • Organisational/divisional structures. • Relevant Executive team briefings.
Interviews	We interviewed the following: • Executive Director of Primary Care (prior to restructure). • Assistant Director of Primary Care. • Consultant in Public Health. • Lead Independent Member for Primary Care. • Head of Primary Care. • Deputy Medical Director.
Observations	We observed the Board Development session focussing on primary care in April 2023.

Appendix 2

A summary of progress against our 2019 recommendations

Exhibit 4 sets out the recommendations we made in 2019 together with our summary assessment of progress in 2023.

Exhibit 4: our recommendations from 2019

Recommendation	Progress
Recommendation R1a Calculate a baseline position for its current investment and resource use in primary and community care.	**Ongoing** – See paragraph 26
Recommendation R1b Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	**Ongoing** – See paragraph 27
Recommendation 2 The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care and publishing an annual report on primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 3a Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 3a Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 3b Review the frequency with which Board and committees receive performance reports regarding primary care.	**Ongoing** – See paragraphs 43 to 49

Recommendation	Progress
Recommendation 3c Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 4a Work with the NCNs to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.	**Ongoing** – See paragraph 30
Recommendation 4b Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs.	**Ongoing** – See paragraph 30
Recommendation 4c Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	**Ongoing** – See paragraph 31
Recommendation 4d Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	**Implemented** – See paragraph 32
Recommendation 5a Review the relative maturity of NCNs, to develop and implement a plan to strengthen its support where necessary.	**Implemented** – See paragraph 36
Recommendation 5b Review the membership of NCNs and attendance at NCN meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	**Implemented** – See paragraph 36

Recommendation	Progress
Recommendation 5c Clarify and publicise the governance and leadership arrangements for NCNs, to ensure better understanding of the responsibilities for decision-making.	**Implemented** – See paragraph 37
Recommendation 5d Ensure all NCN leads attend the Confident Primary Care Leaders course.	**Implemented** – See paragraph 38
Recommendation 5e Consider introducing a locum NCN lead post, to work across all NCNs providing additional capacity and backfill for leads. The post could also be valuable in sharing learning across NCNs.	**Superseded** – See paragraph 39

Appendix 3

Organisational response to audit recommendations

Exhibit 5 below sets out the Health Board's response to our audit recommendations.

Recommendation	Organisational response	Completion date	Responsible officer
Recommendation R1 a) Calculate a baseline position for its current investment and resource use in primary and community care. b) Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	The baseline position for investment and resource in Primary and Community Care has been calculated and this has remained consistent across financial years. Work is ongoing to right size the offer in the community in order to divert demand away from acute.	**September 2024**	**Director of Finance**

Recommendation 2 The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care and publishing an annual report on primary care.	The Health Board's Integrated Medium-Term Plan is based on the life course approach and consequently includes key priorities for primary care to integrate across the whole health care system. Monitoring of the Primary Care related elements of the IMTP follow the same format as other areas, including Executive chaired monthly assurance meetings, mid-year reviews, end of year reviews and issue led discussion at Executive Team, Health Board and other committees. The Division has been invited to lead a number of Board development sessions over the past 12 months, notably the presentation of the Primary Care Sustainability plan, which includes the expansion of the primary care academy and is key in ensuring the workforce of the future. The weekly Executive Team meeting provides a forum to discuss any issues across the operational divisions, and primary care features regularly on the agenda. This will include updates from the primary care contracting team reporting on GP and other independent contractor changes. A potential risk that Primary Care could lose profile at Board level due to re-structure and cessation of the Executive Director for Primary Care post. However, stability has been brought to the Primary Care & Community Services Division through substantive appointment of a new Divisional Director with presence at senior committees within the HB. Welsh Government no longer requires the Health Board to submit an annual plan for primary care, however a report is produced for internal purposes.	**Actions complete and will continue ongoing**	**Director of Corporate Governance/ Divisional Director Primary and Community**

Recommendation 3 a) Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care. b) Review the frequency with which Board and committees receive performance reports regarding primary care. c) Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care.	As with the other operational Divisions, Primary Care forms part of the Health Boards regular agendas across the various Committees and Boards. The Divisions performance is reported as part of the overarching reporting against the IMTP and is presented to each formal Board meeting and the Finance and Performance Committee. The Primary Care Division will be updating the Health Board at the April Development session to report on progress against the sustainability workstream. There is work ongoing to integrate the Divisions data into the Performance Report for the Finance & Performance Committee. Initially this will be a minimum data set with plans to expand reporting in the future. Ad hoc / topic specific reports are requested and shared with the Executive Team / Board on a regular basis.	**Action complete and will continue ongoing** **April 2024** **December 2024**	**Director of Corporate Governance/ Divisional Director Primary and Community**

Recommendation 4a a) Work with the NCNs to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models. b) Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs. c) Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	NCN project evaluation framework has been established. There have been some successes in terms of substantiating services previously funded by NCNs to release funding back into new initiatives. This includes conversion of many practice-based pharmacists to practice-employed status and cessation of funding of direct-access physiotherapy / first contact physiotherapists with the advent of the MSK Hub. Plans being put in place to utilise *Building Capacity through Community Care: Further Faster* funding to scale up other successful projects, such as care home in-reach. Some other initiatives requiring resolution, including future funding of Psychological Wellbeing Practitioners. Significant work has been undertaken to understand the implications of an alternative skill mix model for primary care. Costed workforce plans are being developed with support from Corporate Workforce Team – funded via Strategic Programme for Primary Care. Workforce modelling has indicated the scale of the problem with insufficient training being commissioned by HEIW. The Health Board has subsequently agreed to invest funding – as a cost pressure – into an expanded Primary Care & Community Academy, in agreement that a sustainable future funding model is a priority.	**Actions complete and will continue ongoing**	**Director of Primary & Community Services**

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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Archwilio Cymru
Audit Wales

Review of Workforce Planning Arrangements – Aneurin Bevan University Health Board

Audit year: 2023

Date issued: January 2024

Document reference:

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Contents

Summary report

Introduction 4

Key findings 5

Recommendations 7

Detailed report

Our findings 9

Appendices

Appendix 1 - audit methods 20

Appendix 2 – selected workforce indicators 22

Appendix 3 – organisational response to audit recommendations 28

Summary report

Introduction

1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists (A Picture of Healthcare, 2021). In nursing alone, the Royal College of Nursing Wales reported 2,900 vacancies in their 2022 Nursing in Numbers analysis. In addition, the social care sector is also facing its own workforce issues. The pandemic exacerbated these challenges as the health sector looks to recover services.

2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.

3 National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long term. But there are a range of complex factors which impact on planning assumptions, these include:

- workforce age profile, retirement, and pension taxation issues;
- shifts in attitudes towards full and part-time working;
- developing home grown talent and the ability to attract talent from outside the country into Wales; and
- service transformation which can change roles and result in increasing specialisation of roles.

4 At the time of writing this report, Aneurin Bevan University Health Board (the Health Board) continues to face significant workforce challenges. There are high staff vacancy rates that are creating greater workload pressures and over-reliance on bank and agency staff. In 2022-23, the Health Board workforce spend was £781.25 million which is a 36% increase over the previous five years.

5 The key focus of our review has been on whether the Health Board's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Health Board's strategic approach to workforce planning, operational action to manage current and future workforce challenges, and monitoring and oversight arrangements. Operational workforce management arrangements, such as staff/nurse rostering and consultant job planning, fall outside the scope of this review.

6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

7 Overall, we found that **the Health Board has set clear workforce priorities based on a good understanding of its significant risks. It is working hard to address its immediate workforce challenges and its key actions are appropriately aligned to its agreed People Plan. However, the approach is over-emphasising the short term and operational fixes. There is a clear need to revisit Clinical Futures implementation plans so that they enable the development of financially affordable, efficient, and sustainable service workforce models.**

Key workforce planning challenges

8 The Health Board is facing significant workforce challenges as outlined in paragraph 4. The workforce indicators presented in **Appendix 2** highlight that workforce numbers have increased steadily over the past 5 years but plateauing over the past 2 years **(Exhibit 6)**. Despite the increases, the Health Board continues to face significant workforce challenges that impact on service stability. Its proportion of workforce vacancies at 5.4% are relatively low compared to other health boards but will still be challenging to manage in some key areas **(Exhibit 10)**. Whilst overall joiners exceed leavers **(Exhibit 9)** the reverse is true in two critical categories of nursing and midwifery, and medical and dental professions. This helps to account for the sharp rise in the use of agency staff, which cost the Health Board just over £61 million in 2022-23, further exacerbating an already pressured financial situation **(Exhibit 8)**. Comparatively, the Health Board's staff turnover is high but also in line with comparable health boards at 10.5%. A sickness rate of 6.9%, whilst in line with other health boards, still presents a significant workforce issue in terms of days lost **(Exhibit 11)**.

Strategic approach to workforce planning

9 **The Health Board has a good understanding of its strategic workforce challenges, it is improving data to support workforce planning and is engaging well with its key stakeholders. However, there is a clear need for it to develop workforce plans that support long-term financially sustainable service models.**

10 The Health Board has a good understanding of strategic workforce challenges and the organisation's workforce strategy, and high-level plan are focussed on addressing current, short to medium term workforce risks. The Health Board clearly articulates its strategic workforce ambition through annual plans, the Integrated Medium-Term Plan (IMTP) and the People Plan. However, the Health Board needs to ensure there is sufficient focus on long-term sustainable service workforce models, linked to refreshed Clinical Futures[1] plans.

[1] Clinical Futures is the Health Board's plan for sustainable health and care services including priority programme areas for the whole of Gwent; emphasizing prevention and care closer to home.

11 The Health Board has a good understanding of its current issues demonstrating some examples of good analysis to anticipate future workforce demand. However, as a minimum it needs to ensure it updates its funded establishment to help inform the development of workforce plans. The Health Board is also engaging and collaborating effectively with its internal and external partners to help resolve current and anticipated future workforce challenges.

Operational action to manage workforce challenges

12 **The Health Board is working hard to address the immediate workforce challenges but is not giving sufficient attention to workforce redesign and service transformation. Whilst the Health Board clearly understands its principal risks around recruitment, retention, and sustainability, it is not undertaking longer-term workforce planning and actions for measurable impact that need to underpin a resilient and sustainable workforce.**

13 The Health Board has a reasonable level of central resource to support workforce planning, which has enabled it to support areas such as nursing and some medical workforce planning. There is a need for wider service-based workforce planning to ensure financially sustainable service models that also enable improvement in performance. The Health Board plans to re-establish the Clinical Futures Workforce Group, which should help it to progress the work needed. However, there is also a need to ensure sufficient wider capacity and capability across the organisation.

14 The Health Board clearly understands its short and longer-term risks. It has a reasonable approach for managing its immediate workforce challenges, which include vacancies, recruitment and retention challenges and associated agency use. However, it needs to ensure improvement actions are having the desired impact.

Monitoring and oversight of workforce plan/strategy delivery

15 **There is appropriate Board, Committee and Executive level scrutiny of the Health Board's People Plan, but the reports need to better describe the progress it is making and the impact it is achieving.**

16 The Board and People and Culture Committee receive regular reports that provide assurance on the progress of key workforce actions. While the reports are well articulated, there is a need to ensure that they provide effective assurance on the impact that delivery of the People Plan is achieving, the effectiveness of actions taken to mitigate workforce risks and progress of Clinical Futures workforce plans. There is also scope to benchmark more broadly with individual organisations and regional approaches that are 'best in class', subject to ensuring similar system conditions, demographics and population characteristics make the comparisons valid.

Recommendations

17 **Exhibit 1** details the recommendations arising from this audit. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Workforce plans R1 While the Health Board has a three-year People Plan, the current approach to strategic workforce planning is not balanced and instead biased towards shorter term transactional workforce solutions. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board should update its 5 and 10-year planning process, including clinical futures plans and workforce projections to ensure that they appropriately support the implementation of financially sustainable service models. (**High priority**)
Workforce funded establishment R2 The Health Board does not have an agreed funded establishment that covers all its services. The Health Board should determine its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually. (**High priority**)
Workforce planning capacity R3 Medium to long-term service workforce modelling is out of date and is needed to inform sustainable clinical service models. The Health Board should review their central workforce planning capacity and capability to ensure it is sufficient to support their longer term strategic and operational workforce planning requirements. (**High priority**)
Workforce planning training R4 We found that the Health Board had workforce planning training and support, particularly in relation to the opening of GUH, however this was paused during the pandemic and it now needs to recommence. The Health Board should develop and implement a programme of workforce planning training and once in place create an evaluation framework to measure the success of its training programme. **(High priority)**

Recommendations

Programme infrastructure for strategic workforce priorities

R5 The Health Board is intending to update its strategic priorities, linked to a review of its Clinical Futures approach. While it is re-establishing a Clinical Futures Workforce Group there is insufficient programme infrastructure to support service workforce redesign. Once the Health Board has revised its sustainable Clinical Futures models, it needs to ensure there is a workforce programme to support the necessary redesign and service transformation. (**High priority**)

Reporting on the impact of the People Plan

R6 The People Plan update reports provide a reasonable coverage of the actions and meetings that have taken place since the last update. However, there needs to be greater assurance provided on the impact of delivery of the People Plan (i.e., the extent that it is making a difference). The Health Board should clearly structure its People Plan updates to better describe the impact that delivery is having. (**High priority**)

Benchmarking

R7 Whilst the Health Board benchmarks with other health bodies in Wales, there is potential to benchmark with 'best in class' organisations and clinical models from outside of Wales. The Health Board should look to use benchmarking to inform plans for workforce redesign and service transformation ensuring similar system conditions, demographics and population characteristics make their comparisons valid. (**Medium priority**)

Detailed report

Our findings

18 The following three tables set out the areas that we have reviewed and our findings. These focus on:

- the Health Board's approach to strategic workforce planning (**Exhibit 2**);
- operational action to manage workforce challenges (**Exhibit 3**); and
- monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: strategic approach to workforce planning

19 This section focuses on the Health Board's approach to strategic workforce planning. Overall, we found that **the Health Board has a good understanding of its strategic workforce challenges, it is improving data to support workforce planning and is engaging well with its key stakeholders. However, there is a clear need for it to develop workforce plans that support long-term financially sustainable service models.**

What we looked at	What we found
We considered whether the Health Board's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: • identifies current and future workforce challenges. • has a clear vision and objectives.	We found that **the Health Board's workforce strategy and high-level plan are focussed on addressing current, short to medium term workforce risks. Given the significant financial and service pressures, the Health Board needs to do more to ensure workforce plans effectively enable long-term sustainable service workforce models.** The Health Board has aligned its Annual Plan and IMTP with its three-year People Plan which covers the period 2022 to 2025. The People Plan sets out a reasonable high-level vision. Its three core objectives focus on Staff Health & Wellbeing, an 'Employer of Choice' and creating opportunities for workforce sustainability and transformation. It is supported by 22 high-level

What we looked at	What we found
• is aligned to the organisation's strategic objectives and wider organisational plans. • is aligned to relevant national plans, policies, and legislation. Including the national workforce strategy for health and social care. • is supported by a clear implementation plan.	supporting actions. The Plan and outline delivery framework included plans for a refreshed Workforce and Organisational Development Dashboard. The Plan highlights some longer-term aspirations, although these generally have only a 3-year outlook. The Plan appropriately considers wider national plans and legislative requirements including the National Workforce Strategy for Health and Social Care, Well-being of Future Generations Act and Welsh Language standards. However overall, there appears to be a lack of long-term thinking in the People Plan. The current approach to strategic workforce planning is however not balanced and instead biased towards shorter-term and transactional workforce solutions. There is currently insufficient focus and detail on what innovation and workforce transformation will look like. Profession-based strategic workforce plans are in different states of development. Most Clinical Futures workforce implementation plans, while having a 5-year timeline, are out of date and need updating. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board clearly needs to strengthen how it models and plans its workforce to ensure its services are sustainable in the medium to long-term (**Recommendation 1**).
We considered whether the Health Board has a good understanding of current and future service demands. We expected to see: • use of reliable workforce information to determine workforce need and risk in the short and longer term; and • action to improve workforce data quality and address any information gaps.	We found that **the Health Board has a good understanding of its current issues, demonstrating some examples of good analysis to anticipate future workforce demand. However, there needs to be a far clearer understanding of the Health Board's workforce establishment to help inform the development of workforce plans.** The Health Board has a good understanding of short-term demands and service trends. Workforce planning and demand-based forecasting is more mature in nursing, than in other areas, with workforce projections of up to 5 years in some cases. In general, the Health Board's use of workforce information, and the expertise to analyse it, appears reasonable. The Health Board uses a range of workforce and organisational development (OD) metrics which it has incorporated into data dashboards and infographic summaries. These include recruitment, staff engagement and training

What we looked at	What we found
	metrics. We particularly noted robust operational nursing information that is helping the Health Board to understand the extent that it is complying with the Nurse Staffing Levels (Wales) Act 2016. The Health Board is using its analysis to inform its work on medical staffing, which is seeking to determine its medical workforce establishment[2], job planning[3] and rostering. However, the Health Board needs to do much more to fully determine its required establishment levels across the wider workforce (**Recommendation 2**). Current high-level organisational data including key metrics is available through its workforce performance dashboard. However, we have noted inconsistencies in the way some professions or groups of staff are coded. The Health Board is taking appropriate steps to refine its data quality noting that many issues are common across NHS Wales. Our work also indicated that workforce planning tools do not appear to be the most up to date (excel dominated) which makes is difficult to inform development of workforce establishment and support operational decision making. Nevertheless, the Health Board is taking action to improve its processes.
We considered whether the Health Board is working with partners to help resolve current and anticipated future workforce challenges. We expected to see: • effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues; and	We found that **the Health Board is working effectively with its internal and external partners to help resolve current and anticipated future workforce challenges.** The Health Board has good approaches for ongoing and proportionate engagement with internal stakeholders including via business partners. The Health Board engages with the Local Partnership Forum, although some of the feedback we received suggested relationships with Trade Unions were consultative rather than proactively engaging in shared solutions. The Health Board has implemented its #PeopleFirst/#CynnalCynefin staff engagement initiative over the past 2 years. It appropriately acknowledges and addresses challenges experienced by Health Board staff.

[2] Establishment is the term for the workforce levels, staff roles and the NHS staff bandings that are financially budgeted for.

[3] A job plan is a prospective, agreement that sets out consultant duties, responsibilities, accountabilities, and objectives for the coming year.

What we looked at	What we found
• shared solutions identified with key stakeholders to help address workforce challenges.	Engagement events across hospital and community sites have enabled hundreds of staff to share their challenges, leading to positive feedback from staff. Senior management are working appropriately with external partners especially within community and primary care including action on Accelerated Cluster Development. As a result, cluster plans are helping to shape wider community services, appropriately supported by intelligence on the overall sustainability of the community-based workforce. The Health Board is also engaging appropriately with external partners such as Health Education and Improvement Wales (HEIW) to develop workforce solutions. It is collaborating with HEIW on the development of the Health Board's Nursing Strategy and commissioning student education. Nevertheless, we understand that the Health Board could strengthen relationships with academia. The Health Board needs to continue to build closer university partnerships to ensure effective commissioning of student places, quality of placements and support joint academic and NHS research and innovation posts. This should support recruitment and retention of key staff across acute, primary and community services. However, there is opportunity to strengthen the approach with external partners to find shared solutions for recruitment and on wider systemic workforce transformation. There are examples where this is starting to progress with a renewed commitment to new regional care models and workforce plans. In August 2022, Aneurin Bevan, Cardiff and Vale, and Cwm Taf Morgannwg University Health Boards, renewed their commitment to regional working. The resulting four work programmes, of which Aneurin Bevan University Health Board will lead on ophthalmology, will require careful consideration. The current approach for regional service planning is not sufficiently considering how it will maximise the benefits of truly integrated working. Our review of the ophthalmology proposals, for example are based on co-terminus regional services rather than developing an integrated, resilient, and efficient regional model. The work should explore fully integrated and efficient design of the workforce and services so as not to replicate existing inefficiencies within a new regional treatment setting.

Exhibit 3: operational action to manage workforce challenges

20 This section focusses on the actions that the Health Board is taking to manage workforce challenges. **The Health Board is working hard to address the immediate workforce challenges but is not giving sufficient attention to workforce redesign and service transformation. Whilst the organisation clearly understands its principal risks around recruitment, retention, and sustainability, it is not undertaking longer-term workforce planning and actions for measurable impact that need to underpin a resilient and sustainable workforce.**

What we looked at	What we found
We considered whether the Health Board has identified sufficient resources to support workforce planning over the short, medium, and long term. We expected to see: • clear roles and responsibilities for workforce planning; • appropriately skilled staff to ensure robust workforce planning; • sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan; and • sufficient financial resources to deliver the workforce strategy or plan.	We found that **while having reasonable central resources to support workforce planning, the Health Board does not have sufficient dedicated capacity and capability to support medium to long-term workforce planning. This will be increasingly difficult in the current financially challenging environment.** The Health Board needs to review its overall workforce planning resource. It has a reasonable corporate workforce structure and capacity committed to delivering the high-level workforce plans. This work comes under the Director of Workforce and OD and is supported by an Assistant Director of Workforce, Head of Workforce Planning and a support role. However, this forms one element of their respective roles. Workforce planning sits within the remit of the business partners and again that is only part of their job. The lack of a dedicated resource is a barrier to more detailed workforce planning. With a total annual pay cost of around £800 million and over 12,500 WTE[4] staff, there is a clear need to create sufficient workforce planning capacity and capability across the organisation. At present there is no overarching costed and resourced strategic workforce implementation plan and the Health Board need to assure themselves they have committed sufficient resources to deliver this. (**Recommendation 3**).

[4] Whole time equivalent equates to the number of staff in place if they were working a full week. Because some staff work part time, the actual headcount is higher.

What we looked at	What we found
	The Health Board clearly demonstrated prior to the pandemic that it had the capability and capacity to deliver detailed workforce plans across key service areas. During and since the pandemic, resourcing appears to have prioritised nursing in line with the Nurse Staffing Levels (Wales) Act requirements. Aspects of medical and dental workforce planning is ongoing and in varying states of maturity. However, a number of the service workforce plans provided in evidence were out-of-date, suggesting that current workforce planning capacity beyond the short term is not sufficient. In addition, there was no evidence of current workforce planning training programmes for staff (**Recommendation 4**).
We considered whether the Health Board has a good understanding of the short and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • a good understanding of the barriers that might prevent delivery of the workforce strategy or plan; • plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions; and • clearly documented workforce risks that are managed at the appropriate level.	We found that **the Health Board clearly understands its short and longer-term risks. However, to date, actions to mitigate these risks appear to have had only a limited effect.** The Health Board clearly and sufficiently identifies its workforce risks in its strategic and corporate risk registers including internal controls in place and regular updates on high-level actions undertaken. Its strategic risks include recruitment and retention, staff well-being, effective leadership, and risk of industrial action. Divisional management and workforce groups regularly review separate workforce and organisational development risk registers prior to reporting into the Health Board's People and Culture Committee. The Health Board could better define actions to mitigate workforce risks to focus more on the likely difference it expects to achieve. While the Health Board manages its workforce risks through its risk management arrangements, the trend over time demonstrates that despite action to mitigate risks, they remain largely static. This suggests that a more proactive approach is needed to ensure that workforce risk mitigation actions are impactful, and an agile response is in place to address under-performance. It also seems unlikely that the Health Board can sustainably address its risks without stronger consideration of long-term risks and solutions.

