Audit, Risk & Assurance Committee

Tue 18 April 2023, 09:30 - 12:00

Microsoft Teams

Agenda

1. Preliminary Matters

1.0 Audit Risk & Assurance Committee Agenda.pdf (4 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the Meeting held on 02 February 2023

Paper *Chair*

1.4 Draft Minutes Audit_Risk Assurance Committee_02_02_23 v2 Chair Approved.pdf (10 pages)

1.5. Committee Action Log

Paper *Chair*

1.5 Audit, Risk & Assurance Committee Action Log April 2023.pdf (4 pages)

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. To Approve the Audit, Risk & Assurance Committee Annual Report 2022/23

Paper *Director of Corporate Governance*

2.1 Cover Paper_Audit Risk & Assurance Committee Annual Report 2022-23.pdf (4 pages)
2.1a DRAFT 2022-23 Audit_Risk and Assurance Annual Report.pdf (44 pages)

2.2. To Approve the Audit, Risk & Assurance Committee Work Plan 2023/24

Paper *Director of Corporate Governance*

2.2 Cover Report Audit Risk and Assurance Committee Work Plan 2023-24.pdf (3 pages)
2.2a DRAFT ARA_Committee Work Programme 2023-24 v2.pdf (5 pages)

2.3. Ratification of the use of Single Tender Waivers

Paper *Director of Finance, Procurement & Value*

2.3 Single Tender Action Report 18.04.2023.pdf (3 pages)
2.3a Appendix A- STA Summary 11th January 2023- 24th March 2023.pdf (1 pages)

2.4. Discuss and Note the Financial Governance Report and Ratify Financial Control

Procedures

Paper *Director of Finance, Procurement & Value*

- General Ledger
- Policy and Governance approach for Commissioning Additional (External & Insourced) Non-NHS Clinical Services

2.4 Financial Governance, Reporting & Control Report.pdf (7 pages)
2.4a Appendix 1 ABUHB_Finance_0245 FCP General Ledger_Final.pdf (9 pages)
2.4b Appendix 2 ABUHB_Commissioning_0891 Policy and Governance Approach for Commissioning Additional Non NHS Clinical Services_Final.pdf (8 pages)

2.5. To Approve the Counter Fraud Annual Plan 2023/204

Paper *Director of Finance, Procurement & Value*

2.5 Cover Report Clinical Fraud Annual Work Plan 2023-24.pdf (3 pages)
2.5a ABUHB Annual Counter Fraud Workplan 2023-2024.pdf (30 pages)

2.6. Ratification of the Clinical Audit Plan

Paper *Medical Director*

2.6 Cover Report Clinical Audit Plan.pdf (10 pages)
2.6a Appendix 1 Clinical Audit Policy_Issue 1.1.pdf (15 pages)
2.6b Appendix 2 Clinical Audit Strategy 2022 - 2025.pdf (12 pages)

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3. ITEMS FOR DISCUSSION

3.1. Receive the Annual Report on Clinical Audit Activity

Paper *Medical Director*

3.1 Cover Report Clinical Audit Activity Report.pdf (6 pages)

3.2. Receive the Annual Report on Counter Fraud Activity

Paper *Director of Finance, Procurement & Value*

3.2 Cover Report Counter Fraud Annual Report 2022-23 .pdf (3 pages)
3.2a ABUHB Annual Counter Fraud Report 2022-2023.pdf (42 pages)

3.3. Receive the Strategic Risk & Assurance Report

Paper *Director of Corporate Governance*

3.3 ARAC_Strategic Risk Report_Apr2023.pdf (8 pages)
3.3a Appendix 1_Corporate Risk Regsiter OverviewMar2023.pdf (11 pages)

3.4. Review of Audit Recommendations Tracking

Paper *Director of Corporate Governance*

3.4 Appendix 1_Audit Recc Tracker_IA_EA_Mar23.pdf (47 pages)
3.4 Audit Reccommendations Cover report March23.pdf (15 pages)

3.5. Receive an Update in respect of Post-Payment Verification Activity

Paper *PPV Manager, NWSSP*

3.5 PPV End of Year Report 22-23.pdf (4 pages)
3.5a Appendix 1 Key Points Report ABuHB Audit.pdf (1 pages)
3.5b Appendix 2 GMS -GOS Statistics ABuHB Aud.pdf (1 pages)
3.5c Appendix 3 GMS-GOS Snapshot Apr 22 - M.pdf (1 pages)