What we looked at	What we found
	The Corporate risk register also appropriately identified workforce risks in other key areas. For example, the Medical Training Risk Register Report provides joint assurance to HEIW and the General Medical Council (GMC) regarding the quality of medical training within the Health Board. Risk logs, containing relevant information from various sources including the GMC survey and trainees themselves, are issued by HEIW to health boards for monitoring and investigation. The Health Board's Medical Education Faculty monitors and investigates concerns identified in the risk log to ensure medical training quality. The risk log provides a useful opportunity for open and transparent conversations between HEIW and the Health Board to review and improve the quality of medical education and training.
We considered whether the Health Board is effectively addressing its current workforce challenges. We expected to see: • effective reporting and management of staff vacancies; • action to improve staff retention; • efficient recruitment practices; • commissioning of health education and training which is based on true workforce need; and • evidence that the organisation is modernising its workforce to help meet current and future needs.	We found that **the Health Board has a reasonable approach for managing its immediate workforce challenges, which include vacancies and associated recruitment and retention challenges, and associated agency use. However, it needs to ensure improvement actions are having the desired impact.** The Health Board is also clearly facing financial risks and pressures. Vacancies continue to impact on current service delivery contributing to high use of agency staff and associated costs. The Health Board launched its variable pay reduction programme in September 2022 with an aim of reducing agency workforce use, and particularly more expensive off-contract agency. We understand that the Health Board has achieved a reduction of around 50 WTE agency nurses and over 210 agency healthcare support workers. The Health Board is planning to reduce agency costs to £38 million in 2023-24, but the current trend of agency spend (to August 2023) suggests that total agency expenditure could reach £50 million this year. Proportionately vacancy levels in the Health Board appear to be lower than most other health bodies in Wales with a vacancy rate of 5.4% (**Exhibit 10**). However, the absence of verified establishment figures impacts the reliability of reported vacancy levels. At the same time, there is also a risk that if

What we looked at	What we found
	the Health Board implements wider recruitment control to help it achieve efficiencies, then it may have less capacity to respond to increased service demand, for example responding to winter pressures. This could ultimately result in greater short-term demand for agency staffing. The Health Board is in the process of developing and implementing approaches to improve staff retention, but clearly there is more to do. The Health Board has set up a Retention Working Group and is starting work to understand the causes of staff seeking to leave and put in place preventative approaches, analyse themes arising from exit interviews, and develop a dashboard to track organisation retention. Our analysis indicates a small improvement in turnover between 2021-22 and 2022-23. The Health Board has introduced Chat Cafés for staff to share their experiences, retention roadshows and is actively seeking feedback, particularly from those who have recently entered the organisation, and those that have or are in the process of leaving. The Health Board has identified the risks that might prevent it achieving meaningful improvement in retention and additional action to mitigate those. The Health Board has a range of recruitment approaches in place including an apprentice scheme, a Registered Nurse recruitment programme of events along with nationally led recruitment programmes Train, Work, Live and the Royal College of Nursing (RCN). The Health Board also continues to monitor safe staffing levels (periodically) as part of the Nurse Staffing Act which the Executive Director of Nursing reports on. As a result of concerns about the ability to domestically recruit sufficient staff to fill all vacancies, the Health Board is continuing overseas nurse recruitment. Despite its recruitment and retention initiatives, the Health Board continues to struggle to reduce vacancy levels with 148 medical vacancies and 285 nurse vacancies, and a total vacancy level of around 700 WTE as of July 2023. The Health Board has a reasonable approach for determining its healthcare education needs. Services consider their potential future workforce requirements, which informs the HEIW national education and training plan. As we have seen in some other bodies, the number of graduate appointments recruited into the Health Board falls short of the numbers required. External factors,

What we looked at	What we found
	such as the ability of universities to recruit into programmes, course attrition rates, are outside of the Health Board's control. The ability of the Health Board to attract new graduates and changes in service demand over the period that students are training will also have an impact. As identified earlier, there is a need for the Health Board to develop medium to long-term sustainable service models. This may have a significant impact on the future configuration of the Health Board's workforce. We have seen positive but incremental examples of advanced practitioners, extended scope professionals and support roles being introduced. The Health Board is intending to update its strategic priorities, linked to a review of its Clinical Futures approach. While it is re-establishing a Clinical Futures Workforce Group there is insufficient programme infrastructure to support service workforce redesign. There is a need for a more ambitious approach to workforce modernisation through a coordinating structure to help address longer-term financial pressures and service demand (**Recommendation 5**).

Exhibit 4: monitoring and oversight of workforce plan/strategy delivery

21 This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **there is appropriate Board, Committee and Executive level scrutiny of the Health Board's People Plan, but the reports need to better describe the progress it is making and the impact it is achieving.**

What we looked at	What we found
We considered whether delivery of the Health Board workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see: • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels; • effective action where progress on elements of the workforce strategy or plan are off-track; • performance reports showing the impact of delivering the workforce strategy or plan; and • the organisation benchmarking its workforce performance with similar organisations.	We found that **there is appropriate scrutiny of key strategic workforce activity by the Board, the People and Culture Committee and management. The Board has good monitoring structures and processes, but there is a need to ensure that reports provide stronger assurance on the impact that delivery of plans is achieving.** The People and Culture Committee has the lead role for strategic workforce planning including overseeing progress, assuring, and advising the Board. The committee has a well-rounded agenda that covers a good breadth of workforce matters. The committee routinely oversees the progress of the People Plan, however the People Plan update reports to committee need strengthening. The People Plan update reports provide a reasonable coverage of the actions and meetings that have taken place since the last update. However, there clearly is a need to provide greater assurance on the extent that the People Plan is making a difference and enabling financially sustainable workforce service models (**Recommendation 6**). The report on progress also needs to be more evaluative and describe the difference that delivery of the plan is making. The issue above is also evident at a management level. Monitoring structures and processes appear robust supported by regular reporting, good dashboard information and sufficient 'RAG rated[5]' tracking of the progress of key actions. However, due to the variability in updating of workforce plans

[5] RAG – Red, Amber, Green is an approach often used for assessing risk or progress.

What we looked at	What we found
	in different service areas, it is hard to measure overall system impact and effectiveness. Opportunities also remain to increase the quality and detail of progress and corrective actions in areas of operational underperformance. For example, the impact of staff recruitment and retention actions in reports. This would then make it easier to demonstrate impact across all service areas and better illustrate progress in delivering the workforce strategy, thereby increasing Board assurance. The Health Board uses benchmarking with other Health Boards although this tends to be ad hoc and not used formally as part of service improvement. Consequently, there is an opportunity for a more systematic and evaluative approach to benchmarking against 'best in class' organisations and regional clinical models to drive transformation (**Recommendation 7**).

Appendix 1

Audit methods

Exhibit 5 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Workforce strategy and associated workforce plan(s) • Implementation/delivery plans for workforce strategy – high level and operational • Evidence of evaluation of workforce strategy and/or associated initiatives • Information feeding into workforce strategy development e.g., needs assessment, workforce data, benchmarking exercises, demand and capacity planning, skills gap analysis, horizon scanning • Evidence of stakeholder engagement. • Structure charts for workforce planning functions. • Examples of workforce planning training offered to staff e.g., CIPD, other training formal or informal • Workforce finance and resource plans • Corporate and operational risk registers • Document showing recruitment process and recruitment and retention initiatives • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery
Interviews	We interviewed the following: • Executive Director of Workforce & OD • Executive Director of Planning and Performance • Head of Workforce and OD • Assistant Director of Workforce

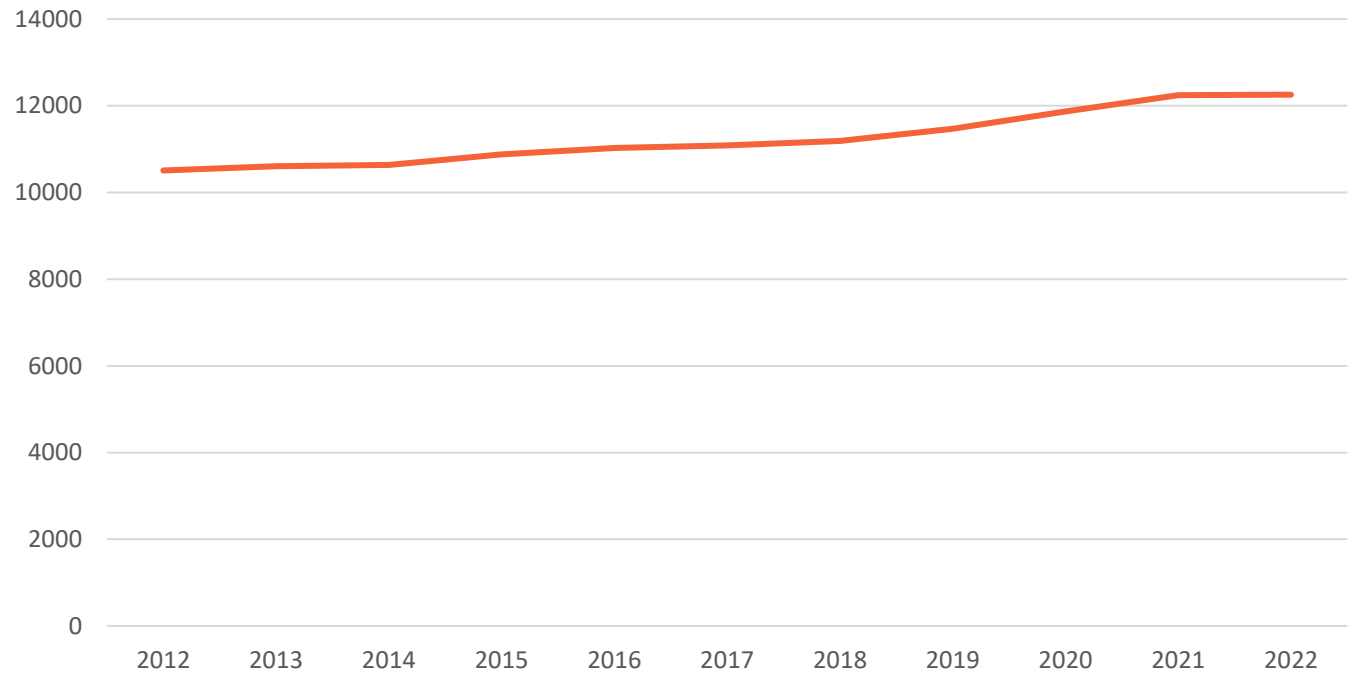
Element of audit approach	Description
	• Interim Assistant Director of Planning and responsible for ABCi[6] • Chair of People and Culture Committee • Deputy Director of Nursing (workforce, education, training, and development) • Deputy Medical Director for Secondary Care • Staff Side and Job Evaluation Lead • Head of Key Systems and Workforce Data
Focus groups	We ran a focus group with: • a selection of service leads involved in clinical workforce planning; and • a selection of service leads involved in the workforce planning of enabler services.

[6] ABCi is a small team of continuous improvement specialists who lead and support improvement across the Health Board.

Appendix 2

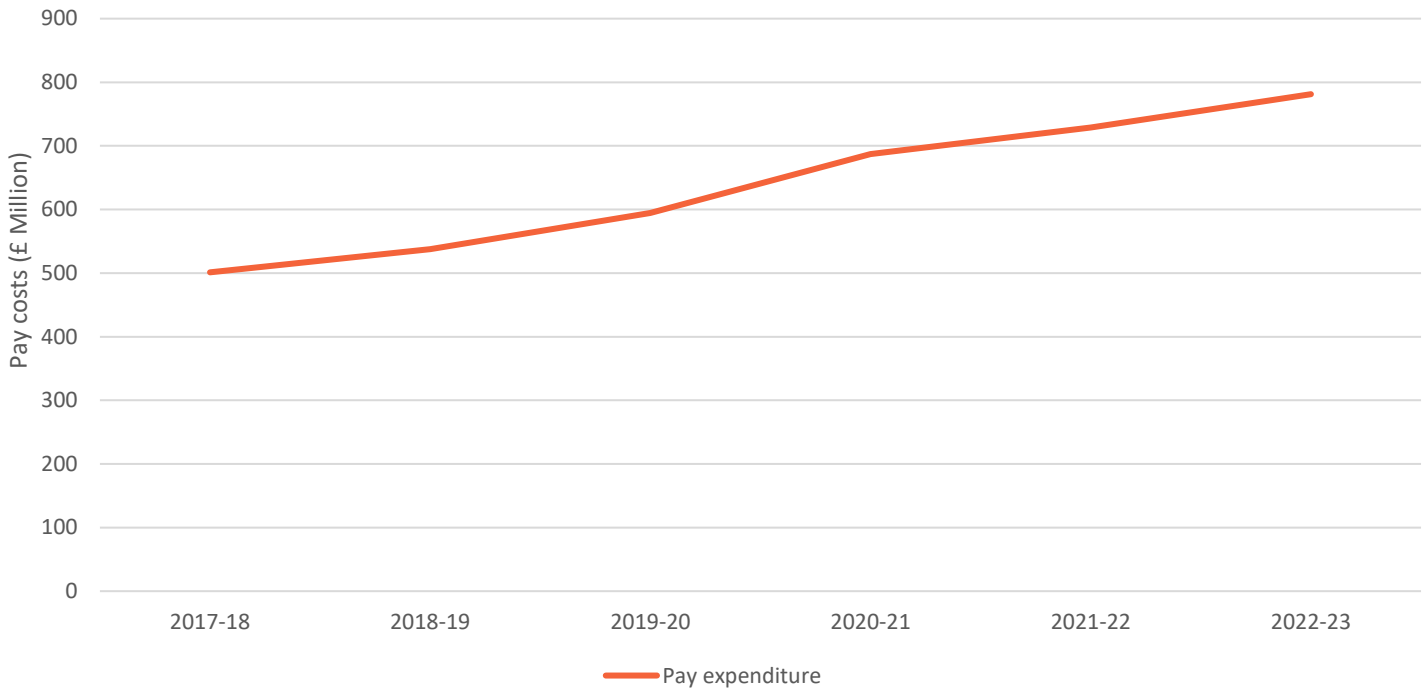
Selected workforce indicators

Exhibit 6: trend in workforce numbers (full time equivalent), Aneurin Bevan University Heath Board



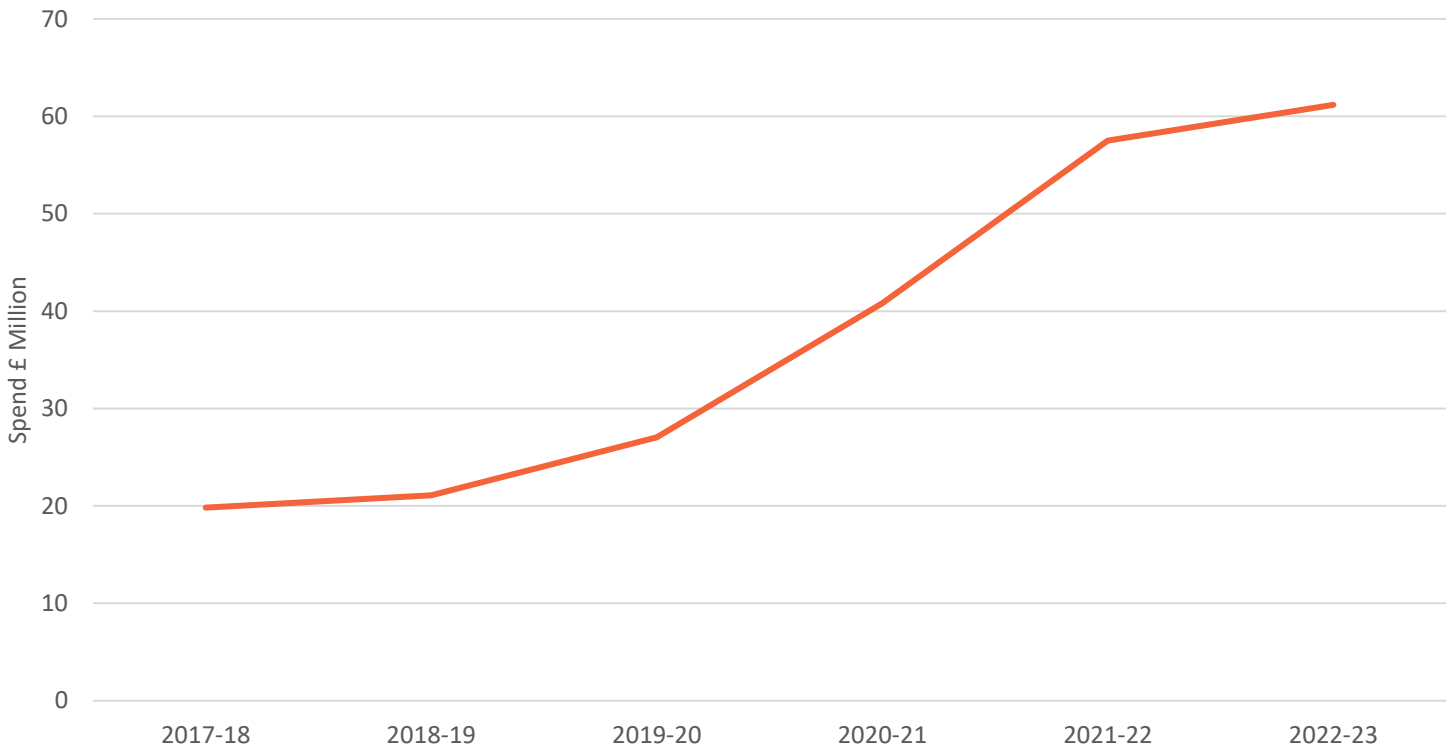
Source: Welsh Government, Stats Wales

Exhibit 7: trend in actual total workforce costs, Aneurin Bevan University Health Board



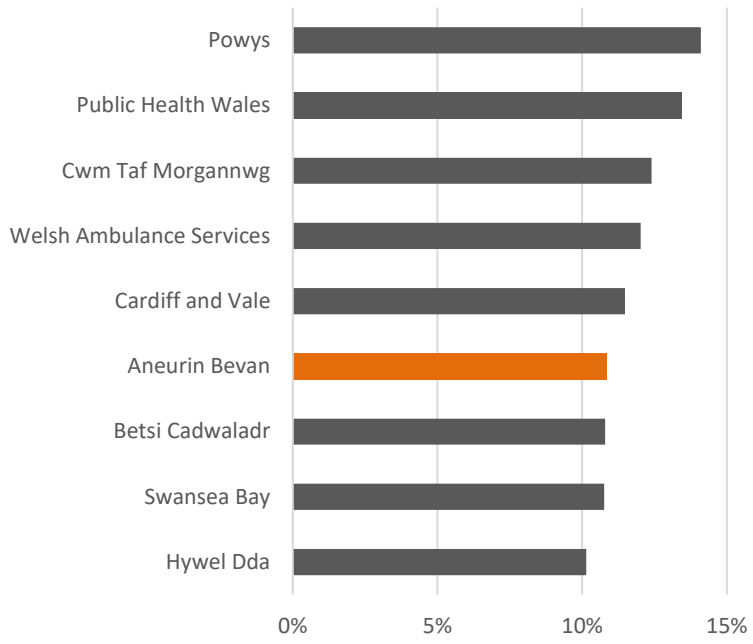
Source: Monthly Monitoring Returns reported to the Welsh Government

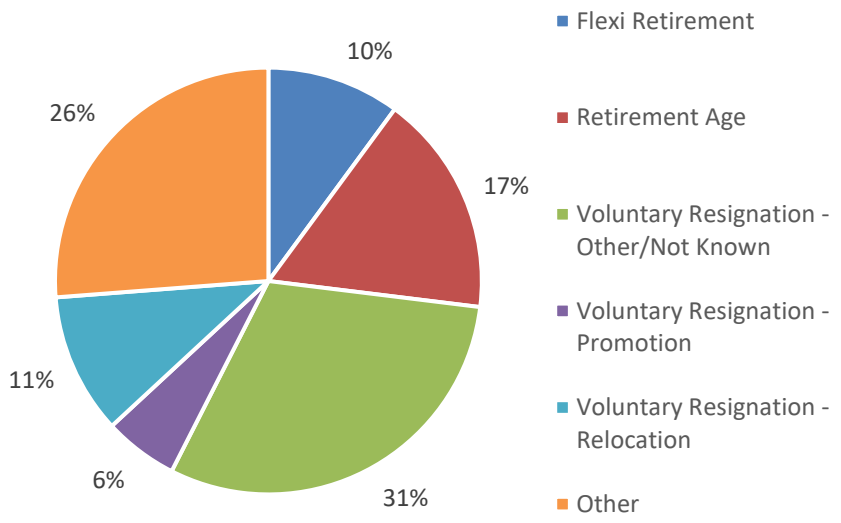
Exhibit 8: trend of expenditure on workforce agency £ million, Aneurin Bevan University Health Board



Source: Monthly Monitoring Returns reported to the Welsh Government

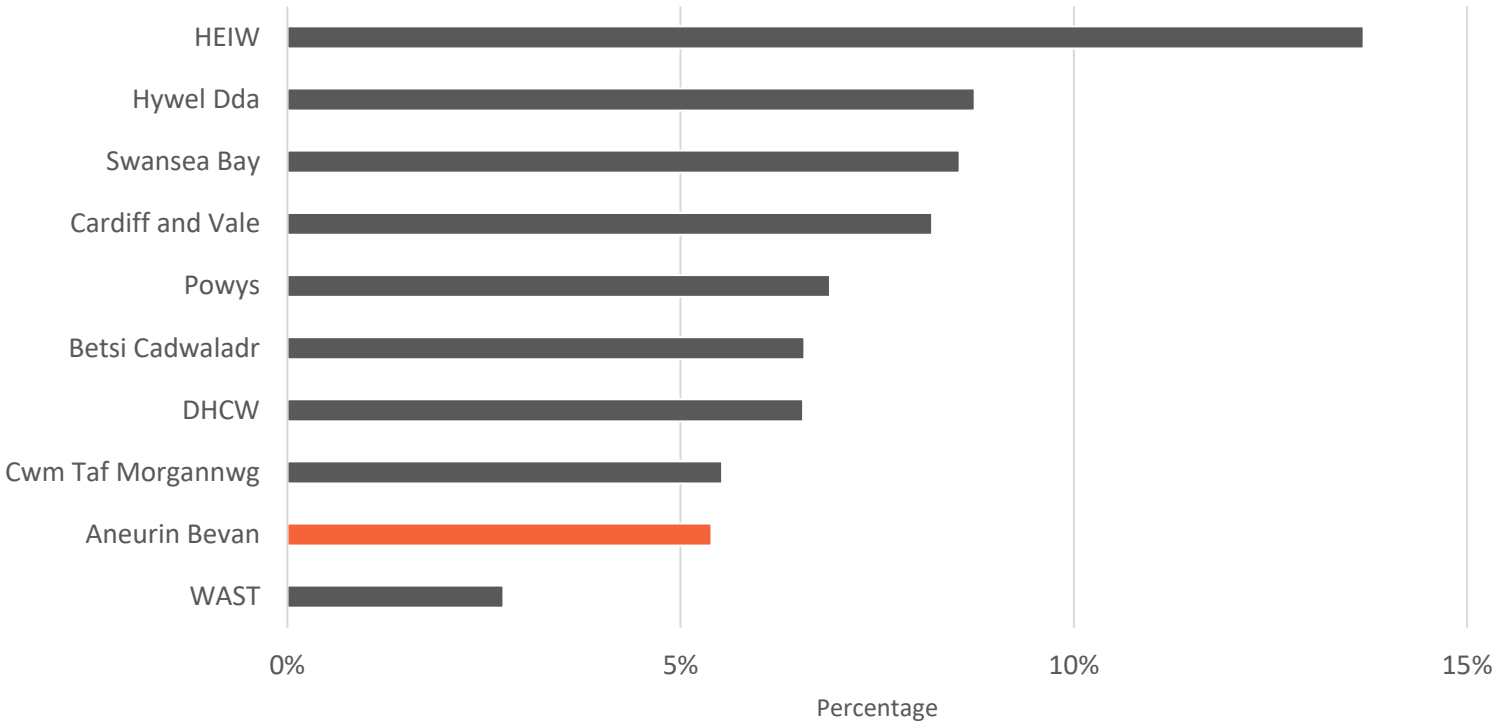
Exhibit 9: annual staff turnover and reason for leaving, 2021-22, and Reasons for Leaving 2021-22





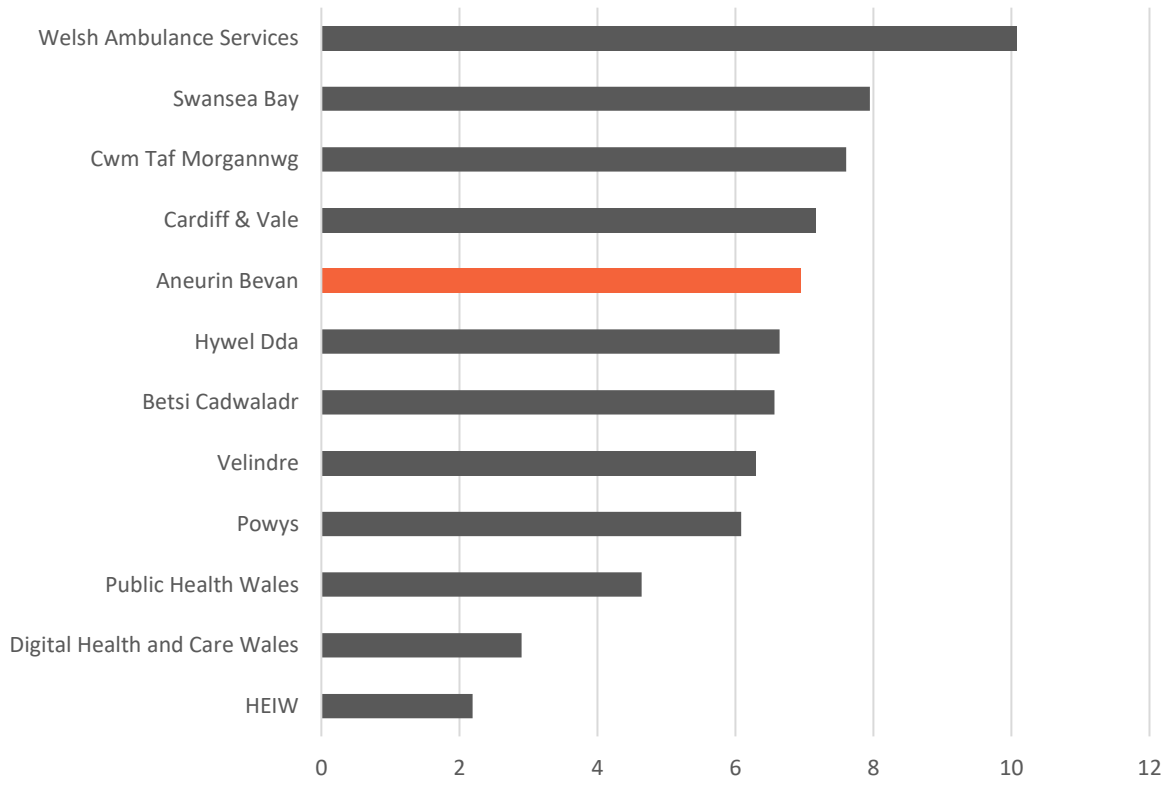
Source: Staff turnover data sourced from Health Education and Improvement Wales. Reason for leaving data sourced from health body data request.

Exhibit 10: vacancies as a percentage of total establishment, as of March 2022



Source: Health body data request

Exhibit 11: sickness absence by organisation, 2022.



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 12: Aneurin Bevan University Health Board's response to our audit recommendations.

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R1	While the Health Board has a three-year People Plan, the current approach to strategic workforce planning is not balanced and instead biased towards shorter term transactional workforce solutions. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board should update its 5 and 10-year planning process, including clinical futures plans and workforce projections to ensure that they appropriately support the implementation of financially sustainable service models. (**High priority**)	The Health Board is currently engaging and will be consulting on a renewed long-term strategy up to 2035 throughout 2024. This will involve developing the strategic outlook to inform and develop workforce planning. The refresh of the People Plan for 2025 will include strategic outlook to 5 and 10-year forecasts based on the work currently undertaken on census, demographics and population needs analysis assumptions. This is addition to development and implementation of National Workforce plans supported by HEIW and Health Board workforce strategies e.g., Nursing, Midwifery, School and Public Health Nursing Workforce Strategy 2023-2026.	December 2024 May 2025	Executive Director Workforce and OD

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R2	The Health Board does not have an agreed funded establishment that covers all its services. The Health Board should determine its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually. **(High priority)**	An All-Wales group has been established to support the implementation of setting funded establishments. The Health Board has commenced work in relation to establishing agreed funded establishments supported by the assistant Finance Director and Workforce Information teams. A targeted approach is being undertaken to support completion e.g., by staff groups. The implementation of the medical E-Systems programme will also support this from a medical workforce perspective.	Project plan to be considered by Executive Committee February 2024	Assistant Finance Director and Assistant Director of Workforce
R3	Medium to long-term service workforce modelling is out of date and is needed to inform sustainable clinical service models. The Health Board should review their central workforce planning capacity and capability to ensure it is sufficient to support their longer term strategic and operational workforce planning requirements. **(High priority)**	We continue to provide longer term planning alongside National Workforce Strategies being developed by HEIW. We will undertake a review of capability and capacity following an assessment of workforce planning requirements via the 2024 IMTP.	July 2024	Executive Director Workforce and OD
R4	We found that the Health Board had workforce planning training and support, particularly in relation to the opening of Grange University Hospital, however this was paused during the pandemic, and it now needs to recommence.	Plans are in place in provide formal training and education in line with the newly revised HEIW workforce planning competency frameworks. The Health Board will also be introducing workforce	Training for Clinical Directors The first of February 2024.	Executive Director Workforce and OD

Ref	Recommendation	Organisational response	Completion date	Responsible officer
	The Health Board should develop and implement a programme of workforce planning training and once in place create an evaluation framework to measure the success of its training programme. (**High priority**)	planning awareness into existing training management and leadership programmes.	Overarching plan to be developed for rollout of training March 24.	
R5	The Health Board is intending to update its strategic priorities, linked to a review of its Clinical Futures approach. While it is re-establishing a Clinical Futures Workforce Group there is insufficient programme infrastructure to support service workforce redesign. Once the Health Board has revised its sustainable Clinical Futures models, it needs to ensure there is a workforce programme to support the necessary redesign and service transformation. **(High priority)**	We agree that formal governance and programme arrangements are required to support the delivery of the Health Board Strategic priorities. The Workforce group has now been formalised to take forward the development and delivery of the workforce plans.	December 2024	Director of Workforce & OD via Clinical Futures Programme Board
R6	The People Plan update reports provide a reasonable coverage of the actions and meetings that have taken place since the last update. However, there needs to be greater assurance provided on the impact of delivery of the People Plan (i.e., the extent that it is making a difference). The Health Board should clearly structure its People Plan updates to	The People Plan deliverables are subject to scrutiny through People and Culture Committee with updates provided to the Board. The People Plan deliverable benefits and outcomes are also supported by a monthly reported Workforce dashboard.	April 2024	Executive Director Workforce and OD

Ref	Recommendation	Organisational response	Completion date	Responsible officer
	better describe the impact that delivery is having. **(High priority)**	We will look at different ways of time series measures over time to demonstrate outcomes and benefits where appropriate.		
R7	Whilst the Health Board benchmarks with other health bodies in Wales, there is potential to benchmark with 'best in class' organisations and clinical models from outside of Wales. The Health Board should look to use benchmarking to inform plans for workforce redesign and service transformation ensuring similar system conditions, demographics and population characteristics make their comparisons valid. **(Medium priority)**	We accept the recommendation to extend benchmarking and work with HEIW in this respect. The Health Board has a compendium of new roles to support and share good practice. The Health Board also has a dedicated intranet site signposting to HEIW sites which also have compendium of roles. It draws on national workforce benchmarking and research when formulating its service workforce plans. This is in addition to workforce standards set by legislation and through respective Professional Bodies.	December 2024	Executive Director Workforce and OD

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
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Archwilio Cymru
Audit Wales

Structured Assessment 2023 – Aneurin Bevan University Health Board

Audit year: 2023

Date issued: November 2023

Document reference: 3866A2023

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Contents

Summary report

About this report 4

Key findings 5

Recommendations 7

Detailed report

Board transparency, effectiveness, and cohesion 9

Corporate systems of assurance 14

Corporate approach to planning 18

Corporate approach to managing financial resources 21

Appendices

Appendix 1 – Audit methods 25

Appendix 2 – Progress made on previous-year recommendations 28

Appendix 3 – Organisational response to audit recommendations 32

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2023 structured assessment work at Aneurin Bevan University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Health Board's corporate approach to setting new well-being objectives in accordance with the sustainable development principle is being undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015

2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on Board transparency, cohesion, and effectiveness, corporate systems of assurance, corporate approach to planning, and corporate approach to financial management. We have not reviewed the Health Board's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between September 2023 and October 2023. The methods we used to deliver our work are summarised in **Appendix 1**.

5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6 **Given its financial and performance challenges, the Health Board needs a clear plan to set out how it will achieve financially sustainable service models. In general, Board and committee governance arrangements and the corporate arrangements for developing plans are reasonably effective. However, there is scope to provide clarity on both the impacts of actions set out in plans and actions taken to improve performance.**

Board transparency, effectiveness, and cohesion

7 We found that **Board and Committee arrangements are reasonably effective; however, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.**

8 Board and committees operate transparently, with appropriate discussions on key financial, performance, and quality challenges. However, there is opportunity to improve public access to committee meeting records. It could do this by ensuring that it livestreams or publishes recording of its committee meetings or publish unconfirmed committee meeting minutes shortly after meetings. The Health Board's committee structure is embedded, and meetings are well chaired. There are reasonably effective arrangements to support flows of assurance from the committees to the Board; however, the quality and timeliness of the information the Board and committees receive requires improvement. The Board is increasingly cohesive and demonstrating a commitment to continuous improvement through its board development programme, and Board and Committee effectiveness self-assessments. Arrangements to hear from patients, services users, and staff are improving.

Corporate systems of assurance

9 We found that **the Health Board is making good progress in developing and refining its systems of assurance. However, it will need to effectively embed new arrangements across the organisation to manage the finance, performance, and quality risks it faces.**

10 The Health Board is progressing work on its arrangements for monitoring risk, performance, and quality and safety of services. It is strengthening its risk management arrangements but needs to ensure that they are embedded across the organisation. The Health Board is implementing a new Performance Management and Accountability Framework, but it needs ensure that performance reports set out clearly the actions required to address underperformance and, where relevant, the impact of past actions taken. Its arrangements for tracking and monitoring outstanding audit and inspection recommendations are improving but will require more focus to close overdue recommendations.

Corporate approach to planning

11 We found that **the Health Board is developing a new long-term strategy which provides an opportunity to plan more sustainable services. There are reasonably effective arrangements for developing corporate plans; however, progress reports do not provide enough detail to demonstrate delivery is on track.**

12 The Health Board's approach for developing its strategic and corporate plans is generally effective. It has engaged appropriate stakeholders as part of strategy and plan development and is now starting to develop a new long-term strategy and annual plan. However, the Health Board is facing increasing challenges, including growing demand for care with need becoming more complex, continued 'legacy' from the COVID-19 pandemic and substantial financial pressures. The Board will need to give careful consideration to sustainable clinical service models to ensure improved efficiency and productivity as part of the strategy development.

13 The Health Board's Integrated Medium-Term Plan (IMTP) for 2023-26 continues to follow the life course approach which aims to reduce inequalities across communities and improving population health. Its arrangements for developing the IMTP and corporate strategies are reasonably effective. However, reports setting out the progress to deliver plans need strengthening. Our review found data quality and timeliness issues, and a lack of information to identify if intended outcomes of improvement actions have been achieved.

Corporate approach to managing financial resources

14 We found that **the Health Board is facing significant financial challenges. Whilst there are reasonably effective financial planning and financial management arrangements, the Health Board needs to establish control over savings delivery to prevent the financial position from deteriorating.**

15 The Health Board did not achieve financial balance for 2022-23 and is forecasting a deteriorating position for 2023-24. While it has a reasonable approach to financial planning, several factors are impacting its ability to achieve the plan, including blocked beds, prescribing spend, Continuing Healthcare costs, service demand and wider inflation-related cost increases. The Health Board established an ambitious savings plan but has not acted quickly enough to respond to delivery risks. The measures it is now taking are unlikely to have the intended positive impact on the 2023-24 financial position. There are generally effective financial management arrangements and scrutiny and oversight of the Health Board's financial performance. Finance reports continue to provide sufficient information, but they should be clearer on the extent that actions that it is taking are having the desired impact. There are also opportunities to enhance the quality of financial information provided in other Health Board reports.

Recommendations

16 **Exhibit 1** details the recommendations arising from our work. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2023 recommendations

Recommendations
Committee Transparency The Health Board does not livestream or publish recordings of its committee meetings. Furthermore, committee meeting minutes are only published after they have been confirmed at the subsequent meeting, therefore limiting timely public access to records of committee business. R1 The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could publish unconfirmed committee meeting minutes shortly after the meeting. **(Medium Priority)**
Quality of Information Board and committee reports can be overly long and detailed, and presentation of some information in supporting papers are occasionally unclear. The Health Board should ensure information is appropriately summarised and attention drawn to key areas of focus. R2 The Health Board should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees. **(High Priority)** R3 The Health Board should establish a robust quality assurance mechanism to review the quality of reports for its Board and committees. **(High Priority)**
Strategic / Corporate Risk Management The Health Board's updated Strategic Risk and Assurance report provides a clear overview of its strategic risks, key controls, improvement plans and sources of assurance. However, further work is required to address assurance gaps. Furthermore, whilst the Health Board is identifying gaps and strengthening aspects of its Risk Management Strategy, it needs to effectively embed the risk management arrangements across the organisation.

Recommendations

R4 The Health Board needs to rapidly complete remaining work to identify and address assurance gaps on its Strategic Risk and Assurance report and ensure it is actively owned by the Board and inform committee agenda setting. **(High Priority)**

R5 The Health Board needs to complete the remaining work on its Risk Management Strategy and effectively embed arrangements across the organisation to help it manage the significant finance, performance, and quality risks it faces. **(High Priority)**

Integrated Performance Dashboard

The Health Board's Integrated Performance Dashboard provides an overview of performance against Welsh Government targets over the last year. While useful in showing performance trends, it does not clearly articulate actions taken to improve performance or whether they are achieving the intended impact.

R6 In the Integrated Performance Dashboard, the Health Board should provide more information on the actions required to address underperformance, the impact of past actions taken and where appropriate include benchmarking with other health bodies. **(High Priority)**

Integrated Medium-Term Plan Progress Report

Our review of the Health Board IMTP Progress Report found several issues around the quality and timeliness of data, a lack of clarity around the impact of past and ongoing improvement actions, and duplication of information.

R7 The Health Board should strengthen the IMTP Progress Report to ensure that it can be used as an effective tool for monitoring progress against the delivery of its strategic objectives. By including up to date data, and clear narrative on the impact of past and ongoing improvement actions. **(High Priority)**

Detailed report

Board transparency, effectiveness, and cohesion

17 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.

18 We found that **Board and Committee arrangements are reasonably effective. However, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.**

Public transparency of Board business

19 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of:

- Board and committee meetings that are accessible to the public;
- Board and committee papers being made publicly available in advance of meetings;
- Board and committee business and decision-making being conducted transparently; and
- Board and committee meeting minutes being made publicly available in a timely manner.

20 We found that **while the Board demonstrates reasonable levels of public transparency, there are opportunities to increase public access to committee business.**

21 Members of the public can observe Board meetings virtually through the livestream and, since January 2023, they can also attend in person. The Health Board provides signposting and instructions to join to upcoming Board meetings via its website homepage and social media channels.

22 The Health Board aims to publish Board and committee meeting agendas and papers on its website a week in advance. However, some papers continue to be updated at short notice. This gives little time for Board members and stakeholders to review all papers in advance **(**See **Appendix 2, R2 2022)**.

23 The Health Board ensures that Board and committee business is conducted in public sessions, with private sessions used only for sensitive and confidential matters. Where private sessions are used, the Health Board provides a good summary of its in-committee/private business in the subsequent public meeting.

24 Board members hold open and frank discussions in Board and committee meetings regarding its performance, finance, and quality challenges. Executive Directors feel they can be open about the Health Board's challenges and the priority areas for action and feel well supported by the entire Board in responding to them.

25 Recordings of Board meeting are made publicly available 24 hours after the meeting. However, the Health Board does not livestream or publish recordings of its committee meetings. Unconfirmed committee meeting minutes are published on the website only when included in papers for the next meeting around 2 to 3 months after. This limits timely public access to records of committee business **(Recommendation 1)**.

Arrangements to support the conduct of Board business

26 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:

- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.

27 We found that **the Health Board has generally good arrangements to support the effective conduct of Board business and is taking appropriate improvement action where needed.**

28 The Health Board has adequate arrangements to support the effective conduct of Board and committee business. It has adopted the Welsh Government's Model Standing Orders and Standing Financial Instructions and the model Scheme of Delegation. These were recently reviewed and approved by the Board in September 2023 and are available on the Health Board's website. The process for declaring interests at Board and committee meetings is well established and up to date.

29 The Health Board's policies on standards of business conduct, which include declarations of interest, and receipts of gifts and hospitality are overdue for review but remains extant. Both we and Internal Audit[1] have previously identified concerns about wider policy management and highlighted a number of policies that require updating. The Health Board has developed an improvement plan to address this during 2023. Some progress has already been made, including targeted work with some divisions to ensure policies are brought up to date.

[1] Audit Wales Structured Assessment Report 2022 and Internal Audit's review on Policy Management in January 2023.

Effectiveness of Board and committee meetings

30 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge;
- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance; and
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.

31 We found that **the Board and committee structure is operating effectively. Meetings are well chaired with reasonably effective scrutiny, however, there are opportunities to strengthen the quality and timeliness of information presented.**

32 The Health Board introduced a new committee structure in March 2022. It is now fully embedded and provides a clear focus on strategy, delivery, performance, and culture. Committee workloads are manageable. The Health Board is establishing a Clinical Advisory Forum and is also planning to review arrangements for the Stakeholder Reference Group which was disbanded in October 2022.

33 The Board and its committees have up-to-date terms of reference, and annual cycles of business are regularly reviewed and updated as appropriate. The Health Board should ensure that cycles of business provide appropriate coverage and consideration of the controls and sources of assurances for strategic risks and any action to close gaps as soon as the Strategic Risk and Assurance report (Board Assurance Framework) is fully populated and live (see **paragraph 53**).

34 Board and committee chairs are actively involved in the agenda setting of meetings. Meetings continue to be generally well chaired, mostly run to time, and demonstrate good discussion on key issues. Independent Members participate fully in meetings, providing reasonably effective scrutiny on the information presented. There is a stronger focus on finance and digital matters in the relevant meetings compared to last year.

35 Board and some committee meetings support both in-person and virtual board member attendance which continues to offer flexibility to Board members. While the use of technology and virtual meeting etiquette is well embedded (see **Appendix 2, R1 2022**), some of the issues we reported in our 2022 Structured

Assessment report remain. For example, there have been occasions where we were unable to see or clearly hear staff presenting reports for specific agenda items.

36 The Health Board has reasonably effective arrangements in place to support flows of assurance from committees to the Board and the referral of information between committees. Committee reporting to the Board is effective and appropriate. There are appropriate processes to ensure actions identified in meetings are transferred to other committees where appropriate. The Chair of Board holds monthly meetings with Independent Members, both collectively and separately, which supports effective information sharing.

37 Board and committee papers are generally clear and contain the information required for effective decision making. However, on occasions, papers are overly long and too detailed. There are opportunities to more effectively summarise information using the revised Board and committee cover report template. We also found the presentation of some information in supporting papers and appendices to be unclear. Whilst officers make suggestions to improve the quality of information presented at committee meetings, report writing training and guidance alongside a robust quality assurance process is necessary to secure required improvements. In paragraph 22 we comment on issues around Board and committee meeting agendas and papers being updated at short notice **(Recommendations 2 and 3)**.

Board commitment to hearing from patients/service users and staff

38 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:

- The Board using a range of suitable approaches to hear from patients/service users and staff.

39 We found that **the Health Board has strengthened its arrangements to hear from patients, services users, and staff.**

40 The Health Board has established a Communications and Engagement strategy and is strengthening its arrangements to hear from patients, service users, and staff. This has provoked good Board member discussion and challenge. It is evident that Board members triangulate this information with performance information and wider intelligence gained from Board member walkabouts. However, the latest Trade Union Partnership Forum Annual Report continues to highlight concerns in relation to the lack of meaningful engagement between Trade Union representatives and managers. This indicates that the Health Board needs to be more proactive on engaging with staff representatives about operational challenges.

41 The Board continues to include a patient and public engagement item at every Board meeting which includes a report from the new citizens' voice body, 'Llais'.

The Patient Quality Safety and Outcomes Committee also receives patient and staff stories and demonstrate a commitment to listening and learning from staff, as illustrated within its performance report (see **Appendix 2, R3 2022**).

Board cohesiveness and commitment to continuous improvement

42 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

43 We found that **the Board is cohesive and committed to continuous improvement, with good Board member induction and training opportunities and ongoing self-assessment arrangements.**

44 The Board is becoming more cohesive, with positive working relationships, good lines of communication, and awareness of respective roles and responsibilities. The Health Board has taken steps to stabilise its leadership arrangements. Since our 2022 Structured Assessment report, the following permanent appointments have been made: Executive Director of Strategy, Planning and Partnerships; Executive Director of Public Health; and Director of Digital. The Medical Director has been confirmed as the Deputy Chief Executive and a new Chief Operating Officer role has been created[2].

45 Executive Director portfolios are generally appropriately balanced and have clearly defined responsibilities. We nevertheless have some concerns about the breadth of the Chief Operating Officer's remit whose additional responsibilities add further pressure to an already demanding role. We understand the Chief Operating Officer is using ringfenced funding to establish a supporting management structure which, if effective, may alleviate the risk. However, the Health Board should keep the role under review.

46 The Health Board is currently in the process of appointing to one Independent Member vacancy, but there is some further turnover expected in 2024 which the Health Board will need to manage.

47 The Health Board has effective local induction arrangements for Executive Directors and Independent Members. These include meetings with other Board

[2]. The Chief Operating Officer role will encompass primary care, community and mental health, and learning disabilities services alongside responsibilities for operational planning and acute services.

Members and stakeholders alongside detailed training materials. Independent members indicated they feel supported in their ongoing learning and development.

48 There are effective arrangements to support Board self-review and evaluation. The Board continues to review its effectiveness using the NHS England Well-Led Framework[3] and are progressing improvement actions. Committees are planning to complete self-assessments during October and November 2023. Board development and briefing sessions cover appropriate topic areas[4], with Board members commenting positively on the quality of these sessions.

Corporate systems of assurance

49 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

50 We found that **the Health Board is making good progress in developing and refining its systems of assurance. However, it will need to effectively embed new arrangements across the organisation to manage the finance, performance, and quality risks it faces.**

Corporate approach to overseeing strategic risks

51 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic and corporate risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives;
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks;
- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and
- the Board providing effective oversight and scrutiny of corporate risks.

52 We found that **the Health Board is improving its approach to managing strategic and corporate risks but reporting and scrutiny require**

[3] The NHS England Well-led framework Sets out how NHs bodies should carry out developmental reviews of their leadership and governance

[4] Including the new requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, risk and assurance, equality and diversity, and primary care sustainability.

strengthening. It also needs to finalise and effectively embed the approach across the organisation.

53 Since our last Structured Assessment report, the Health Board has redesigned its Strategic Risk and Assurance report (Board Assurance Framework), which sets out how it manages its strategic risks. The new Strategic Risk and Assurance report provides a clear summary of the Health Board's strategic risks, and their key controls, improvement plans and sources of assurance. Executive Directors are responsible for strategic risks within their respective portfolios. However, the Health Board needs to identify and take action to address assurance gaps and fully embed the new approach **(Recommendation 4)**. Once, fully embedded this will help to increase the scrutiny of strategic risks by the Board.

54 The Board's approach for managing its risk appetite is maturing. The Health Board has now developed a draft risk appetite statement with the aim of improving how the Board and divisions manage their risks.

55 The Health Board's arrangements for identifying and escalating corporate risks are improving. It is strengthening aspects of its Risk Management Strategy, including providing clear guidance around the risk escalation structure, reporting thresholds, and developing an Executive Risk Register to provide an additional layer of control. The Health Board is also developing a risk on a page report template to reduce the complexity of reports to Board and the committees.

56 Board members commented positively on the progress and planned improvements to the risk management approach. However, it is now crucial that the Health Board finalises and embeds its risk management framework effectively to manage the finance, performance, and quality risks it faces **(Recommendation 5)**.

Corporate approach to overseeing organisational performance

57 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

58 We found that **the Health Board is strengthening its performance management arrangements. However, reporting of performance to the Board and committees does not provide sufficient clarity on the actions needed to improve performance, or the impact of actions taken.**

59 While there have been some in-month performance improvements, the Health Board continues to experience significant service pressures which means that performance against some key Welsh Government performance measures is

below target. These areas include elective, cancer and some mental health service waits and timeliness of unscheduled care services.

60 The Health Board's new Performance Management and Accountability Framework, approved by Board in September 2023, sets out an integrated approach to managing performance covering quality, performance, activity, workforce, and financial expectations. The framework clearly outlines roles and responsibilities, oversight and accountability arrangements, local escalation arrangements and associated support and intervention processes. Nevertheless, the Health Board now needs to ensure the framework is rapidly and effectively embedded across the organisation(see **Appendix 2, R7 2022**).

61 The Health Board is planning to strengthen performance reporting to Board. It reports performance in its Board IMTP progress report. This includes the Health Board's Integrated Performance Dashboard which provides an overview of the performance against Welsh Government targets over the last year. While useful in showing performance trends against these targets, it does not include benchmarking of performance with other health bodies or clearly articulate actions taken to determine whether they are achieving the intended impact. This has led Independent Members to question whether they are receiving the information they need **(Recommendation 6)**. We discuss the remaining elements of the IMTP progress report in **paragraph 85** (see **Appendix 2, R4 2022**).

62 Despite the shortcomings in the Health Board's operational performance reporting, we found scrutiny of the information to be reasonably effective, with Independent Members pursuing knowledgeable and insightful lines of questioning.

Corporate approach to overseeing the quality and safety of services

63 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

64 We found that **the Health Board is strengthening its corporate arrangements for overseeing the quality and safety of services and is focussing on embedding the arrangements across the organisation.**

65 We undertook a review of the Health Board's quality governance arrangements in 2022. In 2024, we intend to follow-up the organisation's progress in implementing our recommendations and as part of this assess the progress that the Health Board is making implementing the requirements of the Health and Social Care (Quality and Engagement) Act (2020). Whilst we will report more fully after that review, our high-level observations of actions the Health Board is taking to strengthen arrangements for overseeing the quality and safety of services includes the development of:

- separate strategies for quality, and patient experience and involvement (approved by the Board in March 2023); and
- a Quality Strategy Implementation Plan, Quality Outcomes Framework, and Quality Governance Assurance Framework (presented to the Health Board's Patient Quality, Safety and Outcomes Committee in July 2023).

66 The Implementation Plan details the deliverables and timescales for their delivery over the next financial year and includes a new governance and reporting structure to provide oversight of quality performance and progress.

Corporate approach to tracking recommendations

67 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

68 We found that **while the Health Board is making good progress in strengthening arrangements for tracking recommendations, there are several overdue recommendations.**

69 The Health Board continues to have reasonably effective arrangements for monitoring progress against internal audit, external audit, and Healthcare Inspectorate Wales recommendations. It uses two trackers, one for internal and external audit recommendations which is received by the Audit, Risk, and Assurance Committee. The Healthcare Inspectorate Wales recommendations are captured on a separate tracker, which is periodically reviewed at the Patient, Quality, Safety and Outcomes Committee. While it has made good progress in addressing overdue recommendations, more work is needed. The latest updates in February and September 2023 highlight a number of overdue recommendations / improvement actions (75 internal audit, 4 external audit, and 43 Healthcare Inspectorate Wales). A recent Internal Audit review of the audit recommendations tracker gave reasonable assurance, but highlighted opportunities for improvement including removing superseded recommendations and updating the implementation timeframes for some overdue recommendations.