3.6. Receive the Internal Audit Progress Report

Paper *Deputy Head of Internal Audit*

3.6 AB Internal Audit and Assurance Progress Report April 2023 ARA Committee .pdf (10 pages)

3.7. Receive Internal Audit Reports

Paper *Deputy Head of Internal Audit*

3.7.1. Substantial Assurance Internal Audit Reports

Paper *Deputy Head of Internal Audit*

- Cyber Security

3.7a AB 2223-22 Cyber Security FINAL Internal Report for Client.pdf (10 pages)

3.7.2. Reasonable Assurance Internal Audit Reports

Paper *Deputy Head of Internal Audit*

- Robotic Process Automation
- IT Strategy
- Financial Sustainability
- Risk Management
- Monitoring Action Plans

3.7b.1 AB 2223-24 Robotic Process Automation FINAL Internal Audit Report.pdf (17 pages)
3.7b.2 AB 2223-25 IT Strategy FINAL Internal Audit Report.pdf (16 pages)
3.7b.3 ABUHB 2022.23 Financial Sustainability FINAL Internal Report for Client.pdf (18 pages)
3.7b.4 AB 2223-01 - FINAL Risk Management Internal Audit Report.pdf (11 pages)
3.7b.5 AB 2223-19- Final Monitoring Action Plans Internal Audit Report.pdf (11 pages)

3.7.3. Limited Assurance Internal Audit Reports

Paper *Deputy Head of Internal Audit*

- Discharge Planning
- Tredegar Health & Wellbeing Centre

Executive Leads attending for this item:

- Director of Nursing
- Director of Primary, Community and Mental Health Services

3.7.c.1 ABUHB 2022-23 Discharge Planning - FINAL Internal Audit Final Report for Client.pdf (24 pages)
3.7c.2 ABUHB Tredegar HWBC Final Audit Report 22-23.pdf (37 pages)

3.8. Receive the Internal Audit Draft Plan 2023/24

Paper *Deputy Head of Internal Audit*

3.8 ABUHB_2023-24_DRAFT Internal Audit Plan v2.0.pdf (30 pages)

3.9. Receive the External Audit Progress Report

Paper *Performance Audit Lead, Audit Wales*

3.9 Audit Risk and Assurance Committee Update - April 2023.pdf (12 pages)

3.10. Receive Audit Wales Outline Plan 2023/24

Paper *Performance Audit Lead, Audit Wales*

3.10 ABUHB 2022-23 Outline NHS Audit Plan.pdf (14 pages)

3.11. Receive Audit Wales National and Local Orthopaedic Report and ABUHB Management

Response

Paper *Performance Audit Lead, Audit Wales / Director of Operations*

- 3.11 Orthopaedic_Services_in_Wales_Tackling_the_Waiting_List_Backlog.pdf (43 pages)
- 3.11a ABUHB Orthopaedics Local Report.pdf (28 pages)
- 3.11b 3289A2022 ABUHB Organisational Response Form 2023.04.04 (003).pdf (7 pages)

3.12. Receive the NHS – Audit of Accounts 2022/23

Paper *Audit Director (financial) Audit Wales*

- 3.12 NHS Audit of Accounts Covering Letter final.pdf (2 pages)
- 3.12a NHS_letter_final_eng.pdf (7 pages)

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4. ITEMS FOR INFORMATION

Oral *Chair*

4.1. Internal Audit Follow-up of High Priority Recommendations

Paper *Chair*

- 4.1 AB 2223-20 - FINAL Follow up Internal Audit Report for Client.pdf (7 pages)

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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:

Oral *Chair*

Draft Annual Accounts
Tuesday 23rd May 2023 14:00 – 16:00

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6. Close of Meeting

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 18th April 2023 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 02 February 2023	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Approve the Audit, Risk & Assurance Committee Annual Report 2022/23	Attached	Director of Corporate Governance
2.2	To Approve the Audit, Risk & Assurance Committee Work Plan 2023/24	Attached	Director of Corporate Governance
2.3	Ratification of the use of Single Tender Waivers	Attached	Director of Finance and Procurement
2.4	Discuss and note the Financial Governance Report and Ratify Financial Control Procedures • General Ledger • Policy and Governance approach for Commissioning Additional (External & Insourced) Non-NHS Clinical Services	Attached	Director of Finance and Procurement
2.5	To Approve the Counter Fraud Annual Plan 2023/204	Attached	Director of Finance and Procurement
2.6	Ratification of the Clinical Audit Plan *(overseen by the PQSO Committee)*	Attached	Medical Director
3	**ITEMS FOR DISCUSSION**		