Corporate approach to planning

70 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

71 We found that **the Health Board is developing a new long-term strategy which provides an opportunity to plan more sustainable services. There are reasonably effective arrangements for developing corporate plans. However, progress reports do not provide enough detail to demonstrate delivery is on track.**

Corporate approach to producing strategies and plans

72 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the IMTP, and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

73 We found that **the Health Board has generally effective arrangements for developing strategic plans and is developing a new long-term strategy which provides an opportunity to plan more sustainable services.**

74 The Health Board's Clinical Futures Strategy has been extant for more than a decade. The Health Board has achieved several of its key objectives, including service reconfiguration associated with the opening of the Grange University Hospital, the establishment of the Enhanced Local General Hospitals network, and developments in community services. However, the Health Board is facing increasing challenges, including growing demand for care with need becoming more complex, the continued legacy from the COVID-19 pandemic and substantial financial pressures. In response, the Health Board is commencing the development of a new long-term strategy with a focus on population health, community-based services, and developing sustainable acute services. The Board will need to give careful consideration to sustainable clinical service models and improved efficiency and productivity as part of the strategy development.

75 An initial Board briefing session on the strategy development during September 2023 considered draft proposals, a development timeline, and required governance arrangements. The proposed governance structure will include groups with both Independent Members and Executive Director representation to ensure collective oversight of strategy development. The Health Board is planning to engage

extensively with both internal and external stakeholders as part of the strategy development. This will provide an opportunity for the Health Board to proactively engage with communities to design sustainable healthcare services. The Health Board intends to publish the long-term strategy by September 2024(see **Appendix 2, R5 2022**).

76 The Health Board's IMTP 2023-26 continues to build on its 'life course approach' which aims to reduce inequalities across communities through improving population health. The approach outlines five clear strategic objectives aligned to key stages in an individual's life course, underpinned by a set of outcomes and measures to achieve them.

77 The Health Board engages well with both internal and external stakeholders when developing operational and strategic plans. It discussed the IMTP 2023-26, Quality Strategy, and Communications and Engagement Strategy with staff in a range of different forums. It shared draft strategies/plans with Independent Members and facilitated discussion at Board development sessions prior to formal approval at public Board meetings. The Health Board involved wider partners in its development of the 2023-26 IMTP including Trade Union Partnership Forum, Cluster Planning Groups, Community Health Council, and Regional Partnership Board.

78 The Health Board is now starting its Annual Plan 2024-25 development on the assumption that it is unlikely to submit a financially balanced three-year IMTP. There is a clear development timeline with opportunities for good Board and stakeholder engagement (see **Appendix 2, R6 2022**).

79 Nevertheless, the financial position, service demand and associated operational pressures represent significant challenges. While some improvements may be achieved over the life of the annual plan, it is likely it will take some time for the Health Board to return to a financially sustainable position.

80 The Health Board has adopted the principles of the Wellbeing of Future Generations Act (Wales) 2015 (the Act) and is intending to formally review its wellbeing objectives during the next year alongside the development of the next Integrated Medium-Term Plan or Annual Plan.

Corporate approach to overseeing the delivery of strategies and plans

81 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[5] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

82 We found that **not all corporate plans are supported by SMART actions and progress reports do not provide sufficient clarity on delivery progress and whether the intended benefits are being achieved.**

83 The Integrated Medium Term Plan 2023-26 and Quality Strategy 2023-24 provide clear objectives and are underpinned by measurable outcomes. They include appropriate information about priorities, supporting actions, milestones for delivery, and intended outcomes.

84 However, in other plans we found there are opportunities to improve the articulation of proposed actions. For instance, in the Communications and Engagement Strategy, actions are categorised as 'ongoing' or 'as required' rather than given a specific target date for delivery. Furthermore, we found that the Research and Innovation Strategy was not underpinned by a detailed delivery plan. The omission of a delivery plan and / or SMART delivery actions means the progress reporting is unlikely to provide sufficient assurance that delivery is on track.

85 The Health Board's IMTP progress reporting needs strengthening. The Health Board uses its quarterly IMTP progress report to track progress in delivering its IMTP priorities, Clinical Futures Programmes priorities, and ministerial priorities. However, our review of the report identified data quality and timeliness issues, and a lack of clarity around the impact of past and ongoing improvement actions **(Recommendation 7)**. A recent Internal Audit review on the IMTP gave reasonable assurance but highlighted required improvements in relation to timeliness of performance data, division-level accountability for IMTP delivery and reporting progress against Clinical Futures delivery milestones.

86 The Board and committees oversee implementation and delivery of some corporate strategies too. For example, a People Strategy update presented at the July 2023 Board meeting set out implementation progress made during the first 12 months. However, there are opportunities to improve reporting delivery of plans to ensure it is clear whether delivery is on track and achieving the intended impact.

[5] Specific, measurable, achievable, relevant, and time-bound

Corporate approach to managing financial resources

87 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

88 We found that **the Health Board is facing significant financial challenges. Whilst there are reasonably effective financial planning and financial management arrangements in place, the Health Board needs to establish greater control over savings delivery to prevent the financial position from deteriorating.**

Financial objectives

89 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:

- the organisation meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
- the organisation being on course to meet its objectives and duties in 2023-24.

90 We found **that the Health Board did not achieve financial balance for 2022-23 and is forecasting a deteriorating position for 2023-24.**

91 The Health Board did not meet its financial duty to spend within its allocation over the three-year period for 2020-23, reporting a £36.8 million deficit in 2022-23 for revenue expenditure. However, it did meet its Capital Resource Limit target of £40.7 million with a small underspend of £0.043 million in 2022-23 and its 2022-25 Integrated Medium-Term Plan was approved.

92 The current and forecast financial position for 2023-24 is challenging. The Month 5 financial report presented at the September 2023 Board meeting highlights a growing underlying deficit and worsening in-year financial deficit forecast. There are several factors impacting the Health Board's financial position including, variable pay, spend to release blocked beds, increasing prescribing spend, Continuing Healthcare costs, service demand and wider inflation-related cost increases. In the Month 5 report, the Health Board forecasted a best-case year-end deficit of £112.8 million, but this will increase further if it does not achieve its savings target, receive anticipated additional funding[6], or experiences further cost pressures. The Health Board has estimated likely and worst-case deficit forecasts of £145 million and £160 million respectively and is due to revise its forecast following an evaluation of the effectiveness of actions that it is taking.

[6] Welsh Government announced an addition £425 million for NHS Wales on 17 October 2023.

Corporate approach to financial planning

93 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

94 We found that **the Health Board has a sound approach to financial planning and has a clear understanding of its financial challenges. However, the delay to establish stronger control over savings delivery means that recently introduced measures are unlikely to have a significant impact on the 2023-24 financial position.**

95 The Health Board's financial plan for 2023-24 was scrutinised and approved by Board in March 2023. The plan acknowledges the Health Board's financial challenges and recognises the unprecedented factors within its internal and external operating environment. The Health Board is focussing on service transformation to help achieve financial sustainability but acknowledges that this alone is not enough and has developed an ambitious savings plan. The Health Board set out in its IMTP 2023-26 that it was aiming to achieve financial balance over the life of the plan, but as reported in **paragraph 92** this is a significant challenge. If the Health Board cannot reduce its underlying deficit, the ability to achieve financially sustainable services in the medium-term is unlikely.

96 As part of the financial planning process, the Health Board established an alternative method for delegating budgets. It has stopped budgeting on the basis of incrementally increasing internal allocations based on historic costs plus inflation. Instead, it is now allocating budgets based on the resources needed to deliver IMTP objectives and the extent that services can deliver financial savings without compromising performance.

97 There is a significant risk that the Health Board's savings plan will not be delivered. The worsening financial position has led to an ambitious £51.5 million savings target. It hasn't yet identified all the specific saving schemes to deliver it and is currently off-track. The Health Board's Month 5 financial report indicated that savings delivery as of August 2023 totalled £9.3 million, with forecast year-end savings of £30.2 million. It will therefore need to deliver existing savings schemes as well as identify and deliver additional schemes to achieve its original £51.5 million savings target.

98 The Health Board recently introduced a Quality Impact Assessment process to assess the potential impact of savings schemes on service performance and

quality and safety of services. As a result of assessments made, the Clinical Advisory Forum recommended the removal of some savings scheme proposals. Board members have indicated the rejected proposals may need to be revisited should the Health Board's forecast position deteriorate. This may require difficult decisions affecting timely patient access to care.

99 The Health Board is introducing savings governance arrangements through a newly established Value and Sustainability Board which will focus on core saving themes. It is too early to comment on the effectiveness of these arrangements. However, the Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

100 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

101 We found that **the Health Board has generally effective arrangements to oversee financial management.**

102 The Health Board intends to review the Scheme of Delegation to ensure financial limits and decision-making authority remain appropriate (see **Appendix 2, R7 2022**). During 2023, Internal Audit has completed work covering Bank Office and Temporary Workers, Off-Contract Agency Staff, and Financial Sustainability. In general, Internal Audit found that the financial controls within these specific areas appear to be reasonably effective, with the exception of the use the off-contact agency staff which was given a limited assurance rating[7].

103 The Audit, Risk, and Assurance Committee effectively oversees financial controls assurances. The committee regularly receives, discusses, and where required questions officers on reports on losses and special payments, counter fraud work,

[7] The Internal Audit review of off-contract agency staff identified weakness in the processes to minimise use of agency staff and the management approval of agency staff use.

public sector payment policy, and procurement controls (such as single tender actions and payments exceeding £100,000). The reports include the required information for assurance and to enable good scrutiny.

Board oversight of financial performance

104 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

105 We found that **Board financial reports are transparent, but there are opportunities for reporting to be clearer on the impact of action taken to improve the financial position.**

106 The Board and Finance and Performance Committee oversees financial performance. Finance reports continue to provide sufficient information to enable appropriate scrutiny and oversight. While broadly similar reports are presented to both forums, the Financial and Performance Committee receive additional reporting on savings delivery and efficiency opportunities, providing opportunities to challenge on specific risks. Finance reports provide sufficient information on the financial position and risks, however, there are opportunities to be clearer on the impact of mitigating actions. There is also scope to increase the level and quality of financial information in other reports, such as the cost and impact on the financial position, to aid decision making.

107 Board reports are open and transparent about the Health Board's financial challenges and the potential impact on service quality and safety when making difficult decisions with the aim of improving the financial position. We identified increasing levels of scrutiny and challenge by Independent Members on financial matters. The Board has had opportunities to collectively scrutinise the financial position at board briefings and Public Board meetings. However, this can impact on the level of scrutiny provided at Finance and Performance Committee. The Health Board is therefore reflecting on the opportunities for scrutiny and challenge at these forums alongside the introduction of the new Value and Sustainability Board.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Public Board • Finance and Performance Committee • Audit Risk and Assurance Committee; and • Patient Quality, Safety and Outcomes Committee

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of Health Board. • Chief Executive. • Director of Corporate Governance. • Executive Director of Finance and Procurement. • Director of Strategy and Partnerships. • Chief Operating Officer. • Independent Member – Finance & Chair of Audit, Risk and Assurance Committee. • Independent Member – Local Authority & Chair of Finance and Performance Committee. • Independent Member - Community

Appendix 2

Progress made on previous year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports.

2022 Recommendation	Description of progress
Agenda / meeting management R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion	Our assessment on progress against the recommendation: **Complete** More detail can be found at paragraph 32 to 37.
Quality of Information to Board and committees R2 Information presented to Board and committees does not always provide the required assurance. Some papers are too long, detailed, and technical. Cover reports continue to follow an SBAR format, but there is variation in their use. The Health Board, therefore, should develop training and guidance for	The Health Board arrangements to ensure the quality and timeliness of information presented to Board and committees still require strengthening. Papers are generally clear and contain the information required for effective decision making. However, there are issues concerning the Health Board's Integrated Performance Dashboard, IMTP progress report and financial reports relating to data quality and timeliness, a lack of information on whether intended outcomes of improvement actions have been achieved and limited benchmarking of performance with other Health Board's. We also found the presentation of some information in supporting papers and appendices

2022 Recommendation	Description of progress
Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	unclear. Board and Committee reports can be overly long and detailed, and there are opportunities to better summarise the information (see **2023 recommendations 2 and 3**). This should help reports focus on key matters and reduce the overall volume of papers for Board and Committee meetings. Our assessment on progress against the recommendation: **Ongoing**
Patient and Staff Stories R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items	Our assessment on progress against the recommendation: **Complete** More detail can be found at paragraph 40 and 41.
Performance Reporting R4 The Integrated Performance Report has remained unchanged for several years, and at present it doesn't clearly articulate the impact of past and ongoing improvement actions. The Health Board should strengthen this report to provide more information to Board and committees on the actions required to address underperformance or the impact of past actions taken.	The Health Boards' Integrated Performance Dashboard provides an overview of the Health Board performance against Welsh Government targets over the last year. While useful in showing the Health Board performance trends and progress against these targets. It continues to not clearly articulate actions being taken to improve performance and their impact. The Health Board recognises the weaknesses in its performance reporting and is planning to complete improvement work alongside embedding its Performance Management and Accountability Framework. Our assessment on progress against the recommendation: **Ongoing**
Clinical Futures Strategy and Long-Term Clinical Plan	The Health Board's is commencing development of a new long-term strategy which will provide an opportunity for it to proactively engage with communities to help design and shape sustainable healthcare services for the region.

2022 Recommendation	Description of progress
R5 The Clinical Futures Strategy has remained in place for over a decade, but the pressures the Heath Board is facing have changed substantially in this time. The Health Board, therefore, should: a. review of the Clinical Futures Strategy to ensure it helps to shape financially and clinically sustainable service models; and b. develop a detailed long-term clinical plan that underpins the Clinical Futures Strategy.	Our assessment on progress against the recommendation: **Ongoing**
Working with wider partners in Integrated medium-term plan development R6 The Health Board discussed plans with both Welsh Government and the Community Health Council during the 2022-25 Integrated Medium-Term Plan development, but there was limited engagement with wider partners. The Health Board, therefore, should better involve wider partners to help collectively develop solutions to growing service challenges, particularly where services interface.	Our assessment on progress against the recommendation**:** **Complete** See paragraphs 77 and 78 for more information.
Schemes of Delegation R7 The Health Board's deteriorating financial position and deterioration in savings deliver indicates that stronger accountability for financial performance and delivery is required. The Health Board, therefore, should review its Scheme of Delegation to ensure it more strongly outlines delegated accountability for	The new Performance Management and Accountability Framework sets out the Health Board's approach for managing financial accountability. The Health Board still intends to review the Scheme of Delegation to ensure financial limits and decision-making authority remain appropriate. Our assessment on progress against the recommendation: **Ongoing**

2022 Recommendation	Description of progress
the budgetary position and achievement of financial efficiencies at and below executive levels.	

Appendix 3

Organisational response to audit recommendations

Exhibit 4: Aneurin Bevan University Health Board response to our audit recommendations

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could publish unconfirmed committee meeting minutes shortly after the meeting. **(Medium Priority)**	The Health Board remains fully committed to operating with openness and transparency. Greater transparency of the Board's committee business will be implemented, building on existing practices.	April 2024	Director of Corporate Governance

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R2	The Health Board should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees. **(High Priority**	The Health Board will be working to review and update its corporate report templates, alongside developing clear guidance and support for the preparation of Board and Committee reports. Securing additional training will also be explored.	April – June 2024	Director of Corporate Governance
R3	The Health Board should establish a robust quality assurance mechanism to review the quality of reports for its Board and committees. **(High Priority)**	The Health Board is currently reviewing its board and committee administration processes, including key performance measures. This will include a focus on the quality assurance process with clarity on expected standards. This will also be supported by work in respect of report writing development (R2).	April 2024	Director of Corporate Governance

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R4	The Health Board needs to rapidly complete remaining work to identify and address assurance gaps on its Strategic Risk and Assurance report and ensure it is actively owned by the Board and inform committee agenda setting. **(High Priority)**	The Health Board is actively progressing work to strengthen its strategic risk and assurance reporting, aligning risks to the Board and Committee business cycles. This work will be progressed alongside work to embed strengthened risk management and assurance arrangements at all levels of the organisation (R5).	April 2024	Director of Corporate Governance
R5	The Health Boards needs to complete the remaining work on its Risk Management Strategy and effectively embed arrangements across the organisation to help it manage the significant finance, performance, and quality risks faced. **(High Priority)**	The Health Board will consider its revised Risk Management Framework and underpinning Policy and its meeting in January 2024. The Audit, Risk and Assurance Committee will receive these in draft form for comment in November 2023. Implementation of these throughout the organisation as the organisation's approach to risk management matures.	January 2024 with implementation ongoing	Director of Corporate Governance

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R6	In the Integrated Performance Dashboard, the Health Board should provide more information on the actions required to address underperformance, the impact of past actions taken and where appropriate include benchmarking with other health bodies. **(High Priority)**	As part of the IMTP progress report specific attention has been given to the improvement actions to address underperformance including assurance mechanisms. This can be seen in the Quarter 2 report and will continue to be strengthened in future reports. Where available the data for the current quarter is presented and dates provided for data availability. Benchmarking data will be included in the dashboard where available. Not all performance measures have benchmarking data available, an assessment of available benchmarking data will be undertaken to determine what benchmarking data can be included in the dashboard.	December 2023	Director of Strategy, Planning & Partnerships

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R7	The Health Board should strengthen the IMTP Progress Report to ensure that it can be used as an effective tool for monitoring progress against the delivery of its strategic objectives. By including up to date data, and clear narrative on the impact of past and ongoing improvement actions. **(High Priority)**	As part of the IMTP progress report specific attention has been given to the improvement actions to address underperformance including assurance mechanisms. This can be seen in the Quarter 2 report and will continue to be strengthened in future reports. Where available the data for the current quarter is presented and dates provided for data availability. It remains important for the Health Board to maintain a mix of definitive progress measures and measures of longer-term population outcome. For population outcome measures the Health Board may not be the sole influencing factor and measurement may be reported over a long-term timescale, however as a population health organisation it is important the Board is sighted on these measures.	December 2023	Director of Strategy, Planning & Partnerships

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

GIG CYMRU NHS WALES	Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 February 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	To Review Standing Orders, Standing Financial Instructions, and Scheme of Delegation.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad Purpose of the Report
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

NHS Organisations are required to keep Standing Orders (SO's) and Standing Financial Instructions (SFIs) under review to ensure that they remain current.

A review of compliance against these documents should be undertaken on an annual basis.

Full details of any non-compliance with Standing Orders, including an explanation and the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance (Board Secretary) who will ask the Audit, Risk and Assurance Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Director of Corporate Governance as soon as they are aware of any circumstance that has not previously been reported.

Cefndir / Background

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.

The Board approved revised model SOs and SFIs in September 2023.

Asesiad / Assessment

Standing Orders:

A review of compliance has been undertaken against the Health Boards Standing Orders; Reservation and Delegation of Powers. An overview of the findings and areas for improvement is provided as Attachment One. Although further work is identified to strengthen arrangements in a number of areas, resulting in an overall amber rating for the section, four (4) key areas have been identified where the Health Board is not currently compliant with the Standing Orders. These are:

Section in Standing Orders	Area of non-compliance	Action to address
Section 1 – Membership, Tenure and roles and responsibilities of the Board	*The LHB will require Board members to confirm in writing their continued eligibility on an annual basis*	Eligibility checks will be undertaken during February 2024 and from then on in March of each year.
Section 5 – Advisory Groups	*The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum.* [Local Partnership Forum is established]	HPF: Work has progressed to establish the Clinical Advisory Forum and further guidance is being sought as to the legislative requirements in ensuring that the forum when constituted complies with SOs. SRG: Terms of Reference being developed for approval by the Board in March 2024
Section 7 - Meetings	*The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;*	The Improving Board Business action plan to be presented to Board in January 2024 will address the statutory requirements of complying with various accessibility standards.
Section 7 - Meetings	*The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business.* (noting that the SOs, as far as they are applicable, also apply to	Introduce livestreaming of committee meetings of the Board by the end of Q4 2023/24.

	meetings of any formal Committees established by the Board)	

Scheme of Delegation: A review of the Scheme of Delegation for Aneurin Bevan University Health Board, specifically, the delegated general financial limits and delegated limits for clinical negligence/personal injury claims at Executive Director level and above, has been undertaken. Following consideration by the Executive Committee, this will be submitted to the Board for formal approval in March 2024.

Standing Financial Instructions: Any reports of non-compliance with SFIs are reported in the Financial Governance, Reporting and Control report each Audit, Risk and Assurance Committee meeting.

Argymhelliad / Recommendation

The Committee is asked to note the review of compliance against Standing Orders and the actions required to address areas of non-compliance.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report

Section in Standing Order	Key points	Current Overall Assessment of Compliance	Further Action
Section 1 – Membership, Tenure and roles and responsibilities of the Board	• The Board comprises 9 Executive Directors, 11 Independent Members (including Chair and Vice Chair) and 3 Associate Members. • All Executive Directors posts, covering the responsibilities identified, are filled on a substantive basis • IM Community vacancy recently appointed • 3 Associate Member posts remain vacant • 2 IMs reach the end of their tenure in April 2024. IM Community appointed to commence April 2024. IM TU currently being advertised • Annual Eligibility – Board members have not previously been asked to complete a self-declaration of eligibility to serve on an annual basis. This will be introduced from February 2024 and annually (in March) thereafter. • Board Champion roles have been agreed.		• Complete recruitment to vacant IM posts • Introduce Annual Eligibility checks in February 2024, then annually in March thereafter • Work to establish clear reporting from Champions into the Board's governance structure.
Section 2 – Reservation and Delegation of LHB Functions	• Board approved revised Standing Orders, Reservation and Delegation of Powers in September 2023. • Process in place for undertaking Chair's Action, with all Chair's Actions reported to the subsequent Board meeting. • Scheme of Delegation of Board functions is in place however, will be further reviewed during 2024/25.		• Review Scheme of Delegation
Section 3 - Committees	• Committee structure established to cover the aspects of Board Business identified in the Standing Orders, with additional responsibilities in recognition of the Board's strategic priorities and the strategic risks it holds; with Board approved Terms of Reference and Membership • Board approved Standing Orders for WHSSC and EASC and receive reports to each Board meeting • Committees provide an assurance report to each Board meeting, drawing attention to any matters for consideration by the Board		• Committee ToR to be reviewed March 2024 • Evaluation of Committee self-assessments to be undertaken

Section in Standing Order	Key points	Current Overall Assessment of Compliance	Further Action
Section 4 – NHS Wales Shared Services Partnership	• The Director of Workforce and OD is the Health Board representative on the NHS Wales Shared Services Partnership		

Section 5 – Advisory Groups	• Trade Union Partnership Forum (LPF) established and operating effectively. These meetings are held in private due to the sensitive nature of discussions. Annual Report provided to the Board.
	• Healthcare Professionals Forum and Stakeholder Reference Group not currently in place.
	• Proposal to establish a Clinical Advisory Forum (HPF) approved by the Board in September 2023 and nominations sought.
			• Establish Clinical Advisory Forum and Stakeholder Reference Group
			  • Work has progressed to establish the Clinical Advisory Forum and further guidance is being sought as to the legislative requirements in ensuring that the forum when constituted complies with SOs.
			  • SRG Terms of Reference being developed for approval by the Board in March 2024

Section 6 – Working in Partnership	• Partnership arrangements in place to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015. • Regional Partnership Board and Public Service Board established with regular reports to the Board and the Partnerships, Planning and Public Health Committee. • Constructive working relationship continues with Llais. • Llais Regional Director invited to all Board meetings, with report on each agenda • Regular meetings with Llais.		• Further develop a comprehensive Partnership Governance Framework, spanning all statutory partnerships
Section 7 - Meetings	• Public Board meetings are open for the public to attend and a 'Teams' invite is published for members of the public to observe the meeting. A recording of the meeting is published to the Health Board's website following the meeting.		• Welsh language requirements: The Improving Board Business action plan to be presented to Board in January 2024 will address the statutory requirements of complying with various accessibility standards.