3.1	Receive the Annual Report on Clinical Audit Activity	Attached	Medical Director
3.2	Annual Report on Counter Fraud Activity	Attached	Director of Finance and Procurement
3.3	Strategic Risk & Assurance Report	Attached	Director of Corporate Governance
3.4	Review of Audit Recommendations Tracking	Attached	Director of Corporate Governance
3.5	Receive a Mid-Year update in respect of Post-Payment Verification Activity	Attached	PPV Manager, NWSSP
3.6	Receive the Internal Audit Progress Report	Attached	Deputy Head of Internal Audit
3.7	Receive Internal Audit Reports		
3.7a	Substantial Assurance Rated Reviews: • Cyber Security	Attached	
3.7b	Reasonable Assurance Rated Reviews: • Robotic Process Automation • IT Strategy • Financial Sustainability • Risk Management • Monitoring Action Plans	Attached	
3.7c	Limited Assurance Rated Reviews: • Discharge Planning • Tredegar Health & Wellbeing Centre	Attached	Director of Nursing & Director of Primary, Community and Mental Health Services
3.8	Receive Internal Audit Draft Plan 2023/24	Attached	Deputy Head of Internal Audit
3.9	Receive External Audit Progress Report	Attached	Performance Audit Lead, Audit Wales
3.10	Receive Audit Wales Outline Plan 2023/24	Attached	Performance Audit Lead, Audit Wales
3.11	Audit Wales Orthopaedic National Report	Attached	Performance Audit Lead, Audit Wales
3.11a	Audit Wales Orthopaedic Local Report and ABUHB Management Response	Attached	Performance Audit Lead, Audit Wales / Director of Operations
3.12	NHS – Audit of Accounts 2022/23	Attached	Audit Director (financial)

			Audit Wales
4	**ITEMS FOR INFORMATION**		
4.1	Internal Audit Follow-up of High Priority Recommendations	Attached	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: Draft Annual Accounts • Tuesday 23rd May 2023 14:00 – 16:00		
	COMFORT BREAK (12:00 – 12:15)		

	IN-COMMITTEE 12.15 – 13:00		
IC1	To receive Audit Wales' Report "Learning from Cyber-attacks" (October 2022) and Management's Response	Attachment	Interim Chief Digital Officer
IC2	Works and Estates Overpayment	Attachment	Director of Workforce and Organisational Development / Director of Operations

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

MINUTES OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DATE OF MEETING	Thursday 2nd February 2023
VENUE	Microsoft Teams

PRESENT	Iwan Jones (Chair)
	Richard Clark (Vice Chair)
	Shelley Bosson
	Paul Deneen
IN ATTENDANCE	Rob Holcolmbe, Director of Finance, Procurement & Value
	Rani Dash, Director of Corporate Governance
	Nicola Prygodzicz, Chief Executive Officer *(left at 10:45, re-joined at 11:45)*
	Mark Ross, Assistant Finance Director
	Simon Cookson, Head of Internal Audit & Assurance, NHS Wales SSP
	Stephen Chaney, Deputy Head of Internal Audit, NHS Wales SSP
	Nathan Couch, Audit Lead (Performance), Audit Wales
	Andrew Doughton, Audit Manager (Performance), Audit Wales
	Lucy Windsor, Corporate Services Manager
	Martin Edwards, Head of Counter Fraud
	Chris O'Connor, Interim Director of Primary, Community and Mental Health Services
	Will Beer, Interim Divisional Director of Primary Care and Community Division
	Stuart Bourne, Deputy Director of Public Health
	Wendy Warren, Head of Emergency Planning
	Cynthia Henderson, Head of Health Records/Referral and Booking
	Melanie Goodman, Internal Audit, NHS Wales SSP
	David Butler, Internal Audit, NHS Wales SSP
	Jennifer Winslade, Director of Nursing
	Sarah Simmonds, Director of Workforce & Organisational Development