Section in Standing Order	Key points	Current Overall Assessment of Compliance	Further Action
	• Papers and meetings are not currently translated into Welsh and work is ongoing to address Welsh Language requirements for Board meetings • Committee meetings are not currently held in public. Agendas and papers are published 7 days in advance of the meetings. • Schedule of Board meetings and development sessions for the coming year in place with associated forward work programme. • AGM held in September 2023 (in line with amended SOs) • Agenda setting discussions held with the Chair, Chief Executive and Director of Corporate Governance • Schedule of Board and Committee meetings published on the Health Board's website, with further communication via social media for public Board meetings • Where business is discussed 'in committee', a report on any decisions taken is reported to the next public meeting • All Board meetings during 2023/24 were chaired by the Chair of the Board and were quorate • There has been no requirement for a vote to be undertaken • Formal minutes of each meeting are undertaken and reported to the following meeting for approval		• Transparency of committee meetings • Further development of the Forward Work Programme, to be approved by the Board and published on the Health Board's website.
Section 8 – Values and Standards of Behaviour	• Health Board Values and Standards of Behaviour Framework and Standards for Business Conduct in place • Board members are required to make annual Declarations of Interest. A register of Interests is maintained, published on the Health Board's website and included in the Annual Governance Statement. • Declarations of Interest are also a standard item on all Board and Committee agendas with any interest relating to items on the agenda recorded in the minutes. • A register of gifts, hospitality and sponsorship is also maintained by the Director of Corporate Governance		• Review Standards of Business Conduct Policy

Section in Standing Order	Key points	Current Overall Assessment of Compliance	Further Action
Section 9 – Signing and Sealing of Documents	• The register for the use of the common seal, and the seal, is held by the Director of Corporate Governance. • A report of all sealings is reported to each Board meeting via the 'Governance Matters' report • The Chair (or Vice) and Chief Executive (or Deputy) undertaken signing on behalf of the organisation		
Section 10 – Gaining Assurance on the Conduct of LHB Business	• Approved Board Assurance Framework in place. Revised Risk Management Framework to be submitted to Board January 2024. • Joint Committee Assurance reports presented to each Board meeting. • Internal Audit Work Programme approved and monitored via the Audit, Risk and Assurance Committee. • Head of Internal Audit Opinion included within the Annual Report • Board self-assessment undertaken against the NHS England Well-led Framework for Leadership and Governance Departmental Reviews • Committee Annual Reports submitted to the Board May 2023 • Committee self-assessments undertaken in Q3 • Structured Assessment 2023 undertaken, with findings presented to ARAC and Board • HIW inspections and actions plans reported to PQSOC		• Implement areas for improvement identified in the Board Self Assessment • Analyse results from committee self assessments • Implement recommendations from Structure Assessment
Section 11 – Demonstrating Accountability	• Performance and Accountability Framework approved by the Board in September 2023. • The Board has been involved in the development of, and approved, the IMTP for 2023-26 • The Board receives quarterly outcome and performance reports on progress against the IMTP, with interim performance reports. • Performance Report 2022/23 published as part of the Annual Report		

Section in Standing Order	Key points	Current Overall Assessment of Compliance	Further Action
Section 12 – Review of Standing Orders	• Revised Standing Orders were approved by the Board in September 2023 • Review of compliance against Standing Orders reported to ARAC in February 2024		

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Declarations of Interest and Register of Gifts and Hospitality
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the full Register of Interests declared by Board Members, Consultants and staff at Band 8a and above, as at the 16th January 2024. Also, the Register of Gifts and Hospitality declared during 2022 and 2023.

Cefndir / Background

It is a requirement within the Health Board's Standing Orders that all Board members and those employed by the Health Board declare any personal or business interests they may have, which may affect, or could be perceived to affect, the conduct of their role as a Board member or employee of Aneurin Bevan University Health Board.

In line with Standing Orders, the Audit, Risk and Assurance Committee is required to review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, and for gifts, hospitality and sponsorship. This report provides for the Audit, Risk and Assurance Committee the current register of interests declared by Board Members, Consultants and Staff at

Band 8a and as at 16th January 2024 (Attachment One) and the Register of Gifts and Hospitality for 2022 and 2023 (Attachment Two).

Asesiad / Assessment

All Board Members annually declare their interests and these are reported in the Annual Accountability Report. Senior staff and consultants are also asked to make annual declarations.

The Health Board has an approved Standards of Business Conduct Policy, and there are documents on the Health Board's sharepoint site, which provide further information and guidance for staff on what and how to declare any interests and gifts and hospitality. PADR documentation also includes a specific 'Declarations of Interest and Staff Conduct' section and examples to facilitate discussion with staff.

The Director of Corporate Governance holds the Register of Interests and Register of Gifts and Hospitality. These are updated during the year, as appropriate, to record any new interests or changes to the interests previously declared and any offers of gifts and hospitality, whether accepted or not.

Declarations of Interest are also a standard agenda item at each Board and Committee meeting to enable individual Board members to declare any interests in relation to any specific aspect of the agenda. Any declarations made are formally recorded within the minutes of the meeting. An annual review is also undertaken to ensure that all Board members review their Declarations of Interest.

It should be noted that the onus is on the individual to inform the corporate governance team of any changes in their declarations. There is also no feedback when a member of staff leaves the organisation for their interest to be removed. Therefore, although the full DoI register contains declarations made by staff at all levels in the organisation, it has not been possible to validate that all staff on the register remain employed by the Health Board. Therefore, the names of consultants and those at band 8a or above within the register of interests have been cross checked against a list of current staff to ensure that they remain health board staff and this is provided as Attachment One.

In line with current policy, prior to accepting any gifts, the employee should consult with their line manager or Board Secretary for advice. If following advice the employee decides to accept the gift a declaration is made and the gift is retrospectively added on to the Health Board's Register of Gifts and Hospitality.

A key corporate governance priority within the IMTP is to further strengthen mechanisms for recording and reporting declarations of interest, gifts, hospitality and sponsorship.

A review of these policies is taking place and is due to be completed by the end of Q4. This includes consideration of the issues raised in this report, and more effective ways of receiving and recording declarations for disclosure, based on national discussions. This will also include training and awareness regarding the appropriate acceptance of gifts and hospitality in order to embed robust governance throughout the Health Board.

Argymhelliad / Recommendation
The Audit, Risk and Assurance Committee is asked to note the current note the arrangements in place and the current Register of Interests and Register of Gifts and Hospitality.

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

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

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

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

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
Executive Directors						
Nicola Prygodzicz	Chief Executive	Nil Declaration				24/2/2022
James Calvert	Medical Director / Deputy Chief Executive	Director	Calvert Services Ltd	Unpaid	Self	19/12/2023
		Pharmaceutical Company Activity	Following consultation with Astra-Zeneca, ABUHB in receipt of donation of goods and services to support development of Severe Asthma Team. Payments received for conference attendance and South Wales Severe Asthma meeting	Paid (<£5000)	Self	
			Network lead for the All Wales Neonatal Network		Spouse	
Sarah Simmonds	Director of Workforce and OD	Nil Declaration				20/12/2023
Leanne Watkins	Director of Operations	Nil Declaration				
Rani Dash	Director of Corporate Governance	Nil Declaration				10/2/2022 (confirmed no change 19.12.23)
Peter Carr	Director of Therapies and Health Science	Nil Declaration				6/1/2022 (confirmed no changes 22/12/22)
Robert Holcombe	Director of Finance and Procurement	Nil Declaration				6/1/2022
Jennifer Winslade	Director of Nursing	Trustee	Hospice Care Devon	Unpaid	Self	16/01/2024

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
Hannah Evans	Director of Strategy, Planning and Partnerships	Nil Declaration				28/12/2023
Paul Solloway	Director of Digital	Nil Declaration				19/12/2023
Tracy Daszkiewicz	Director of Public Health	Board of Trustee for Swinon Domestic Abuse Support Charity				13/01/2024
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (until 30/04/2023)	Nil Declaration				07/03/2022 (confirmed no changes 22/12/22)
Independent Members						
Ann Lloyd	Chair	Nil Declaration				21/12/2023
Pippa Britton	Vice Chair	Non- executive director/trustee	British Paralympic Association	Unpaid	Self	02/01/2024
		Board Member	Charity Commission	Paid	Self	
		Ambassador	Healthy Weight (Welsh Government)	Paid	Self	
Shelley Bosson	Independent Member (Community)	Director	Howards Furnishers (EV) Limited	Unpaid	Self	28/12/2023
		Vice Chair	Tai Tarian Limited	Paid	Self	
Louise Wright	Independent Member (Trade Union)	Director/Owner	Coleg QS	Paid	Husband	01/04/2021

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
						(confirmed no changes 28/12/22)
Richard G Clark	Independent Board Member	Director	Shared Resources Services (SRS)	Unpaid	Self	24/01/2024
		Director	CSC Foundry	Unpaid	Self	
		Company Secretary and Trustee	Torfaen Voluntary Alliance	Unpaid	Self	
			Torfaen Museum Trust			
			Monmouthshire & Torfaen YOS Local Management Board			
			Monmouthshire Farm School Endowment Trust			
			Cwmbran Centre for Young People Management Board			
		Elected Member, Deputy Leader & Exec Member	Children Families and Education, Torfaen County Borough Council	Paid	Self	
Paul Deneen	Independent Member	Trustee	Walter Scott Educational Charitable Trust – Ross-on-Wye	Unpaid	Self	13/01/2024
		Trustee	Pashley Trust – Educational – Walford Primary School, Walford, Ross-on-Wye	Unpaid	Self	

Designation	Role	Organisation		Paid/Unpaid	Self or Family Member	Date
		District Secretary	National Education in Union in Herefordshire	Paid	Self	
		Member	Employment Tribunals (West Midlands and Cardiff)	Paid	Self	
		Deputy Lieutenant of Herefordshire	Life Member of Magistrates Association, Chair of Governors at Walford Nursery and Primary Schools	Unpaid	Self	

Phil Robson	Special Advisor to the Board	Trustee	Hospice of the Valleys	Unpaid	Self	10/2/2022
Prof. Helen Sweetland	Independent Member (University)	Nil Declaration				03/01/2024
Iwan Jones	Independent Member (Finance)	AE Innovations Ltd			Self	21/12/2023
		Golf Union of Wales Ltd			Self	
Dafydd Vaughan	Independent Member (Digital)	Director and Shareholder	Cedyrn Ltd	Paid	Self	25/01/2024
		Chief Technology Officer	Consulting Practice, Public Digital Ltd	Paid	Self	
		Member	Member of Advisory Panel, Centre for Digital Public Services (Welsh Gov Body)	Unpaid	Self	

		Director/Shareholder	Mimulus HQ Ltd	Paid	Wife	
		Senior Partner (major Projects)	TPX Impact Ltd	Paid	Wife	
Katija Dew	Independent Member (Third Sector) (until 01.04.23)	Trustee	Newport Live	Unpaid	Self	13/01/2022
		Director of Services	The Care Collective de Cymru Ltd	Paid	Self	17/05/2022

Surname	Forename	Title	Declaration (Nil/Paid/Unpaid)
Bale	Sue	R&D Director	South East Wales Academic Health Science Partnership (Director - Paid Secondment 1 day a week
			European Wound Management Association (Unpaid)
			Innovation Advisory Council Wales (Unpaid)
			Respiratory Innovation Wales (Unpaid)
Bowen	Richard	111 National Programme Director	Nil Declaration
Bishop	Lloyd	Assistant Director of Performance & Information	Nil Declaration
Brayford	Hannah	Senior Planning and Service Development Manager	Nil Declaration
Brooks	Cathy	Senior Business Partner - Head of Workforce Planning	Nil Declaration
Callen Davies	Robert	Operational Lead, MH&LD	Board Trustee – Wales Mindfulness Charity
Codd	Bryony	Head of Corporate Governance	Spouse - Consultant Colorectal & General Surgeon
Dawson-Morris	Christopher	Assistant Director Strategy, Planning & Partnerships	Newydd Housing Association – paid (self)

Surname	Forename	Title	Declaration (Nil/Paid/Unpaid)
Gosling	Matthew	Head of Financial Planning and Performance	Nil Declaration
Harris	Tristan	Finance Manager - Clinical Futures	Volunteer - St Johns Ambulance (Review of area accounts)
Hobbs	Caroline	Head of Management Accounting and Costing	Nil Declaration
Jackson	Deb	Head of Midwifery and Associate Director of Nursing	Interest declared
Jones	Suzanne	Head of Strategic Finance & Innovation	Nil Declaration
Jones	Garvin	Senior Manager Legal Services	Nil Declaration
Lacey	Freda	Mental Health and Learning Disabilities Partnership Manager	Chair of Trustees/Directors - Cymryd Rhan Unpaid
Morgan	Helen	Divisional Nurse/Clinical Futures Transformational Manager	Nil Declaration
Overs	Chris	Divisional Nurse	Nil Declaration
Roberts	Craig	Directorate Manager of Pathology	Nil Declaration
Ross	Mark	Assistant Finance Director	Nil Declaration
Thomas	Ian	General Manager, Mental Health Learning Disabilities	Nil Declaration
Westwood	Daniel	Service Performance and Delivery manager	Voluntary member of St John Cymru Wales Parent is a Voluntary Commissioner for Gwent St John Cymru Wales
Wilde	Lynne	Head of Transformation	Nil Declaration
Williams	Dave	Assistant Divisional Director Family & Therapies	Children in Wales Trustee (Not paid)
Luongo	Rob	Estates Manager	Nil Declaration
Key	Michelle	Service Improvement Manager - Workforce, Facilities	Nil Declaration
Lane	Matthew	Energy and Carbon Manager, Works and Estates	Nil Declaration
Lewis	Sarah	Haematology	Nil Declaration

Surname	Forename	Title	Declaration (Nil/Paid/Unpaid)
Arscott	Mark	Engineer, Works and Estates	Skenrith Mews Management Company (No financial gain)
Crook	Ian	Estates officer, Works and Estates	Nil Declaration

Surname	Forename	Division	Directorate	Declaration
Abourahma	Youssef	Family & Therapies	Paediatrics	Nil Declaration
Addams-Williams	Julia	Scheduled Care	Ear, Nose and Throat	Director Julia Addams-Williams Ltd - St Josephs Hospital (Private Practice - Paid)
Ahmed	Zahra	Scheduled Care	Dermatology	Nil Declaration
Ahuja	Alka	Family & Therapies	CAMHS	Harebell Investments Ltd (director)
Allman	Anneli	Family & Therapies	Paediatrics	Nil Declaration
Allman	Louise	Scheduled Care	Anaesthetics	Provides sedation in Private Dental Practice (Paid)
Anderson	Joseph	Unscheduled Care	Neurology	Nil Declaration
Ashraf	Makiya	Family & Therapies	Obstetrics and Gynaecology	Practice at St. Josephs Hospital as Consultant O&G
Axe	Kate	Unscheduled Care	Gastroenterology	Nil Declaration
Ayas	Syed	Scheduled Care	Rheumatology	Private Practice - St Josephs Hospital
Bagwell	Andy	Consultant - Anaesthetics	Anaesthetics	Nil Declaration

Surname	Forename	Division	Directorate	Declaration
Basu	Nilanjan	Mental Health & Learning Disabilities	Psychiatry	Nil Declaration
Batra	Meenakshi	Scheduled Care	Pathology	Private Practice - St Josephs Hospital
Bebb	Rachel	Family & Therapies	Paediatrics	Nil Declaration
Beer	Roger	Mental Health & Learning Disabilities	Adult Mental Health	Nil Declaration
Bekhit	Sameh	Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration
Bell-Thomas	Sue	Family & Therapies	Obstetrics and Gynaecology	Spouse has partial shares in St Josephs Hospital
Berry	Nidhika	Scheduled Care	Pathology	Director of Pvt company (Sandeep & Nidhika Berry Pvt Ltd)
				Spouse – Consultant ENT surgeon (Cardiff and Vale UHB)
				Spouse- Consultant, Spire Hospital and Vale Clinic/ Hospital
Biswas	Mousumi	Scheduled Care	Medicine	Director of Maple and Spice - e-book company
Brouns	Matt	Unscheduled Care	Acute	Nil Declaration
Brown	Angharad	Scheduled Care	Orthodontics	Specialist in NHS Care and Private Contracts
Burden	Thomas	Family & Therapies	CAMHS	Nil Declaration
Byrne	Mike	Scheduled Care	Anaesthetics	Nil Declaration
Callagha n	Rob	Scheduled Care	Rheumatology	South Wales Rheumatology Services Limited (Private Practice)
Campbell	Philip	Unscheduled Care	Cardiology	Philip Campbell Consultancy Limited
				Shares - St Josephs Hospital
Carter	Adam	Scheduled Care	Urology	Nil Declaration
Chance	Patrick	Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration
Clarke	Jonathan	Scheduled Care	Ear, Nose and Throat	Nil Declaration
Cloete	Yvette	Family & Therapies	Child Health	Nil Declaration
Collins	Jemma	Scheduled Care	Dermatology	Secretary of Welsh Dermatology Forum (audit group in Wales for all the Dermatologists) - No expenses received

Surname	Forename	Division	Directorate	Declaration
Cozens	Thomas	Unscheduled Care	Acute	Council Member of Welsh Acute Physicians Society (WAPS) Education and pastoral care
Curtis	Edward	Scheduled Care	Anaesthetics	Nil Declaration
Davies	Kathryn	Community	Frailty	Nil Declaration
Dawson	Ken	Unscheduled Care	Neurology	Dr Kenneth Dawson Neurological Services Limited
				Private Practice - St Josephs Hospital and Glan Usk Suite
Dumont	Steve	Scheduled Care	Anaesthetics	Nil Declaration
Edwards	Gareth	Family & Therapies	Obstetrics and Gynaecology	Private Practice
Edwards	Llifon	Unscheduled Care	Emergency Department	Nil Declaration
Edwards	Paul	Scheduled Care	Surgery	Charitable Fund within ABUHB
				Honorary Senior Lecturer Cardiff University Medical School
				Visiting Professor University of South Wales
Edwards	Stephen	Scheduled Care	Anaesthetics	Nil Declaration
El-Farhan	Nadia	Scheduled Care	Pathology	Undertakes private sessions at St. Josephs Hospital on a case by case basis
Elliott	Rachel	Scheduled Care	Haematology	Nil Declaration
Ellis	Elin	Mental Health & Learning Disabilities	Community Mental Health	Nil Declaration
Evans	Geraint	Scheduled Care	Pathology	Spouse has private sector practice as dietician trading as 'The Abergavenny Dietician'
Evans	Nest	Scheduled Care	Radiology	TREASURER OF THE SOUTH EAST WALES RADIOLOGY GROUP WHICH RECEIVES ANNUAL SPONSORSHIP FROM CANNON MEDICAL FOR ITS BIANNUAL EDUCATIONAL MEETING
Evans	Teresa	Scheduled Care	ITU	Nil Declaration
Farquharson	Rhian	Unscheduled Care	Emergency Department	Nil Declaration
FloodPage	Patrick	Unscheduled Care	Respiratory Medicine	Private practice at St Joseph’s Hospital, Newport and at Spire Hospital Cardiff
Ghuman	Sekina Sardar	Unscheduled Care	Gastroenterology	Nil Declaration
Gillespie	Gordon	Scheduled Care		Director South Wales Knee Clinic Ltd

Surname	Forename	Division	Directorate	Declaration
			Trauma and Orthopaedics	Private practice at St Josephs Hospital, Newport and at Spire Hospital Cardiff
Gleeson	Aoife	Community	Palliative Care	Gleeson Coaching and Consulting Limited
Gokhale	Leena	Family & Therapies	Obstetrics and Gynaecology	Vice President of British Gynaecological Imaging (No payment)
Gomez	Kelvin	Scheduled Care	Surgery	Bearsden Consulting - Private Company
Goyal	Nimit	Scheduled Care	Radiology	Director - NM Medical Services
				Private practice at St Josephs Hospital, Newport and at Spire Hospital Cardiff
Goyal	Sunil	Family & Therapies	Child Health	Nil Declaration
Griffiths	Jonathon	Scheduled Care	Anaesthetics	Nil Declaration
Gupta	Nakul	Family & Therapies	Child Health	Nil Declaration
Gwilliam	Jane	Unscheduled Care	Emergency Department	Spouse - Former Area Manager AstraZeneca
Haboubi	Nadim	Unscheduled Care	Care of the Elderly	Nil Declaration
Harding	Lloyd	Scheduled Care	Anaesthetics	Nil Declaration
Harley	Meeta	Family & Therapies	Paediatrics	Nil Declaration
Harrison	James	Scheduled Care	Pathology	Private practice at St Josephs Hospital, Newport and at Spire Hospital Cardiff
Hoad	Simon	Scheduled Care (moving to Clinical Support Services)	Pathology Directorate Manager	Common Law partner (Rachel Ward) is Pathology manager for Spire Hospital Cardiff. We provide Pathology services for Spire Cardiff covered by an SLA .The SLA includes prices for services. Rachel is not a director or shareholder in Spire Healthcare.
Hobbs	Ryan	Unscheduled Care	Acute	Nil Declaration
Holland	Phil	Scheduled Care	General Surgery	Nil Declaration
Huey	Brian	Scheduled Care	Radiology	Occasionally take part in studies at Cardiff Uni
Intzedy	Laszlo	Scheduled Care	Histopathology	Private Practice - St Josephs Hospital
Ionescu	Alina	Unscheduled Care	Respiratory Medicine	Private Practice - St Josephs Hospital

Surname	Forename	Division	Directorate	Declaration
Ivenso	Chineze	Mental Health & Learning Disabilities	Mental Health	Attended Advisory Board - Edinburgh to provide expert advice (Paid)
Jackson	David	Scheduled Care	Radiology	Private Practice - St Josephs Hospital
				Medica Reporting Limited
Jackson	Helen	Scheduled Care	Haemotology	Preparing and delivering two presentations on managing chronic lymphocytic leukaemia and follicular lymphoma at an evening educational meeting for haematology nursing staff in South Wales Meeting (Paid)
				Sponsorship from Janssen pharmaceuticals to attend British Society for Haematology annual scientific meeting in Glasgow April 2019
				Received sponsorship from Janssen pharmaceuticals to attend British Society for Haematology annual scientific meeting in Glasgow April 2019
James	Nirmal	Unscheduled Care	Emergency Department	Nil Declaration
Janes	Joanne	Family & Therapies	Anaesthetics	Nil Declaration
Jeffs	Sue	Scheduled Care	Pain Management	Nil Declaration
Jenkins	Chris	Scheduled Care	Pathology	Nil Declaration
Jewitt	Helen	Scheduled Care	Anaesthetics	Nil Declaration
Jones	Hywel	Scheduled Care	Anaesthetics	Nil Declaration
Jones	Sally	Unscheduled Care	Emergency Department	Nil Declaration
Jose	Michael	Unscheduled Care	Emergency Department	Nil Declaration
Joshi	Mandar	Scheduled Care	Anaesthetics	Speaker at Educational presentations organised by Grunenthal Ltd and previously Pfizer
Kadambande	Sujit	Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Kandaswamy	Pugazh	Family & Therapies	Paediatrics	Nil Declaration

Surname	Forename	Division	Directorate	Declaration
Kannapiran	Rajarajan	Family & Therapies	Neonatology	Nil Declaration
Kemp	Mark	Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Knapper	Carys	Family & Therapies	Sexual and Reproductive Health	Nil Declaration
Lawthom	Charlotte	Unscheduled Care	Neurology	Private company Lawthom Medical Limited – dissolved April 2018. Never active and no transactions.
Lefemine	Valentina	Scheduled Care	General Surgery	Private Practice
Lewis	David	Scheduled Care	General Surgery	Private Practice - Director of D R Lewis Vascular Specialist Services ltd
Lewis	Hilary	Family & Therapies	Paediatrics	Nil Declaration
Lewis	Mark	Scheduled Care	Trauma and Orthopaedics	Private Practice - St Josephs Hospital
Lewis	Sarah	Scheduled Care	Haemotology	Speaker fees from meetings/presentations inc travel and accommodation
Lim	Karene Arete	Scheduled Care	Radiology	Director of Lim Perkins Healthcare Ltd
				Private Practice - St Josephs Hospital
Lipetz	Clare	Family & Therapies	Sexual and Reproductive Health	Previous role a Medical Examiner for Heddlu Gwent Police
Lloyd	John	Scheduled Care	Trauma and Orthopaedics	Shares - St Josephs Hospital
Mackie	Ian	Scheduled Care	Trauma and Orthopaedics	Private Practice - Glan Usk Suite, Nevill Hall Hospital (Spouse acts as Private Secretary)
Mason	Nick	Scheduled Care	Anaesthetics	Chair of Trustees - IPPG (UK Reg. Charity 1143221 (Reimbursement of Travel Costs)
Massey	Louise	Family & Therapies	Sexual and Reproductive Health	Spouse - Architectural Business
				Occasional honorary work for Bayer (Paid)
Masters	Ollie	Scheduled Care	Anaesthetics	Joint Director of Masters medical services with spouse. Limited company providing private medical services

Surname	Forename	Division	Directorate	Declaration
Mehta	Hemang	Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Mills	Caroline	Scheduled Care	Dermatology	Nil Declaration
Morgan	Nicola	Unscheduled Care	Emergency Department	Nil Declaration
Nichols	Paul	Scheduled Care	Anaesthetics	Ceased practice at St Josephs Hospital in 2019
Obi	Ebube	Scheduled Care	Trauma and Orthopaedics	Nil Declaration
OConnor	Chris	Mental Health & Learning Disabilities	Psychiatry	Nil Declaration
Oweis	Furat	Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Papworth	Susan	Family & Therapies	Neonatology	Nil Declaration
ParryJones	Nilima	Scheduled Care	Haemotology	Secretary of UKCLL forum (registered charity 1104229)
Parveen	Sajitha	Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Passant	Carl	Scheduled Care	Ear, Nose and Throat	Private Practice - St Joseph's Hospital
Pasunuru	Kavitha	Family & Therapies	Child Health	Nil Declaration
Pennadam	Shaha	Scheduled Care	Medicine	Nil Declaration
Pinto	Anurag	Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Pinto	Leo	Unscheduled Care	Diabetes and Endocrinology	Nil Declaration
Poon	Chuen	Family & Therapies	Child Health	Nil Declaration
Pryce	Rebekah	Family & Therapies	Paediatrics	Nil Declaration
Pullen	Huw	Scheduled Care	Trauma and Orthopaedics	Shares - St Joseph's Hospital
				Private Practice - St Josephs and Nuffield
Pynn	Emma	Scheduled Care	Dermatology	Nil Declaration