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ARAC/0202/01	**Welcome and Introductions** The Chair welcomed members to the meeting.
ARAC/0202/02	**Apologies for Absence** • Katija Dew, Independent Member • Richard Harries, Audit Wales • Tracy Veale, Audit Wales
ARAC/0202/03	**Declarations of Interest** There were no Declarations of Interest raised relating to items on the agenda.
ARAC/0202/04	**Committee Action Log** It was noted that all actions within the Committee's action log had been completed or were in progress, as outlined within the paper. **Action: AC 0112/15** – Rani Dash (RD), Director of Corporate Governance would clarify if the Memorandum had been circulated following discussions at the Executive Committee on 5th January and circulate, if not actioned.
ARAC/0202/05	**Minutes of the Previous Meeting** The minutes of the meeting held on were agreed as a true and accurate record.
	ITEMS FOR APPROVAL/RATIFICATION/DECISION
ARAC/0202/06	**Ratification of the Counter Fraud, Bribery and Corruption Policy** Martyn Edwards (ME), Head of Counter Fraud informed the Committee that the policy had been updated to reflect changes in legal requirements. The Committee acknowledged the imminent retirement of the Head of Counter Fraud and thanked him for his service to the Health Board. The Committee **RATIFIED** the Counter Fraud, Bribery and Corruption Policy.
ARAC/0202/07	**Ratification of the use of Single Tender Waivers** Mark Ross (MR), Assistant Finance Director presented the report highlighting the Single Quotations / Actions that had been submitted and approved for the period 10th November 2022 to 12th January 2023.

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	The Committee **APPROVED** the use of Single Tender Waivers.
ARAC/0202/08	Mark Ross (MR), Assistant Finance Director presented the Financial Governance Report and requested the approval of four (4) Financial Control Procedures. • Engaging Off Payroll Workforce • Accounts Payable • Patient's Property • Purchasing Cards. The Committee was informed that Audit Wales had requested that Welsh Government extend the date for finalisation of accounts from mid-June to the end of July 2023. This was due to sustained resource and capacity issues within Audit Wales compounded by the implications of the new international financial standard (ISA 315) that had been introduced. The ISA 315 standard would necessitate detailed risk assessments to determine the level of testing and resources needed to ensure robust scrutiny of accounts. The All Wales Directors of Finance had requested explicit clarification on the requirements from the Auditor General to enable Health Boards to ensure adequate preparation for audit efficiency. Final confirmation of the requested extension to deadlines for end of year reporting was awaited and would be communicated with the Health Board in due course. The Committee **NOTED** the Governance Report and **APPROVED** the Financial Control Procedures.
	ITEMS FOR DISCUSSION
ARAC/0202/09	**Review of the Committee Programme of Business 2022/23** The Committee **NOTED** the Committee Annual Programme of Business 2022/23.
ARAC/0202/10	**Implementation of the Governance Priorities set out within the IMTP 2022-25** Rani Dash (RD), Director of Corporate Governance, presented the report, highlighting that progress against the priorities were included in the Audit Wales Structured Assessment, but that more work was needed to achieve the objectives outlined in the Integrated Medium-Term Plan (IMTP).

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	The Committee was encouraged by the work undertaken to date and noted the plan to deliver on the Corporate Governance objectives. The Committee **NOTED** the Implementation of the Governance Priorities set out within the IMTP 2022-25 report.
ARAC/0202/11	**Review of Audit Recommendations Tracking and Associated Procedure** Rani Dash (RD) Director of Corporate Governance presented the Committee with an overview, as of 31st January 2023, against all identified internal and external audit recommendations and implementation status. The Committee requested that a further review of the Tracker be conducted prior to the next Audit, Risk and Assurance Committee meeting to provide an accurate position of live, high-level recommendations, with timeframes. RD responded that the Tracker is an evolving process, and that more work was needed with teams to understand the current position and work required to provide updated target dates. It was agreed that additional work with Executive Directors would be undertaken, and that revised target dates would be included in the next iteration of the report, where gaps had remained. Following the development work with Executive Directors, and if gaps in target dates remained, the lead Executive Director would be asked to attend the next scheduled meeting to explain and provide assurance on progress and expected completion of those recommendations. The Committee **NOTED** the position in respect of overdue audit recommendations and **APPROVED** the proposed revised dates for implementation in respect of several audit recommendations outlined.
ARAC/0202/12	**Review of the Committee Risk Report and Detailed Risk Assessments** Danielle O'Leary (DO'L), Head of Risk & Assurance, provided an overview of the Corporate Risk Register including a breakdown of high, medium, and low-level risks. DO further explained that at the December 2022 meeting, the Committee had requested a 'deep dive'

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review into the two risks for which it was responsible. Therefore, a report in collaboration with the Executive risk owners of these risks and respective service leads had been presented to the Committee. Chris O'Connor (C'OC), Interim Director of Primary, Community, and Mental Health Services, Will Beer (WB), Interim Divisional Director of Primary Care and Community Division, Stuart Bourne (SBo), Deputy Director of Population Health, and Wendy Warren (WW), Head of Emergency Planning, were in attendance to answer any queries related to the detailed risk assessments.

Risk CRR042 -Inability to provide adequate quality of care to asylum seekers, migrants populations and Unaccompanied Children Asylum Seekers.
The Committee was encouraged to hear of all the work the Health Board had been doing as well as the work with partner agencies to support asylum seekers and the migrant population.

WB stated that there were concerns in respect of infrastructure across Gwent which was impacting integration into communities; those concerns were being shared with Welsh Government.

The Committee queried what action was being taken to achieve the target risk score. It was suggested that the risk be revisited, and that consideration be given to what additional action needs to be taken to achieve the target score or to change the risk appetite/tolerance level.

Rani Dash (RD) stated that the Board would need to collectively determine its appetite, and that the Executive Team would conduct a deep dive into the Corporate Risk Register before presenting it at the next Board meeting. ACTION: Director of Corporate Governance/Head of Risk and Assurance

CRR004 - Failure to comply with the Well Being of Future Generations Act

SBo informed the Committee that, as a result of the deep dive, the current risk score had been raised to 8 due to uncertainty about whether the internal controls in place were operating effectively. The work to re-establish the internal controls was expected to be completed by the end of March 2023.

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	The Chair requested that the assessment be presented to the Committee to provide assurance that the revised controls were adequate to achieve and maintain the target score. **Action** • Committee Secretariat to add to the Committee Forward Work Programme an Update Report on Failure to comply with the Well Being of Future Generations Act. The Committee **NOTED** the Committee Risk Report and Detailed Risk Assessments.
ARAC/0202/13	**Internal Audit Plan Progress Update** Stephen Chaney (SCh), Deputy Head of Internal Audit, provided an update to the Committee on progress against the plan, noting that all audits scheduled for 2022/23 were on track for completion by the end of the financial year. The Committee requested that management responses to internal audit recommendations include financial savings and expected outcomes. This would provide greater assurance on what the actions were aiming to achieve, in conjunction with milestones indicating when benefits would be realised and any residual impact. The Committee **NOTED** the Progress Report.
ARAC/0202/14	**Reasonable Assurance Rated Reviews:** Stephen Chaney (SCh), Deputy Head of Internal Audit, provided an overview of the reasonable assurance reports. <Could we note the reports presented here> The Committee made several suggestions to improve the quality of the management responses. These included: • assigning responsible officers to management responses to ensure ownership and accountability of actions, • strengthening the language of management responses to provide assurance of the actions being taken. • ensure target dates were achievable.

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	The Committee sought assurance regarding how project learning would be carried forward and implemented in future projects. Nicola Prygodzicz (NP), Chief Executive Officer, stated that the governance framework was being strengthened to ensure a consistent approach across all projects and that learning from all audits would be applied to new projects. Shelley Bosson (SB), Independent Member, requested more information to understand the capital investment and business case scrutiny and approval process. Rani Dash (RD), Director of Corporate Governance, stated that the overarching governance framework for Capital would be presented to the Finance and Performance Committee. **Action** • Committee Secretariat to add the Capital Governance Framework to the Finance and Performance Committee Forward Work Programme. The Committee **NOTED** the Reasonable Assurance Internal Audit Reports.
ARAC/0202/15	**Limited Assurance Rated Reviews** Stephen Chaney (SCh) Deputy Head of Internal Audit provided an overview of the limited assurance reports. **Records Management** Nicola Prygodzicz (NP), Chief Executive Officer, and Cynthia Henderson (CH), Head of Health Records/Referral and Booking, updated the Committee that significant progress had been made on both paper record storage and the digitisation project, noting that ABUHB was the only Health Board to have digitised 0.5 million records. However, it was acknowledged that further work was required to improve record management across the Health Board. Paul Deneen (PD), Independent member, expressed concern about staff training for record management and stated that he would discuss this with the Chair and Lead Executive for the People and Culture Committee. Rani Dash (RD), Director of Corporate Governance, stated that work had begun on implementing an overarching strategic group with underpinning governance and assurance boards focused on information governance and security, as well as clear escalation processes.