Surname	Forename	Division	Directorate	Declaration
Ramakrishna	Sharan	Unscheduled Care	Care of the Elderly	Nil Declaration
Rashid	Majid	Scheduled Care	Pathology	Private Practice - St Josephs and Spire
Raza	Ali	Scheduled Care	Ear, Nose and Throat	Shares - St Joseph's Hospital
Raza	Ali	Scheduled Care	Ear, Nose and Throat	Private Practice - St Josephs
Reddy	Sunil	Family & Therapies	Neonatology	Locum Shifts (Honorary Contract - NEST, Bristol)
Rice	Robin	Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Richards	Cerys	Scheduled Care	Anaesthetics	Nil Declaration
Roberts	Sarah	Family & Therapies	Physiotherapy	Nil
Robinson	Kristina	Scheduled Care	Pathology	Nil Declaration
Robinson	Mark	Scheduled Care	Radiology	Director of Rholben Radiology - spouse provides secretarial support
Robinson	Mark	Scheduled Care	Radiology	Private Practice - St Josephs
Rogers	Andrew	Scheduled Care	Trauma and Orthopaedics	Private Practice - St Josephs (Director) and Nuffield
Ruth	Pauline	Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration
Saleem	Haris	Unscheduled Care	Acute	Nil Declaration
Schmidt	Marion	Family & Therapies	Child Health	Nil Declaration
Shah	Varsha	Scheduled Care	Pathology	Private Practice - St Josephs
Singh	Inder	Unscheduled Care	Care of the Elderly	Nil Declaration
Singh	Jyoti	Family & Therapies	Obstetrics and Gynaecology	Nil Declaration
Singh	Sukhdev	Scheduled Care	Radiology	Director of RSG Radiology Limited
Singh	Sukhdev	Scheduled Care	Radiology	Private Practice - St Josephs and Spire
Somasekar	Krishnamurthy	Scheduled Care	General Surgery	Private Practice - Glan Usk Suite, Nevill Hall Hospital

Surname	Forename	Division	Directorate	Declaration
Stone	Natalie	Scheduled Care	Dermatology	Private Practice - St Josephs and Glan Usk Suite, Nevill Hall Hospital
Sun	Phoebe	Unscheduled Care	Cardiology	Nil Declaration
Sutton	Lynne	Unscheduled Care	Emergency Department	Nil Declaration
Szakmany	Tamas	Critical Care	Critical Care	Director – I am your Gasman ltd Trustee – Intensive Care National Audit and Research Centre
Tagg	Catherine	Scheduled Care	Radiology	Nil Declaration
Tanaka	Hiro	Scheduled Care	Trauma and Orthopaedics	Chairman of the Education and Revalidation Committee (not paid) British Orthopaedic Association
Thiagarajah	Ramya	Scheduled Care	Radiology	Nil Declaration
Thompson	Ian	Scheduled Care	Pathology	Private Practice - St Josephs
Thornhill	Laurence	Unscheduled Care	Cardiology	Nil Declaration
Tozer	James	Scheduled Care	Anaesthetics	Nil Declaration
Turner	Matt	Scheduled Care	Anaesthetics	Private practice – Nuffield and St Joseph's
Valentine	Ed	Unscheduled Care	Emergency Department	Medical Director for Great Western Air Ambulance Charity
Valentine	Ed	Unscheduled Care	Emergency Department	Work occasional trauma team leader shifts at Southmead Hospital in Bristol (North Bristol Hospitals NHS Trust)
Vannet	Nicola	Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Vasishta	Sanjeev	Unscheduled Care	Care of the Elderly	Nil Declaration
Vaswani	Jyotsna	Family & Therapies	Paediatrics	Nil Declaration
Wales	Deborah	Unscheduled Care	Respiratory Medicine	Nil Declaration
Walker	Russell	Scheduled Care	Trauma and Orthopaedics	Nil Declaration
Walpole	Rachel	Scheduled Care	Anaesthetics	Nil Declaration

Surname	Forename	Division	Directorate	Declaration
Wartan	Sonia	Scheduled Care	Anaesthetics	Nil Declaration
Webster	Louise	Scheduled Care	Anaesthetics	Nil Declaration
Whelan	Jonathan	Scheduled Care	Anaesthetics	Private Practice - St Josephs
Whelan	Jonathan	Scheduled Care	Anaesthetics	Secondment from ABUHB to WAST and EMRTS Wales for a number of sessions per week (paid per session)
White	Lindsay	Scheduled Care	Maxillofacial	Part of Medical Team for Dragons and Newport Rugby Club (Paid per match)
Williams	Gethin	Scheduled Care	Surgery	Nil Declaration
Williamson	Ian	Unscheduled Care	Respiratory Medicine	Reansa Medical Services Limited
Williamson	Ian	Unscheduled Care	Respiratory Medicine	Private limited company providing medical legal reports
Williams	Richard	Scheduled Care	Radiology	Nil Declaration
Woollard	Sarah	Unscheduled Care	Acute	Locum Shifts undertaken at NHH
Yearsley	Karen	Unscheduled Care	Gastroenterology	Nil Declaration
Zheng	Rui	Mental Health & Learning Disabilities	Older Adult Mental Health	Nil Declaration

Agenda Item:3.14

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide assurance to the Audit, Risk, and Assurance Committee that the strategic risks associated with achieving the Board's strategic priorities are effectively managed.

Cefndir / Background

The Audit, Risk, and Assurance Committee's role is to assure the Board that the risk management processes in place are effective in reducing or mitigating the level of risk to the Board's strategic priorities. By receiving this report, the Committee has oversight of the strategic risks and can determine whether the risk management processes, controls, and assurances in place are adequate to mitigate or prevent the risk being realised.

Since the Committee's last meeting in December 2023, changes to the Strategic Register have been approved by the Board at its meeting in January 2024. The Board approved the de-escalation of **SRR 003B** to the Corporate Risk Register, which will be monitored by the Executive Committee. The addition of one new

overarching risk **SRR 010** and two sub-risks, one under overarching risk **SRR 001** and the other under **SRR 007**, as outlined below.

SRR 003B – There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abused. *Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care professionals.*

SRR 010 – There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. *Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.*

SRR 001H – There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population. *Due to low core funding, the Directorate is heavily reliant on non-recurrent funding grants*.

SRR 007B - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population. *Due to the impact of fragile services across the regional and supra regional geography.*

Asesiad / Assessment

The table below provides an overview of the high-level strategic risks as at end January 2024, with the full Strategic Risk Register (SRR) included at **Appendix A** and detailed risk assessments for the **21** sub-risks included at **Appendix B**.

All **21** sub-risks were reviewed and updated for the Board meeting in January 2024 and will be presented to their delegated Committee for focused scrutiny.

High-Level Strategic Risks	Number of Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (8 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**7** (A - H)	2	2	People	People and Culture Committee
		2	1	Service Delivery	Partnerships, Public Health & Planning Committee
		-	1	Financial Sustainability	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**2** (A -B)	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee

SRR 003 - There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	**1**	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**1**	-	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	**1**	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**3** (A – C)	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	**2** (A - B)	-	1	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
		-	1	Service Delivery	
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	**1**	-	1	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 009 - The Health Board will be unable to protect those most vulnerable to serious disease.	**1**	-	1	Compliance and Safety	Partnerships, Population Health, and Planning Committee
SRR 010 - There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	**1**	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee

Total High-Level Strategic Risks	Total Sub-Risks	Risk Level	
		High (8 – 12)	Extreme (15 – 25)
10	**21**	**8**	**13**

Work will continue with risk owners to assess and refine the controls and assurances, as well as to focus on the financial context and its impact on the individual strategic risks, to ensure a thorough assessment of the risk. This will be

completed and documented as part of the next reporting cycle to the delegated committees and to this Committee and the Board for strategic oversight and assurance.

Furthermore, work with Executive Directors is underway to identify and record any high-level operational risks in the Corporate Risk Register (CRR). These will be risks that require a higher level of ownership than an individual Executive Director can provide and will thus be owned by the Executive Team. In line with the Risk Management Framework's Escalation Process, the risks included in the CRR will typically span two or more divisions or require plans and resources that are beyond the Division's capability or capacity to implement.

At its next meeting, the Committee can expect to receive a risk report that includes all strategic and corporate (high-level operational risks) for oversight and assurance.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the Strategic Risk Register and Risk Assessments for the 21 sub-risks; and,
- **NOTE** the ongoing work to develop the Corporate Risk Register.

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

Gwybodaeth Ychwanegol:

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

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

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 001	People & Culture Committee	People	Director of Workforce and Organisational Development	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reliance on agency and bank staff •Litigation & Financial Penalties	4	4	16	Extreme	Above Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	**Staff attendance** Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work., "Hot spot" areas identified and plans in place to support. **Recruitment** Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor, Annual programme of Apprentice recruitment, Overseas Nursing (All Wales), Nursing Workforce Strategy, Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) , Partnerships with employability schemes such as Kickstart and Restart, Actively working with Local Authorities to promote joint recruitment activities and Registration – Temporary register extended for 2 years to enable staff to return to practice. **Retention:** Development of career pathways (e.g., non-clinical to clinical), Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR, Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts, Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return, Agency reduction and Plan in place to monitor and review all agency, bank pay incentives supply and demand. **E- Systems** Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff, Development of alternative and new roles , Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP, Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. and Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. **Training** The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies, HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy, Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 staff. **Vacancy Numbers and establishment control** Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies and Development of ESR establishments commenced on a national basis w/c 03/09/23.	Medium	3	2	6	Low	12/01/2024	12/02/2024
					b) Due to a deterioration in, and a failure to improve, the well-being of our staff	•High absence levels, with some sustained long periods •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reputational damage to the health board as an employer •Work-related industrial injury claims •Moral injury	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars)., Increase wellbeing initiatives: Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites, Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders), Train Mediators so there is team and organisational resilience and network, Regular Schwartz rounds arranged across the Health Board, Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. Close links with the Arts in Health programme, Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. Chaplaincy service for staff , Re-launching Chill out in the Chapel, Recruitment of staff counsellors, Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being , Scope, design and deliver a programme of research 'Healthy Working Day', Enhanced our financial well-being offer. Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management, Drafting of a 10-year plan focusing on optimising the employee experience of work , The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. **Occupational Health** Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes, Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted, Support equality and diversity of workforce Review of staff diversity networks, Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. **Other** Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC, Reducing fatigue poster developed	Medium	3	3	9	Moderate	12/01/2024	12/02/2024
					c) Due to insufficient and ineffective leadership levels throughout the organisation.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Poor levels of accountability and delivery •Reputational damage to the health board as an employer •Adverse impacts on staff recruitment and retention	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Talent and Succession Planning lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. Development leadership capabilities Designing learning journeys and access to Gwella Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Medium	3	2	6	Low	12/01/2024	12/02/2024
					d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Litigation & Financial Penalties •Reputational damage to the health board and loss of public confidence	4	4	16	Extreme	Above Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Services Business continuity plans in place. All Wales training sessions provide by legal and risk to support industrial action. Ensure early identification of mandated Statutory, and core critical clinical services. Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. Reducing impact on patients - Support for early supported discharge prior to industrial action. Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). Establish WOD hub with emergency planning to stand up as required Ensure early identification of mandated Statutory, and core critical clinical services. Review of business continuity plans Map services and staff provision and impacts of industrial action. Assess variable pay usage in case of work to rule applies. Assess current vacancies. Working with partners in Gwent on a system wide basis. Implementation of business continuity plans. Communication plans. Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	Medium	2	4	8	Moderate	12/01/2024	12/02/2024
					e)Due to inadequate strategic plans which respond to population health and socio-economic needs	•Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to train teams in multi-morbidity management •Failure to comply with the Wellbeing of Future Generations Act (Wales) •Reputational damage and loss of public confidence	2	4	8	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	Medium	2	3	6	Low	12/01/2024	12/02/2024

	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Strategy, Planning and Partnerships.			Implication: Damage and loss of public confidence														
					f)Due to unsustainable service models	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	Medium	2	3	6	Low	12/01/2024	12/02/2024
	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement		g)Due to long term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes	•Breach of statutory duty to breakeven over 3 years •Instigation of NHS Wales Escalation & Intervention Arrangements •Non – delivery of health board priorities, required improvements and achieve longer-term sustainability •Prioritisation and possible disinvestment in service delivery •Reputational damage and loss of public confidence	5	4	20	Extreme	Above Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	Medium	2	4	8	Moderate	08/01/2024	08/04/2024
	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Public Health and Strategic Partnerships		h) Due to low core funding, the Directorate is heavily reliant on non-recurrent funding grants.	Avoidable harm ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Unable to substantially improve the health of the population ➢ Reputational damage and loss of public confidence ➢ Multi-year CIP calculated on non-recurrent funding ➢ Major grants subject to funding cuts 24/25 ➢ No determined staffing establishment ➢ Possible at-risk TUPE posts ➢ £1.5 million temporary staff funding (RIF + EYP) majority on permanent contracts ➢ Government grants focused on particular risk factors	5	4	20	Extreme		Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Business cases being written for PIP to increase core funding to deliver objectives. • Through Pip process work towards a funded establishment reduce risks associated with permanent staff being funded through temporary funding which impacts on the ability to plan long term.	Negative	2	3	6	Moderate	13/01/2024	13/02/2024
SRR 002	Partnerships, Public Health & Planning Committee	Compliance and Safety	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation & Financial Penalties	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	At this stage, the controls in place are appropriate and practicable to monitor the issues and prepare medium-term responses in line with the timelines within the expert report.	Medium	1	2	2	Very Low	12/01/2024	12/02/2024
					b) Due to significant levels of backlog maintenance and Structural Impairment	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.	Medium	3	2	6	Low	12/01/2024	12/02/2024
SRR 003	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Chief Operating Officer	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	b)Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	•Harm or injury to patients and/or staff •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	4	5	20	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.	Medium	2	2	4	Low	12/01/2024	12/02/2024
	Partnerships, Public		Director of	There is a risk that the Health Board is unable to respond in a	a)Due to ineffective and insufficient emergency	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Harm or injury to patients and/or staff					Above	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as	Testing programme of business continuity plans. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. Joint planning with PH response in response to infection disease and public health incidence. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and							

SRR 004	Partnerships, Public Health & Planning Committee		Strategy, Planning and Partnerships.	timely, efficient and effective way to a major incident, business continuity incident or critical incident	Insufficient emergency planning arrangements at a corporate and operational level	•Harm or injury to patients and/or staff •Health Board breaches statutory duties under the Civil Contingencies Act 2004 •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**5**	**15**	**Extreme**	**Above Appetite Level**	Risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Operational. Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. Continue to promote awareness in a timely manner. Continue to promote awareness of the requirement for BC across the Health Board. A tabletop BC exercise is planned for the 10th of October 2023. Continuing participation in multi-agency exercises. Programme plan to be developed to address the weaknesses in business continuity planning. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Development of Pandemic Plan.	**Medium**	**2**	**3**	**6**	**Low**	12/01/2024	**12/02/2024**
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below Appetite Level**	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	**Medium**	**3**	**3**	**9**	**Moderate**	12/01/2024	**12/04/2024**
SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a)Due to the full or partial failure of existing digital infrastructure and systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**5**	**15**	**Extreme**	**Below Appetite Level**	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Information Governance and Cyber Security governance and assurance processes are now under review. Governance group terms of reference agreed, and reporting arrangements discussed with Director of Corporate Governance. Meetings will commence in November with clear reporting on progress to the relevant committees on our cyber security action plan. SIRO training arranged for the 25th September for the Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO).	**Medium**	**2**	**4**	**8**	**Moderate**	10/12/2023	**10/01/2024**
					B)Due to an adverse impact on service delivery in the implementation of new digital systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below Appetite Level**	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Medium**	**2**	**3**	**6**	**Low**	10/12/2023	**10/01/2024**
					c)Due to a failure to develop digital solutions that are sustainable and fit for the future	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below Appetite Level**	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	New governance structures to be put in place by the end of 2023. Review of New Digital Request processes considering governance changes.	**Medium**	**2**	**4**	**8**	**Moderate**	10/12/2023	**10/01/2024**
SRR 007	Partnerships, Public Health & Planning Committee	Transformation and Partnership Working	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to ineffective relationships with strategic partners	•Unmet patient need resulting in harm •Ineffective use of combined resources •Delayed decision making •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence	**2**	**4**	**8**	**High**	**Below Appetite Level**	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Governance review of Regional Partnership Board undertaken in August 2023. Renewed Strategy for strategic partnership Capital in place and revised governance processes. New Long-Term Strategy for Health Board to focus on Partnership approach.	**Medium**	**2**	**2**	**4**	**Low**	10/10/2023	**10/04/2024**
					b) Due to the impact of fragile services across the regional and supra regional geography	Changes of regional flow in an unplanned way Additional demand on UHB workforce to support fragile services Unmet patient need resulting in harm Ineffective use of combined resources Delayed decision making Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence	**3**	**3**	**9**	**High**	**Below Appetite Level**	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a recent review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with recognition that these need to be 're baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions. Discussion to be had at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work.	**Reasonable**	**2**	**2**	**4**	**Low**	16/01/2024	**16/04/2024**
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff,	Due to inadequate arrangements to listen and learn from patient experience	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability	**2**	**4**	**8**	**High**	**Below Appetite**	Open = 16 or below - Willing to consider all potential options subject to continued application and/or	Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives.	**Medium**	**2**	**2**	**4**	**Low**	11/01/2024	**11/04/2024**

				the public and partners	and enable patient involvement	•Reputational damage and loss of public confidence •Failure to deliver Duty of Quality					Level	establishment of controls recognising that there could be a high-risk exposure.	Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. National directives around new national surveys that need to be managed additional to internal roll out programme. Volunteer feedback to be reviewed to identify themes.						
SRR 009	Partnerships, Public Health & Planning Committee	Compliance and Safety	Director of Public Health and Strategic Partnerships	The Health Board will be unable to protect those most vulnerable to serious disease	Due to delays in providing COVID-19 vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as changes to the vaccination delivery programme.	•Adverse impacts on the delivery of vaccinations to patients across the vaccine service for routine and seasonal vaccines • Inability to support response to outbreaks as required in 'Wales Outbreak Plan', and ABUHB Public Health Incident Response plan. • Potential increase in communicable disease incidence, with impact on healthcare use and also staff sickness • Reputational damage and loss of public confidence • Patients not being sufficiently protected therefore increases the incidence of disease and avoidable harm from Vaccine preventable diseases. • Increased disease will lead to increased admissions through acute settings therefore bed pressures on the wider system. •ABUHB not delivering in line with JCVI and WG guidance/milestones. •ABUHB not delivering in line with NHS performance framework uptake standards ABUHB not delivering vaccinations in line with the funding provided. •ABUHB already has the lowest spend on COVID vaccinations in Wales, further disinvestment would make us more of an outlier reputationally. •Lack of resources to stand up sampling and testing as a preventative/protective measure as needed for patients and staff during peak in activity. • Inability to provide sufficient interventions in closed settings for the most vulnerable population such as care homes and special schools. • Reduction in capacity to deliver equity work to provide HP intervention and screening to vulnerable groups. • Until it transfers to UPC, a lack of resources to deliver AV service will mean our most vulnerable patients not accessing clinical treatment within the treatment window leading to avoidable harm and unnecessary hospital admissions	**5**	**4**	**20**	**Extreme**	**Above** Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Secured additional funding against the existing allocation for bank vaccination staff. • Exploring deployment options to the Vaccination programme and use of those previously trained as vaccinators that are on the bank. • Alternative advertising methods of vacant shifts to improve uptake – liaising with bank co-ordinator to improve this. • Draft community pop-up plan to be further explored. If required, extend venue licence in key location(s).	**Medium**	**2**	**3**	**6**	**Moderate**	15/01/2024	**15/02/2024**
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Satey of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	4	4	16	**High**	**Above** Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	**Negative**	2	3	6	Moderate	11/01/2024	**11/02/2024**

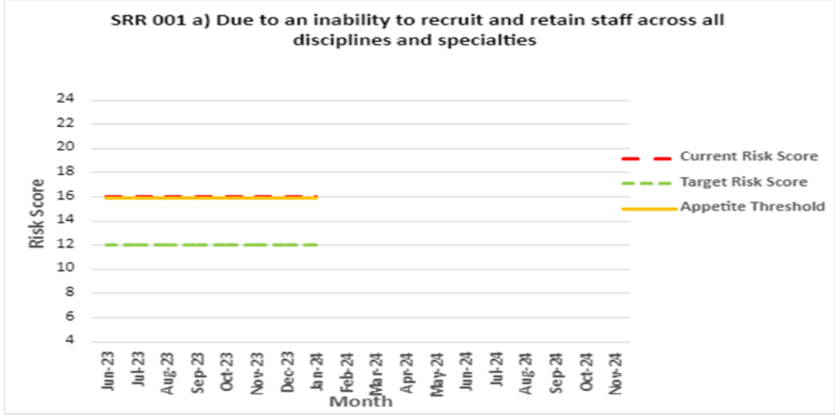
RISK THEME	PEOPLE
Strategic Risk (SRR 001)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**
Strategic Threat	**a) Due to an inability to recruit and retain staff across all disciplines and specialties.**
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reliance on agency and bank staff ➢ Litigation & Financial Penalties

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Workforce & Organisational Development			
Monitoring Committee	People & Culture Committee	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	12 January 2024	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*
Next Review	12 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Health Care Support Worker tracker. • Agency Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Development of new roles to support vacancies. • Recruitment KPI's. • IMTP Educational Commissioning.	**Staff attendance** • Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support. **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales) • Nursing Workforce Strategy • Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) • Partnerships with employability schemes such as Restart. • Actively working with Local Authorities to promote joint recruitment activities. • Registration – Temporary register extended for 2 years to enable staff to return to practice ending March 2024.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Workforce reports to the Nurse Strategic Workforce Group. • Daily sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls. • Occupational Health and Wellbeing dashboards report KPIs. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation	**Gaps in Assurance** **Action to Address Gaps in Assurance**	**Positive Assurance**

• Workforce Establishment controls national working group has been instigated.	• Accommodation continues to be problematic for overseas recruitment and therefore a current formal tender process is in progress with an end date of approx. 29th January 2024. **Retention:** • Retention lead appointed with programme action plan in place. • Development of career pathways (e.g., non-clinical to clinical). • Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. • Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. • Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return. **Agency reduction** • Plan in place to monitor and review all agency, bank pay incentives supply and demand. **E- Systems** • Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff. • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. • NCN workforce planning workshops completed Dec 23. An action plan has been developed and to be agreed with PCCS senior management team, NCN board with enabling actions to highlight key challenges and opportunities to support longer term workforce sustainability. • Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. **Training** • The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies. • HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 staff. • Workforce planning within new competency framework commencing Jan 24. **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies. • Development of ESR establishments commenced on a national basis w/c 03/09/23. Local delivery action plan to be developed by end of February 2024.	• Measurements of Wellbeing through the ABUHB Staff Survey. • Routine Reporting against nurse staffing levels. • Variable Pay Programme Board **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 -24** 1. Long Term Sickness Absence Management (Q4) 2. Flexible Working (Q4) • External quarterly vacancy reporting to WG • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

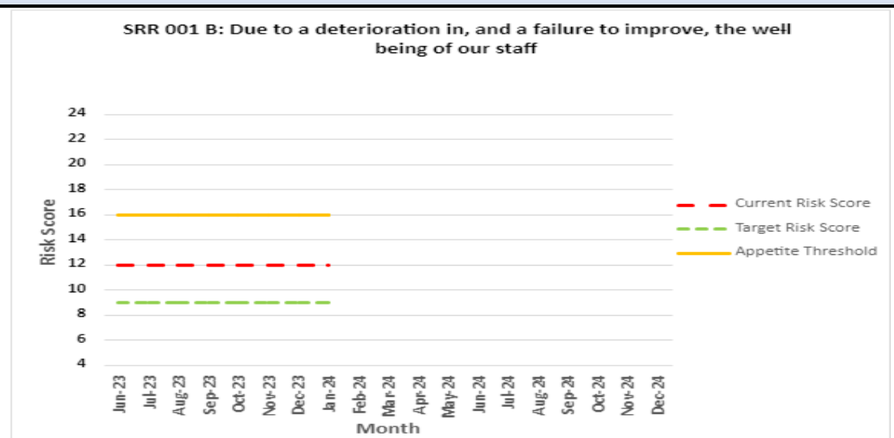
RISK THEME	PEOPLE
Strategic risk (SRR 001)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**
Strategic Threat	**b) Due to a deterioration in, and a failure to improve, the well-being of staff.**
Impact	➢ High absence levels, with some sustained long periods ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reputational damage to the health board as an employer ➢ Work-related industrial injury claims ➢ Moral injury

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Workforce & Organisational Development			
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*
Next Review Due	12 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Monitoring Framework to support roll out of the People Plan. • Monitoring delivery of the #peoplefirst project though Executive Team reports, KPI sickness metrics underpinned by People Plan Delivery framework. Engagement ongoing with divisional management teams. • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance • Staff related policies.	• Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars). • Increase wellbeing initiatives: • Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders) • Trained mediators so there is team and organisational resilience and network. • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. • Chaplaincy service for staff • Recruitment of staff counsellors • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being • Scope, design and deliver a programme of research 'Healthy Working Day'. • Enhanced our financial well-being offer. • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monitoring Framework to support roll out of the People Plan 22-25 • Monitoring of demand on wellbeing services • Staff diversity networks • Race/LGBT groups • Wellbeing resources • Occupational Health Service **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and Facilities **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • National workforce surveys	**Gaps in Assurance** • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. **Action to Address Gaps in Assurance** • Meetings with Divisions ongoing.	**Positive Assurance**

	• Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 5th July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has recently won two NHS Wales awards. • The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely initiative within ABUHB. This workstream began in October 23 and will be developed over the next 12 months with a strong emphasis on evidence analysis and culture. • An external Employee Assistance Programme has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff. **Occupational Health** • Additional occupational health resources secured to reduce waiting times over winter • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. **Support equality and diversity of workforce** • Review of staff diversity networks • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. • A part time Disability Inclusion Officer has been seconded to the EDI Team (Dec 2023 – Dec 2024). • Recruiting to a Band 5 EDI Officer role (Jan 2024). • Inclusive Leadership sessions to be embedded in the Leading People Programme from Jan 2024 onwards. • Reverse Mentorship Programme to launch Feb 2024. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC. • Reducing fatigue poster developed	• Monitoring and compliance of BMA Rest and Facilities via NHS Employers		

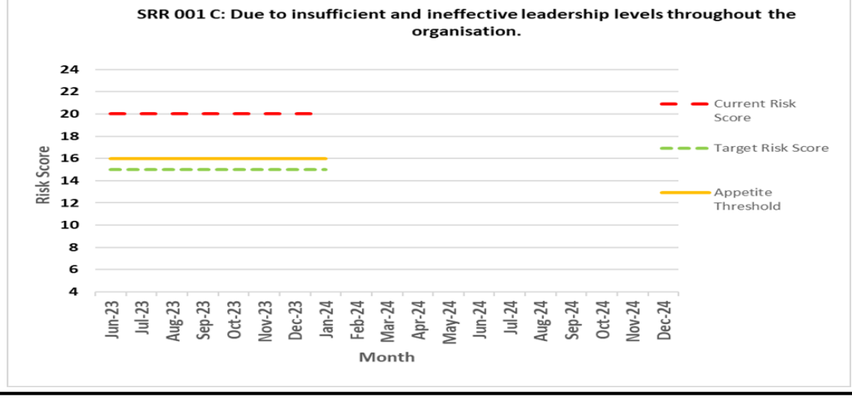
RISK THEME	PEOPLE
Strategic risk (SRR 001)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**
Strategic Threat	**c) Due to insufficient and ineffective leadership levels throughout the organisation**
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Poor levels of accountability and delivery ➢ Reputational damage to the health board as an employer ➢ Adverse impacts on staff recruitment and retention

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Workforce & Organisational Development			
Monitoring Committee	People & Culture Committee	Likelihood	**3** *(Possible)* *x*	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	Impact	**4** *(Major)*	2 *(Minor)*
Last Reviewed	12 January 2024	Risk rating	**= 12** *(High)*	**= 6** *(Moderate)*
Next Review Due	12 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Monitoring Framework to support roll out of the People Plan- focus on Talent and Succession Planning • Monitoring frameworks with HEIW	**Talent and Succession Planning** • Lead appointed in July 2023 on a secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB • Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy • Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. • 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level • 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. **Development leadership capabilities** • Designing learning journeys and access to Gwella • Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. • CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs • 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Level 1 Operational *(Implemented by the department that performs daily operation activities)* • WOD Divisional reporting • Evaluation of internal leadership programmes Level 2 Organisational *(Executed by risk management and compliance functions.)* • Reporting to People and Culture Committee - progress against People Plan 22-25 **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Review • Talent and Succession Board	**Gaps in Assurance** **Action to Address Gaps in Assurance**	**Positive Assurance**

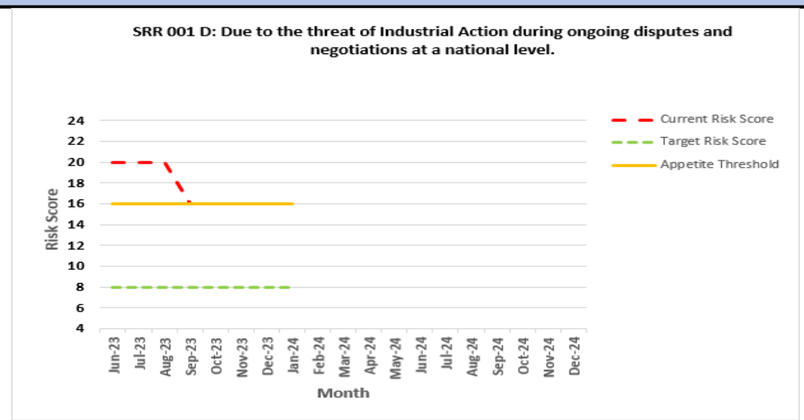
RISK THEME	PEOPLE
Strategic Risk (SRR 001)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**
Strategic Threat	**d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level**
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Litigation & Financial Penalties ➢ Reputational damage to the health board and loss of public confidence

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Workforce & Organisational Development			
Monitoring Committee	People & Culture Committee	**Likelihood**	**4** *(Likely)* x	**2** *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**4** *(Major)*
Last Reviewed	12 January 2024	**Risk rating**	**= 16** *(Extreme)*	**= 8** *(High)*
Next Review Due	12 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Under sections 231 and 231A of the 1992 Act a union must, as soon as reasonably practicable after holding an industrial action ballot, take steps to inform all those entitled to vote18, and their employer(s), of the number of individuals entitled to vote in the ballot; the number of votes cast in the ballot. • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture • Operational planning, led by the Chief Operating Officer, to respond to implications of strikes action in other NHS organisations.	• Services Business continuity plans in place. • Pay agreements in place for medical cover • Confirmed rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). • Command and control structure and leads established • Derogation test completed • Executive and Senior Manager leads established links with national planning cells. • All Wales training sessions provide by legal and risk to support industrial action. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Implementation of business continuity plans. • Communication plans- public, stakeholders and partners • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application • Picketing guidance supported and agreed • Debriefing session planned to reflect and capture learning for any potential future action (national)	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Local Staff re-deployments assessment • Local Negotiating Committee (LNC) • Trade Union Partnership meetings **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • All Wales IA group and Welsh Government planning cell.	**Gaps in Assurance** • BMA have provided notice of consultant and SAS Dr ballot **Action to Address Gaps in Assurance**	**Reasonable Assurance**

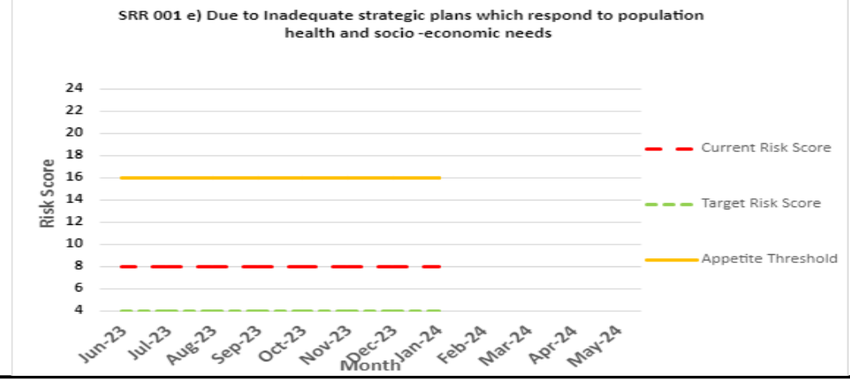
RISK THEME	SERVICE DELIVERY
Strategic risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**
Strategic Threat	**E) Due to inadequate strategic plans which respond to population health and socio-economic needs.**
Impact	➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to train teams in multi-morbidity management ➢ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➢ Reputational damage and loss of public confidence

Risk Appetite Level - Open
Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Tolerance Level - Open Score 16 and below
Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but within the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning and Partnerships.			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)*	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 (*Major)*	3 *(Moderate)*
Last Reviewed	12 January 2024	**Risk rating**	**= 8** *(High)*	**= 6** *(Moderate)*
Next Review Due	12 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Qliksense – performance information • SFN – performance information **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023-24** 1. IMTP Planning (Q1) Outcome – Reasonable Assurance	**Gaps in Assurance** **Under review** **Action to Address Gaps in Assurance**	**Reasonable Assurance**

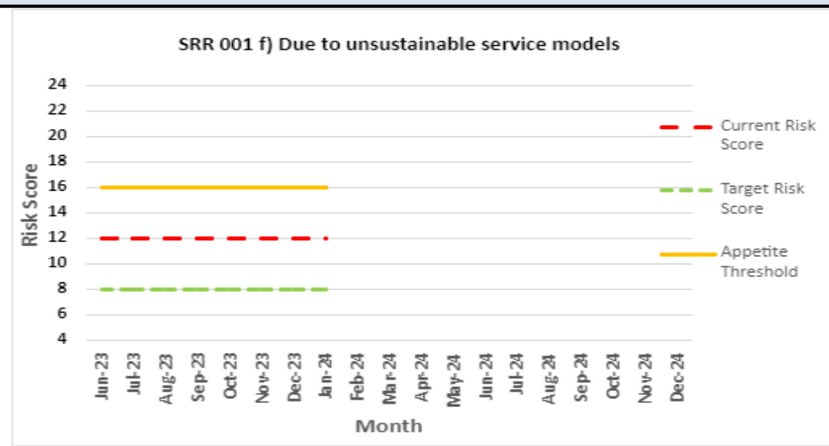
RISK THEME	SERVICE DELIVERY
Strategic risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**
Strategic Threat	**F) Due to unsustainable service models**
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to deliver health board priorities, required improvements and achieve sustainability. ➢ Reputational damage and loss of public confidence

Risk Appetite Level - Open
Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Tolerance Level - Open Score 16 and below
Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning and Partnerships.			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due	12 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• The Health Board IMPT and associated KPIs • Clinical Futures Transformation programmes. • Public Health Wales surveillance data – Covid, flu and other communicable diseases. • Qliksense – performance information. • Population needs assessment and area plan development by the RPB. • Southeast Wales Plan for fragile services.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy – to launch Summer 2024.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023-24** 1. IMTP planning Q1 Outcome – Reasonable Assurance.	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

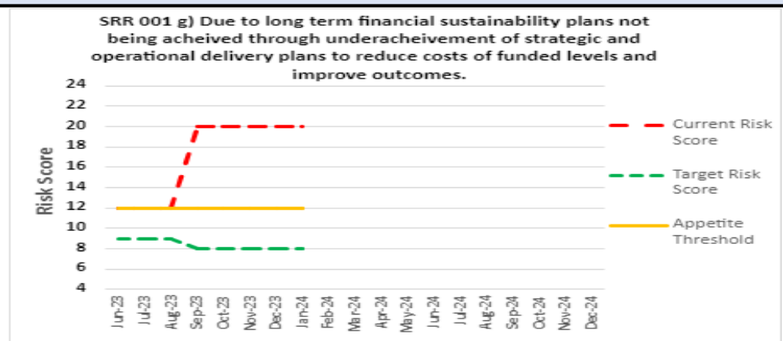
RISK THEME	FINANCIAL SUSTAINABILITY
Strategic Risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**
Strategic Threat	**G) Due to long-term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans which would reduce costs to funded levels and improve outcomes.**
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence

Risk Appetite Level - Cautious.
Preference for safe, through accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - Score 12 and below
Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies.

SUMMARY
the current risk level is **outside** of the target and appetite threshold. The target level to be achieved is **within** the set appetite threshold.

Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	5 *(Almost certain)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	08 January 2024	**Risk rating**	**= 20** *(Extreme)*	**= 8** *(Moderate)*
Next Review	08 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Budget holder training • Cost intervention procedures • 23/24 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Quarterly financial budget plan approach agreed. Executive groups and structures established to deliver statutory duties	• Update performance management framework – in place • Assessment of financial control environment within divisions and corporate teams. – in place • Financial Escalation Meetings – in place • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 - 24** 1. Savings Programmes Q3 - Not yet undertaken. Report expected Q1 2024/25 2. Financial Controls Q2 – Not yet reported. Report expected Q4 2023/24 3. Asset Management Q3 – Report to be received at ARAC 08/02/24. **External Audit Reports 2023 -24** 1. Efficiency Review Q3/Q4 – Not yet reported. 2. Structured Assessment - Received at ARAC November 2023. 3. Audit of Financial Statements Q4 2023/24 – Not yet reported. Financial assessment and review reports to Welsh Government – monthly Enhanced monitoring meetings with Welsh Government – monthly	**Gaps in Assurance** Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. **Action to Address Gaps in Assurance** Revise accountability arrangements being progressed as part of Executive governance. – in place 2024/25 IMTP plans focussed on 'living within budget levels' – currently work in progress.	**Reasonable Assurance**

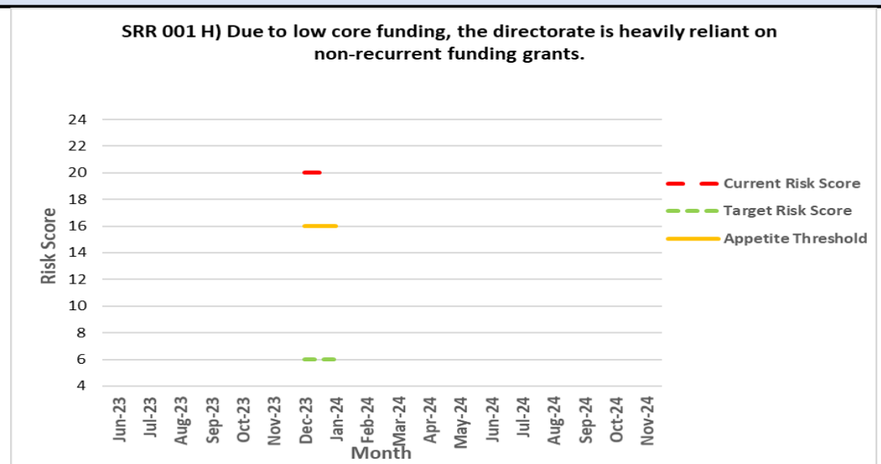
RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**
Strategic Threat	**h. Due to low core funding, the Directorate is heavily reliant on non-recurrent funding grants.**
Impact	➢ Avoidable harm ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Unable to substantially improve the health of the population ➢ Reputational damage and loss of public confidence ➢ Multi-year CIP calculated on non-recurrent funding ➢ Major grants subject to funding cuts 24/25 ➢ No determined staffing establishment ➢ Possible at-risk TUPE posts ➢ £1.5 million temporary staff funding (RIF + EYP) majority on permanent contracts ➢ Government grants focused on particular risk factors

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure**.**

Risk Appetite Threshold – SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.

Lead Director	Director of Public Health & Strategic Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Population Health, and Planning Committee	**Likelihood**	5 *(Almost Certain)* *x*	2 *(Unlikely)* *x*
Initial Date of Assessment	01 December 2023	**Impact**	4 (*Major)*	3 *(Moderate)*
Last Reviewed	13 January 2024	**Risk rating**	**= 20** *(Extreme)*	**= 6** *(Moderate)*
Next Review Due	13 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Advice from HR on structure • Meetings established to review and redesign structure. • Meetings with finance to determine TUPE level and CIP calculation. • Local public health risk register with risk clearly identified risk relating to structure and finance. • Business cases being written for PIP for preventative adverse deaths, health protection and other public health areas. • SMT meetings to discuss progress on delivery of objectives linked to available budget.	• Business cases being written for PIP to increase core funding to deliver objectives. • Through Pip process work towards a funded establishment reduce risks associated with permanent staff being funded through temporary funding which impacts on the ability to plan long term.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monthly finance meetings in place with Director and Assistant Director • Weekly reporting on finance levels **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Escalation to the Strategic Risk Register for Board oversight **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* • Report delivery of local progress against the national public health strategy through Public Health Peer Group	**Gaps in Assurance** • Unable to determine the full impact of the reduction in funding on the Public Health portfolio **Action to Address Gaps in Assurance** • Determine where the cuts will impact and how the Health Board can sustain PH services.	**Negative Assurance**

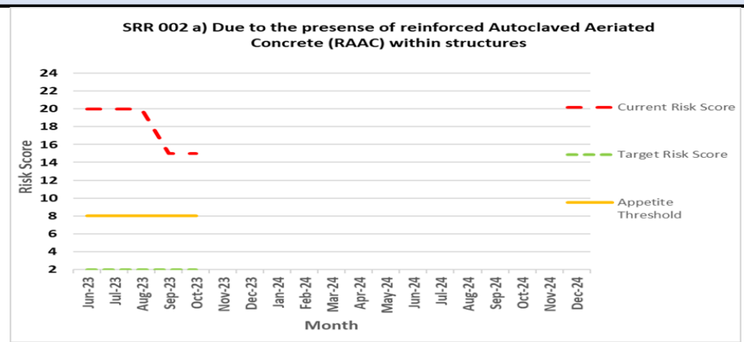
RISK THEME	COMPLIANCE AND SAFETY
Strategic Risk (SRR 002)	**There is a risk that there will be significant failure of the Health Boards Estates.**
Strategic Threat	**a. Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.**
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties

Risk Appetite Level - MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold

		Risk Exposure	Current Level	Target Level
Lead Director	Chief Operating Officer			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare*) x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	12th January 2024	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*
Next Review Due	12th February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Work to assess the risk has been undertaken with expert external surveyor advice and repeat surveys have recently been completed. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance. • Remediation work to areas of high-risk areas • The estate's function has controlled access to roof areas and has developed and implemented toolbox talks for awareness for estate teams and contractors to work in those areas. • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management. • Weekly dialogue with Welsh Government and Shared Services Estates. • Links with NHS England and other Health Boards in Wales for shared learning.	• Additional Surveys are to take place with expert surveyors to inform the next steps relating to further remediation of the issues.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Weekly checks in place for the props in place and will be reduced to fortnightly as the frequency of checks is not demonstrated to be of benefit or required. • Ongoing engagement with expert surveyor and monitoring of RAAC with additional surveys continuing. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Risk assessments completed by the Health and Safety function in those departments with props to manage any consequences of the presence of props. Note: H&S assessments were around the location of props not of RAAC itself and they flagged no issues or alterations. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Ongoing engagement of external surveyors for regular monitoring of the situation in line with recommended timelines.	**Gaps in Assurance** • Ongoing management of the issues. **Action to Address Gaps in Assurance** • Repeat surveys have been completed and additional more specific and technical surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues.	**Reasonable Assurance**

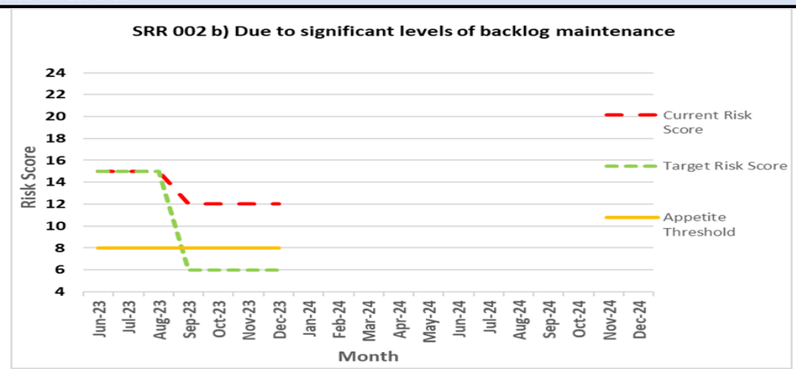
RISK THEME	COMPLIANCE AND SAFETY
Strategic Risk (SRR 002)	**There is a risk that there will be a significant failure of the Health Board Estates.**
Strategic Threat	B) **Due to significant levels of backlog maintenance and structural impairment.**
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties.

Risk Appetite Level – MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Chief Operating Officer			
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** *(Minor)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Next Review Due	12 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Asbestos reinspection programme (over the next 3 years)	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Estates and Facilities division improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Outcome of the Asbestos reinspection programme • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023- 24** 1. Estates Assurance - Estate Condition audit completed and will be with Audit Committee in February • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	**Gaps in Assurance** • AE reports have shown a deterioration in ratings last year. • Membership of HB-wide compliance groups continues to be extended providing wider HB intelligence of the issues. **Action to Address Gaps in Assurance** • The Divisional Director (and DP) has implemented a clear approach to compliance monitoring and escalation of AE reports. • HB-wide groups on compliance (such as Ventilation and water) are being widened in membership to ensure clinical services are active participants.	**Reasonable Assurance**

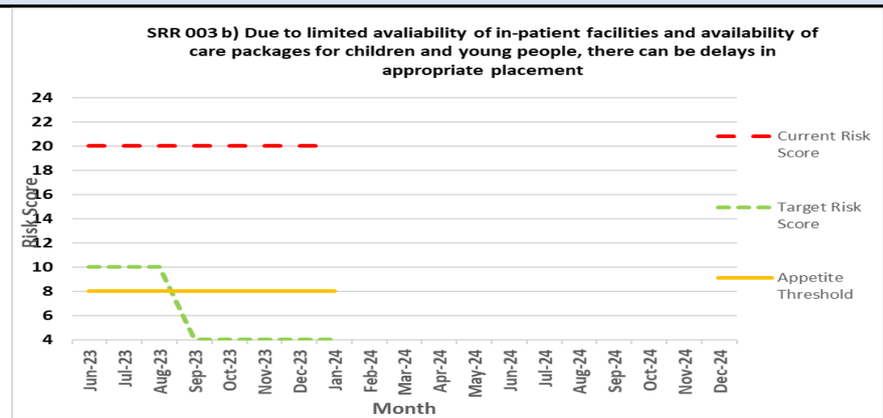
RISK THEME	COMPLIANCE AND SAFETY
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**
Strategic Threat	b. **Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.**
Impact	➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

Risk Appetite Level -Minimal
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – Minimal SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Chief Operating Officer			
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Unlikely)*
Last Reviewed	12 January 2024	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*
Next Review Due	12 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• CAMHS now have a team of healthcare support workers, at band 4 (our BOOST team), who are in the process of being trained, prior to being ready to be available over 7days to directly support young people who are in hospital because of a delayed discharge. • CAMHS have an agreement with adult Mental Health Services in place, enabling us to access a 'holding bed 'situated in the Extra Care area at Ty-Cyfanol ward, at YYF. This allows us to support young people experiencing suspected serious mental illness for up to 72 hours, whilst a gatekeeping assessment is carried out by our colleagues at the tier 4 in-patient unit. • Our Emergency Liaison Team are present at GUH on a daily basis, assessing young people at the point of need. • Windmill farm therapeutic residential home, a partnership project between CAMHS and social services, is now open and can accommodate young people struggling with complex mental distress that are environmental and not organic. There are 4 places at the home, and we have already successfully placed, supported, and transitioned several young people who may previously have required an out of county placement. • BOOST team manager in place. • Crisis Outreach Team are the designated team who manage and co-ordinate admission to the holding bed.	Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: • Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. • Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. • Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Senior Management Team meetings to track progress against the Improvement plan. • Twice-daily X-Site flow meetings to provide a position report. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee • Regular reporting to the Mental Health Act Monitoring Committee • Reporting to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • HIW Inspections of Mental Health Wards across all sites	**Gaps in Assurance** • Development of CAMHS Crisis Hub Project build. **Action to Address Gaps in Assurance** • The CAMHS Crisis Hub Project development is ongoing – tenders for contracts were return 20th December 2023 within identified capital budget constraints. Tenders are currently with Quantity Surveyors Faithful & Gould for a two-week review to check for omissions or anomalies. • Tenders have all identified estimated completion of the CAMHs Crisis Hub by August 2024. • CAMHS Crisis Hub Project Team meet monthly – update reports are provided to the CAMHS Senior Management Team and ABUHB Capital Group.	**Reasonable Assurance**

• Standard Operational Policy in place for CAMHS teams to be able to access BOOST workers. • Agreed referral process to Windmill Farm, with a gatekeeping team comprised of CAMHS and social care colleagues who are able to advise whether or not a referral is suitable; attendance at Complex Needs panels to operationalise the gatekeeping process. • Standard operational policy and care pathway in place for admission to the holding bed. • Detailed Standard Operational Policy in place for Windmill Farm. • Regular communication meetings between CAMHS teams and the Windmill Farm team. • Mental Health Improvement Plan	• Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.			