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	Policy Management The Committee was informed that an overarching 12-month improvement plan was in place, with a focus on the policy framework, management systems, and the central database. Progress updates in respect of this work would be provided as part of the ongoing review of implementation of the Governance Priorities. **Off Contract Agency** SCh informed the Committee that a new protocol had been implemented since the audit's conclusion, which had resulted in a reduction in the use of off-contract agency. Once the new process had been established for an agreed period additional sample testing would be undertaken to assess adherence to the protocol and determine if it was the cause of the reduction. Following additional testing, an addendum to the report would be issued. Sarah Simmonds (SS) Director of Workforce & Organisational Development informed the Committee that the use of off-contract agencies had reduced as a result of a number of factors, including new booking rules for agencies, the variable pay reduction programme and subsequent recruitment events. To continue to reduce the use of off-contract agency, the Director of Nursing and divisional nurses agreed to work towards eradication of off-contract agency beginning 01 March 2023; agreed targets for the use of off-contract agency would be implemented, but an escalation process would be included to appropriateness of decision making. Jennifer Winslade (JW), Director of Nursing, stated that future-proofing workforce supply was a priority. The Committee **NOTED** the Limited Assurance Internal Audit Reports.
ARAC/0202/16	**External Audit Progress Report** Nathan Couch (NC) Audit Lead (Performance), Audit Wales presented the Performance Update report noting completed work, work that had begun and planned work that had not yet begun. The Committee **NOTED** the Progress Report.
ARAC/0202/17	**External Audit Annual Audit Report**

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	Andrew Doughton (AD) Audit Manager (Performance), Audit Wales presented the report and highlighted that the report provided a summary of the audit work completed for 2022. The Committee **NOTED** the Annual Audit Report.
ARAC/0202/18	**2022 Structured Assessment Report and Management's Response** Nathan Couch (NC), Audit Lead (Performance), Audit Wales, provided an overview of the report and noted that while the Health Board had taken positive steps to improve the effectiveness of its governance arrangements, there were still opportunities to improve arrangements to address key risks and operational pressures. Shelley Bosson (SB), Independent Member, requested clarification on which Health Board Estate Group is reviewing estate utilisation, supporting agile working models, and determining options for decommissioning poor quality or no longer needed estate. **Action** • Director of Corporate Governance to request a brief on the estates management structure be shared with Committee Members. SB observed that Third Sector were mot mentioned in recommendation 6: Working with wider partners in Integrated medium-term plan development and would have expected to have seen Gwent Association of Voluntary Organisations (GAVO) and Gwent Drug and Alcohol Services (GDAS) listed. RD responded that the list was not exhaustive but that the updated response would include Third Sector partners and would be included in the Audit Tracker. The Committee **NOTED** the 2022 Structured Assessment Report and Management's Response Report.
ARAC/0202/19	**Review of Efficiency Savings Arrangements** Andrew Doughton (AD), Audit Manager (Performance), Audit Wales, presented the report and stated that the focus of the report was on achievable savings due to the Health Board's financial position being the most significant risk.