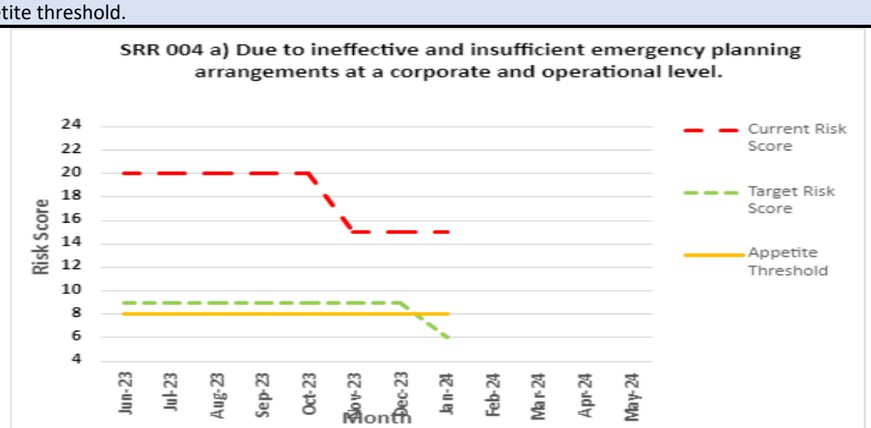
RISK THEME	COMPLIANCE AND SAFETY
Strategic risk (SRR 004)	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.**
Strategic Threat	**a. Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.**
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties under the Civil Contingencies Act 2004 ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

Risk Appetite Level – Minimal
Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls**.**

Risk Appetite Threshold – Minimal Score 8 and below
Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning and Partnerships			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 (*Catastrophic)*	3 *(Moderate)*
Last Reviewed	12 January 2024	**Risk rating**	**= 15** *(Extreme)*	**= 6** *(Moderate)*
Next Review Due	12 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Major Incident • Health Board major incident plan in place, refreshed plan going to the Executive Board January 2024. • Local/Divisional action cards are in place. • Training undertaken service-specific relating to local response. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • **Business Continuity (BC) /Critical Incident** • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. • 3 C (Command/Control, Communication) structure in place to respond to incidents. • Ongoing Participation in exercise UK, Wales, LRF and HB.	• Major Incident Exercise 'Euclid' planned for 20th June 2024 – Faculty in place to plan scope and detail of exercise • Testing programme of business continuity plans. • Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Repository on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. • Joint planning with PH in response to infectious diseases and public health incidence response. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Continue to promote awareness in a timely manner. • Continue to promote awareness of the requirement for BC across the Health Board. • Continuing participation in multi-agency exercises.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Departmental debrief following an incident to inform learning and enhance controls. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Debrief with key stakeholders following an incident to inform learning and enhance controls. • Report to the Executive Committee following any incident. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Review(s)** 1. Business Continuity Planning 2023-24 (Q2) outcome report published – Reasonable Assurance Outcome and feedback from national exercises	**Gaps in Assurance** • Robustness of service business continuity plans **Action to Address Gaps in Assurance** • Recommendations for strengthening resilience following testing of service business continuity plans	**Reasonable Assurance**

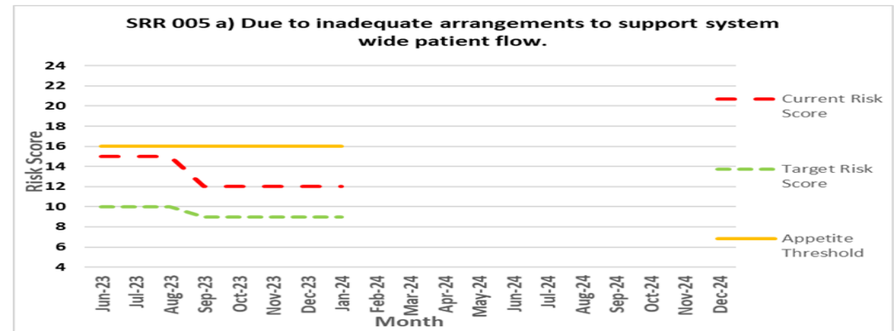
RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 005)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**
Strategic Threat	a. **Due to inadequate arrangements to support system-wide patient flow**
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

Risk Appetite Level - Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Chief Operating Officer			
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	Likelihood	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	Impact	4 *(Catastrophic)*	3 *(Minor)*
Last Reviewed	12 January 2024	Risk rating	= 12 *(High)*	= 9 *(High)*
Next Review Due	12 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*

• Escalation Policy.
• Performance and Accountability Framework
• Major incident Procedures
• Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks.
• Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team.
• Weekly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven.
• Range of performance measures/metrics in place
• Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards.
• Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained.
• Planned care recovery meetings with the NHS execs.
• Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.
• WG – IQPD meetings to review areas of focus.
	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale.
	• Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure:
	  • Focus
	  • Processing power
	  • Capacity
	• Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites.
	• Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions.
	• Improve regional acceptance of flow processes with neighbouring Health Boards.
	• Industrial Action – command and control structures across gold, silver and bronze to ensure service continuity and patient safety throughout any medical strikes.
		Level 1 Operational *(Implemented by the department that performs daily operation activities)*
		• The Escalation Framework has been enacted and is effective in mitigating threats and impact to services.
		• Performance report against measures/metrics
		Level 2 Organisational *(Executed by risk management and compliance functions.)*
		• Divisional Assurance reviews.
		• Performance against measures/metrics reported to the Executive Committee
		Level 3 Independent *(Implemented by both auditors internal and external independent bodies.)*
		• **Internal Audit Reviews**
		  1. Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024.
		• External inspections/visits.
			Gaps in Assurance
			• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers.
			• The impact of the Performance and Accountability framework in improving patient flow
			Action to Address Gaps in Assurance
			• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
				Reasonable Assurance

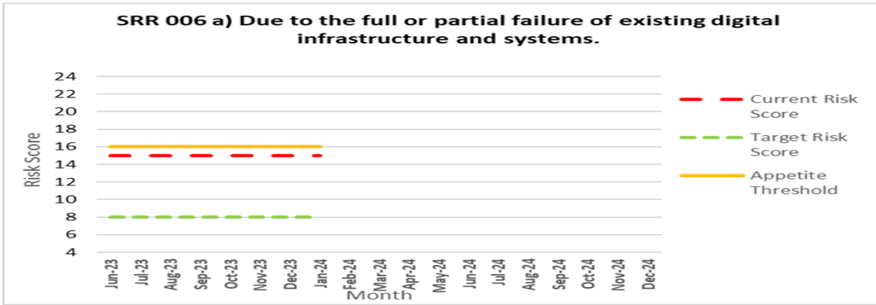
RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**
Strategic Threat	**a. Due to the full or partial failure of existing digital infrastructure and systems.**
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

Risk Appetite Level - OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold.

Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	4 *(Major)*
Last Reviewed	08 December 2023	**Risk rating**	**= 15** *(Extreme)*	**= 8** *(Moderate)*
Next Review Due	01 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber and the Teams to review compliance levels against policy. Results are captured within the monthly Cyber Report. • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk management process. • Cyber has maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. • Cyber has begun the roll out simulated phishing campaigns. The initial phish has been tested on ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023	• Implement the recommendations from Templar report	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting on progress to the Finance & Performance Committee on our cyber security action plan. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal audit** 1. Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance**	**Reasonable assurance**

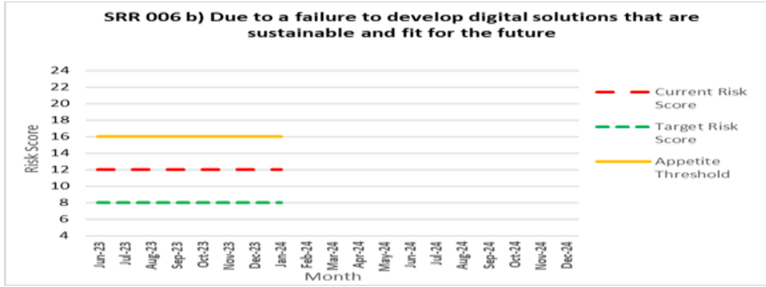
RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**
Strategic Threat	**b. Due to an adverse impact on service delivery in the implementation of the new digital systems.**
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

Risk Appetite Level - OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital			
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* *x*	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	08 December 2023	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due	08 March 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project works packages. • Each clinical project has clinical leaf who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track and ensures any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required • Cyber Security Subgroup ToR and membership agreed.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Project Boards meet monthly and report into the quarterly Programme Delivery Board • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit** Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance	**Gaps in Assurance** • Governance and assurance groups. • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance** • Information Governance Sub Committee Terms of Reference have been drafted and are under review.	**Reasonable assurance**

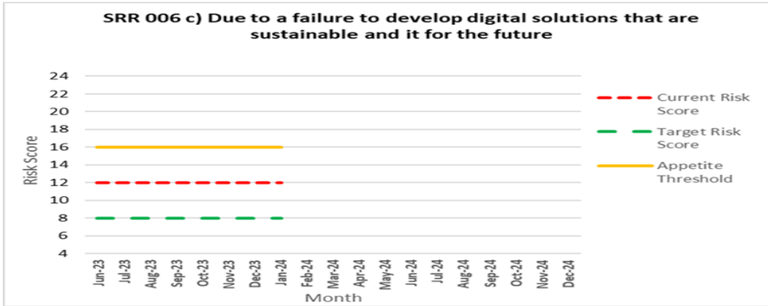
RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**
Strategic Threat	**c. Due to failure to develop digital solutions that are sustainable and fit for the future.**
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital			
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	08 December 2023	**Risk rating**	**= 12** (High)	**= 8** *(Moderate)*
Next Review Due	10 March 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
New Digital Service Request process in place which provides governance in several key areas: 1. Information Governance – ensuring new services have appropriate controls to keep patient information safe. 2. Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. 3. Patient Safety – ensuring services do not introduce any patient safety risks. 4. Records – ensuring new systems comply with the requirements of records management. • Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. • Business change function which ensures implemented systems are effective and deliver the benefits required. • Formal framework in place for the adoption of new digital services and best practice guidance followed. • Operational delivery aligned to ITIL standards	• New governance structures to be put in place by the end of 2023. • Review of New Digital Request processes considering governance changes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks and to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit** • LINC Programme 23/24 – Not yet undertaken. • Network Infrastructure (VPN) 23/24 Q3 - Outcome reasonable assurance	**Gaps in Assurance** • To be determined once the new governance changes have been implemented. **Action to Address Gaps in Assurance**	**Reasonable assurance**

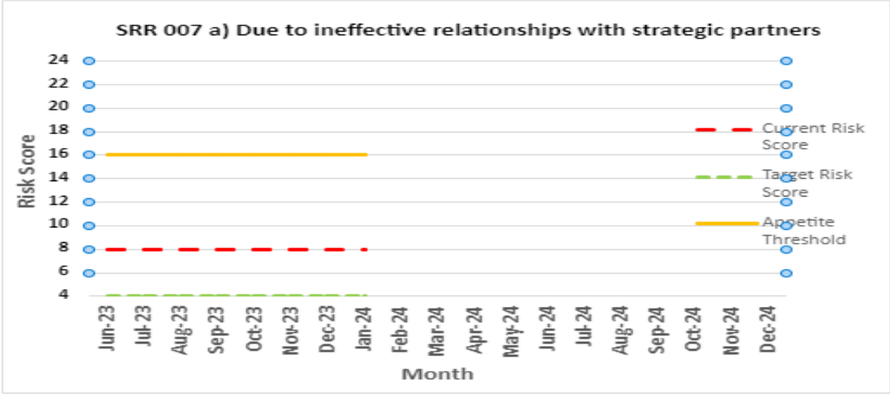
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING
Strategic Risk (SRR 007)	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**
Strategic Threat	a. **Due to ineffective relationships with strategic partners**
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence

Risk Appetite Level - OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold - SCORE 16 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning, and Partnerships.			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	10 January 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*
Next Review Due	10 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: 1. **The Gwent Public Services Board (Gwent PSB)** brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. 2. **The Gwent Regional Partnership Board** As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Governance Review 2023/24 (Q2) – Underway – due to be reported to the Audit, Risk & Assurance Committee in February 2024.	**Gaps in Assurance** • Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements **Action to Address Gaps in Assurance** • Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach.	**Reasonable Assurance**

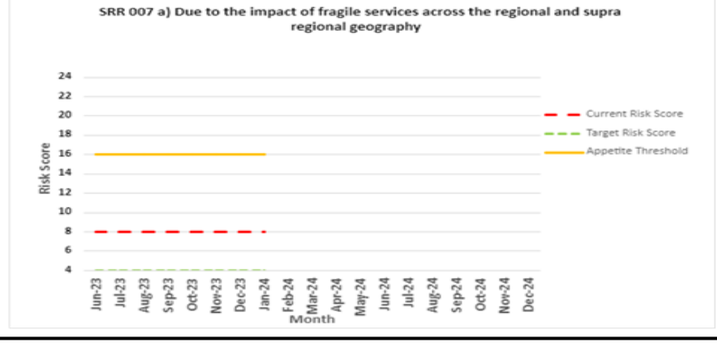
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING
Strategic Risk No: SRR 007B	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population**
Strategic Threat	**b. Due to the impact of fragile services across the regional and supra regional geography**
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence

Risk Appetite Level - OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold - SCORE 12 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy Planning and Partnerships			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	04 January 2024	**Impact**	*3 (Moderate)*	2 *(Minor)*
Last Reviewed	16 January 2024	**Risk rating**	***= 9*** *(High)*	***= 4*** *(Moderate)*
Next Review Due	16 April 2024			



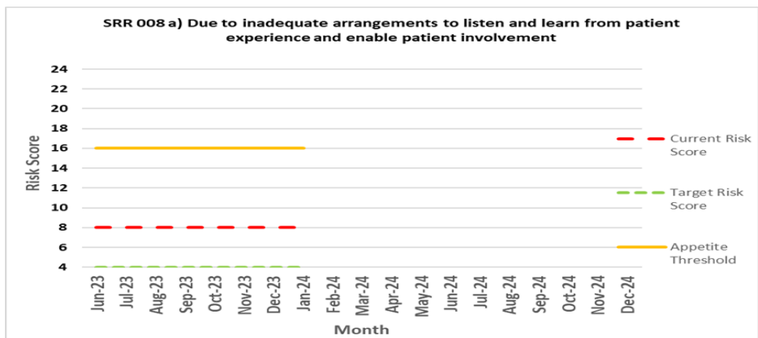
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• A robust Southeast Wales Regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. • The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. • 4 workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. • Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. • When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. • In addition to these formal arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a recent review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with recognition that these need to be 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions. Discussion to be had at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Service Divisions reporting to the Chief Operational Officer **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 008)	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**			
Strategic Threat	a. **Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	11 January 2024	**Risk rating**	**= 8** *(High)*	**= 4** *(Moderate)*
Next Review Due	11 April 2024			

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure

Risk Appetite Threshold – Open SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target but within the appetite threshold. Target level is **within** the set appetite threshold.



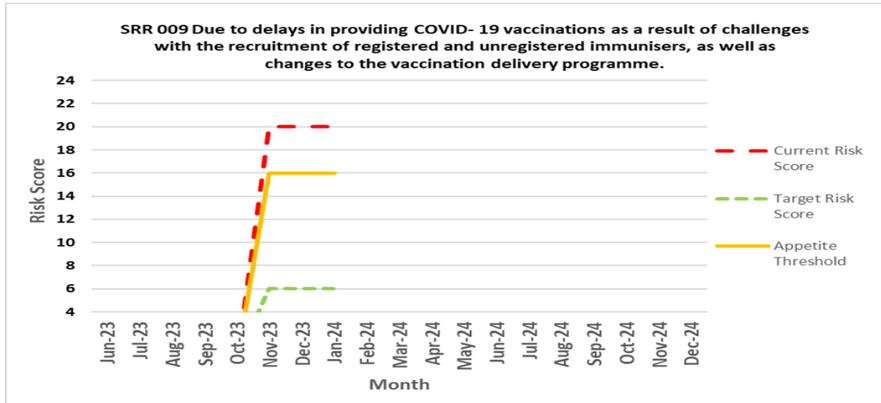
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff, and relatives. • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Person Centred Care Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • LLais Reports • HIW inspections	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor • PALS Single point of contact is being established. PALS officers will have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. • PCC KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Implement PALS DATIX Module	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 009)	**The Health Board will be unable to protect those most vulnerable to serious disease.**
Strategic Threat	**a. Due to delays in providing COVID-19 vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as changes to the vaccination delivery programme.**
Impact	➢ Adverse impacts on the delivery of vaccinations to patients across the vaccine service for routine and seasonal vaccines ➢ Inability to support response to outbreaks as required in 'Wales Outbreak Plan', and ABUHB Public Health Incident Response plan. ➢ Potential increase in communicable disease incidence, with impact on healthcare use and staff sickness ➢ Reputational damage and loss of public confidence ➢ Patients not being sufficiently protected therefore increases the incidence of disease and avoidable harm from Vaccine preventable diseases. ➢ Increased disease will lead to increased admissions through acute settings therefore bed pressures on the wider system. ➢ ABUHB not delivering in line with JCVI and WG guidance/milestones. ➢ ABUHB not delivering in line with NHS performance framework uptake standards ➢ ABUHB not delivering vaccinations in line with the funding provided. ➢ ABUHB already has the lowest spend on COVID vaccinations in Wales, further disinvestment would make us more of an outlier reputationally. ➢ Lack of resources to stand up sampling and testing as a preventative/protective measure as needed for patients and staff during peak in activity. ➢ Inability to provide sufficient interventions in closed settings for the most vulnerable population such as care homes and special schools. ➢ Reduction in capacity to deliver equity work to provide HP intervention and screening to vulnerable groups. ➢ Until it transfers to UPC, a lack of resources to deliver AV service will mean our most vulnerable patients not accessing clinical treatment within the treatment window leading to avoidable harm and unnecessary hospital admissions

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Lead Director	**Director of Public Health & Strategic Partnerships**			**Risk Exposure**	**Current Level** / **Target Level**
Monitoring Committee	**Partnerships, Population Health, and Planning Committee**			**Likelihood**	5 *(Almost Certain)* x / 2 *(Unlikely)* x
Initial Date of Assessment	**06 November 2023**			**Impact**	4 (*Major*) / 3 *(Moderate)*
Last Reviewed	**13 January 2024**	**Next Review Due**	**13 February 2024**	**Risk rating**	**= 20** *(Extreme)* / **= 6** *(Moderate)*

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Dedicated pool of bank staff to fill shifts – although there have been challenges in filling shifts within this pool of staff. • Opening venues on additional days to allow more vaccine appointments to be offered (provided staff are available) • Daily monitoring of public vaccinations administered. • Weekly planning and delivery meetings to monitor progress, identify alternative solutions, and implement or escalate as appropriate. • Weekly programme board to approve key decisions and escalate potential risks. • Health protection Incident plan has been drafted for approval by the Executive Committee (Dec 2023)	• Secured additional funding against the existing allocation for bank vaccination staff. • Exploring deployment options to the Vaccination programme and use of those previously trained as vaccinators that are on the bank. • Alternative advertising methods of vacant shifts to improve uptake – liaising with bank co-ordinator to improve this. • Draft community pop-up plan to be further explored. • If required, extend venue licence in key location(s). • Review infrastructure for Health Protection and Vaccinations separately. Consider options for Vaccinations to align more closely to broader operational delivery, and for health protection to be reviewed using a clear evidence base to	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Costs of bank staff reported to Programme Board • Uptake on staff vaccination reported to Programme Board • National and regional data shared with Programme Board on the % of the population vaccinated **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Risk monitored by the Partnerships, Population Health, and Planning Committee via the Committee Risk Report • Exception reporting to the Executive Committee regarding uptake of the vaccine by staff and public, and capacity to deliver the milestones. **Level 3 Independent**	**Gaps in Assurance** • Reporting on filled and non-filled shifts to determine the slippage in milestones of the programme. **Action to Address Gaps in Assurance** • Start reporting the filled and non-filled shifts report to the Programme Board • Model delivery based on the current resource, dedicated bank staff, and	**Reasonable Assurance**

• Monitoring filled/non-filled shifts report. • Monitoring costs associated with the use of Bank staff. • Monitoring uptake of staff vaccination • Dedicated internal and external communications support. • Alternative service models to deliver core functions within available budget • Business continuity plans to ensure core service delivery with unforeseen staffing challenges e.g. funding • Identify sustainable assets for venues to reduce high costs of using externally rented spaces.	understand potential and likelihood of threats to ensure we are maximising mitigation and structures to respond effectively. • Strengthen ways of working around known national threats such as Pandemic Flu and Measles • Focus performance of vaccination and health protection against national targets not best in Wales, to maximise the protection of our population.	*(Implemented by both auditors internal and external independent bodies)* • Monthly reporting to Welsh Government on uptake • PHW national data on vaccination uptake	wider bank staff to determine the workforce resource to deliver.	

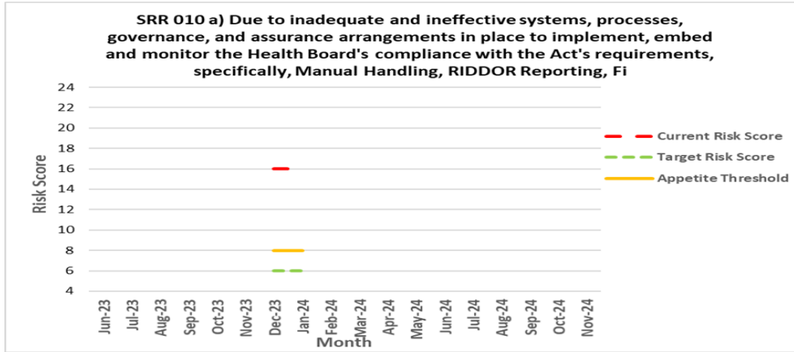
RISK THEME	COMPLIANCE & SAFETY
Risk No: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**
Strategic Threat	a. Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.
Impact	➢ Unintended physical harm; ➢ Punitive actions from the Health and Safety Executive (HSE); ➢ Increased levels of staff sickness; ➢ Loss of estate due to unsafe environments; ➢ Financial implications; ➢ Adverse publicity; and, ➢ Reputational damage

Risk Appetite Level - MINIMAL.
Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.

Risk Appetite Threshold - Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**

SUMMARY
The current risk level is **outside** of target level and **outside** appetite threshold. The target level to be achieved is **within** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Therapies & Health Science			
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	**4** (*Likely*) **x**	**2** (*Unlikely*) **x**
Initial Date of Assessment	01 December 2023	Impact	***4*** *(Major)*	**3** *(Moderate)*
Date Reviewed	11 January 2024	Overall Risk Rating	**= 16** *(Extreme)*	**= 6** *(Moderate)*
Date of Next Review	11 February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	• Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee) • Develop and Implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Board Training /development • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Health and Safety compliance data extracted from ESR and Datix and reported **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Performance reviews at All Wales Health and Safety Management Steering Group • Internal Audit – H&S processes Review to be included in 2024/25 Plan. • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	**Gaps in Assurance** • Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions **Action to Address Gaps in Assurance** • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	**Negative Assurance**

Archwilio Cymru
Audit Wales

Stakeholder perceptions research

Report: June 2023

Summary of findings

- Audit Wales scores well for ratings of **driving improvements** (87%) and **credibility** (82%) amongst stakeholders
- **Providing insight** scores less highly (72%) however just over 1 in 4 (26%) stakeholders say that they "neither agree nor disagree" with this statement suggesting that whilst they don't outright reject that Audit Wales provides insights, they are not currently seeing it for themselves
- Whilst scores for driving improvements are high, qualitatively stakeholders did question **how this is measured** and where Audit Wales' role in **facilitating change** comes in
- Audit Wales score very highly on perceptions of **independence** (92%), and it is the second word that comes to mind when stakeholders think about the organisation (62%), behind "**professional**" (67%)
- This is very important to stakeholders as it **provides reports/outputs with credibility**. The only questions about independence came from wanting to understand **why certain decisions are made or areas of focus are chosen**

Summary of findings - performance

- Overall stakeholders are satisfied* with the value that the work of Audit Wales brings to their organisation (79%)
  - Although over 1 in 3 (35%) are not sure about the **value it brings beyond statutory requirements** and just under half (46%) are unsure or negative **about value for money**
- Audit Wales brings value to stakeholders through **strong relationships**, **clear evidence-based recommendations** and through providing **sector wide leanings** which can be applied to their own organisation
- One area of concern is **delays to delivery** and **long timelines** for reporting
- Whilst 79% of stakeholders say that they are **satisfied with the speed at which they work with Audit Wales**, over 1 in 3 (36%) are either don't agree or disagree that **work is delivered in a timely manner**
  - Delays in report delivery can have negative knock-on effects for stakeholders who are working towards their own internal deadlines
- Concerns around delivery times are closely linked to perceptions of **lack of resource** at Audit Wales, with some stakeholders questioning the organisation's ability to deliver in the future if staffing levels are not addressed

Summary of findings – outputs and reports

- **Audit of accounts work** (79%) and **local performance audit work** (62%) are the most commonly used products/services, with both being used to provide assurance and to inform scrutiny, whilst performance work is also used to drive internal improvements

- Over half of stakeholders are using **Audit Wales' Strategy, Plans and Annual Report** (59%) and **public interest reports** (54%) with the strategy, plans & annual report mainly being used to inform scrutiny and both being used to drive improvements

- At an overall level **satisfaction with reports and publications is high** (85%)

- Specifically, stakeholders give high ratings for reports being **clear & easy to understand** (87%), **impactful** (82%), **insightful** (77%) and of an **appropriate length** (77%)

- Qualitative suggestions on improvements to reports & outputs include having **clearer summaries up front**, providing **strategic level recommendations** and producing content with **cross-cutting themes**

Summary of findings - relationships

- The majority of stakeholders (87%) are engaging with Audit Wales **at least quarterly**, with over 1 in 3 (36%) doing so on at least a monthly basis
- Satisfaction with **main contact** (92%) and c**ommunications** (85%) is high
- Ratings for **effective communication** (89%), being **easy to work with** (87%), **staff expertise** (87%), **informative staff** (87%) and **sharing clear and relevant information** (87%) are all strong
- Just over 1 in 4 (26%) are less sure about Audit Wales **acting on feedback shared** with them
- Relationships **have not been negatively impacted since the Covid-19** pandemic, with around half (49%) of stakeholders saying that there has been no change and just under a quarter (23%) saying that it is now better. The majority of the rest “don’t know” (26%) with just 3% saying it is now worse

Recommendations

Providing insight scored the lowest of KPIs

Focus on reporting which tells stakeholders something new, challenges existing knowledge or provides additional sector context

Audit Wales' independence is highly valued

Reaffirm this perception by providing clarity on decisions such as areas/topics of focus

Continue to share sector knowledge that stakeholders can utilise

Consider producing reports on cross-cutting themes and focusing on areas of relevance to stakeholders

Maintain the high quality of outputs

And place emphasis on the "so what" of reports, helping stakeholders to summarise findings and understand what to act on

Address concerns over Audit Wales resourcing

Through hiring more high-quality auditors, communicating with stakeholders about how deadlines will be met and working with them to create timelines that met their requirements