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	The report acknowledged the Health Board's track record of delivering savings and noted that identifying savings and efficiencies would require a focus on short-term control measures in addition to long term transformation approaches. The Committee sought assurances that management responses were being implemented and that agreed-upon deadlines would be met. Nicola Prygodzicz (NP), Chief Executive Officer advised that the recommendations had been broken down into various workstreams, and the work had been aligned to the Integrated Medium Term Planning phase. The accountability framework would be strengthened as a result of the actions taken to address the recommendations. The Committee **NOTED** the Efficiency Savings Arrangements Report.
	ITEMS FOR INFORMATION
ARAC/0202/20	There were no items scheduled for discussion.
ARAC/0202/21	**Items to be Brought to the Attention of the Board and Other Committees** • Nothing Raised
ARAC/0202/22	**Any Other Urgent Business** • Nothing Raised
	Date of the Next Meeting: Tuesday 18th April 2023 at 09:30am via Microsoft Teams

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CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
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
Dec 2022	**AC0112/03** Consultant Job Planning	Following the implementation of the automated job planning process an update report is to be received at a future meeting to close off Audit Recommendations.	Secretariat / Medical Director	**08 February 2024**	**Not Due** Due to the Audit, Risk and Assurance Committee's 2023/24 schedule, an update has been scheduled for February 2024. This ensures that enough time has passed between implementation and progress to be reported. The Board's People and Culture Committee will receive an update on progress at its meeting on, 18th October 2023.
Feb 2023	**AC 0202/04** Committee Action Log	AC 0112/15 - Check to see if the Memorandum has been circulated to Committee Members following discussions	Director of Corporate Governance	**02 February 2023**	**Completed.** The Final Annual Accounts Memorandum was circulated to Committee members on 16 February 2023.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		at the Executive Committee on January 5th and circulate if not.			
Feb 2023	**AC 0202/12** Review of the Committee Risk Report and Detailed Risk Assessments	Add to the Audit, Risk & Assurance Committee Forward Work Programme an Update Report on Failure to comply with the Well Being of Future Generations Act following the completion of the assessment of controls.	Committee Secretariat	**02 February 2023**	**Completed.** Added to the Audit, Risk & Assurance Committee Forward Work Programme
Feb 2023	**AC 0202/12** Review of the Committee Risk Report and Detailed Risk Assessments	For the Committee to take an enhanced level of assurance that the Corporate Risk Register has the appropriate controls in place to achieve target scores, the Board would need to collectively determine its appetite. To support this approach, the Executive Team would conduct a full in-depth review of the Corporate Risk Register before presenting it at	Director of Corporate Governance / Head of Risk & Assurance	**29 March 2023**	**Completed.** The updated CRR was presented to the Board on 29 March 2023 and has been included in the Audit, Risk and Assurance Committee's substantive Risk item.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		the Board meeting in March 2023.			
Feb 2023	**AC 0202/14** Internal Audit Reasonable Assurance Rated Reviews	Add the Capital Governance Framework to the Finance and Performance Committee Forward Work Programme.	Committee Secretariat	**09 February 2023**	**Completed.** Added to the Finance and Performance Committee Forward Work Programme
Feb 2023	**AC 0202/18** 2022 Structured Assessment Report and Management's Response	A brief on the estates' management structure will be circulated to Committee Members to clarify which Health Board Estate Group is reviewing estate utilisation, supporting agile working models, and determining options for decommissioning poor quality or no longer needed estates.	Director of Operations / Interim Director of Planning and Performance	**18 April 2023**	**Completed.** The Director of Operations requested that the Interim Director of Planning and Performance respond to the action as the request was broader than Estates and required input from strategic planning. The Strategic Capital and Estates Programme Director provided a response which was shared with the Committee Members on 06 March 2023.

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.

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit, Risk and Assurance Committee Annual Report 2022 - 23
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Corporate Services Manager – Policies and Procedures

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 paper presents the Audit, Risk and Assurance Committee Annual Report 2022-23, referred to as the Annual Report throughout this paper.

The Annual Report (Appendix A) is provided for endorsement prior to submission to the Board on 24th May 2023.

Cefndir / Background

Section 2 of Aneurin Bevan University Health Board's Standing Orders states that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

The Audit, Risk and Assurance Committee has been established by the Board with the purpose of supporting the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

Each Committee is responsible for developing an annual report for submission to the Board via the Chair within 6 weeks of the end of the reporting year, setting out its activities during the year and including the review of its performance.

The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

The Annual Report seeks to provide a comprehensive evaluation on the business undertaken by the Committee over the course of the 2022-23 financial year including any issues, and gaps in assurance that have required escalation to the Board.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to **CONSIDER** and **ENDORSE** its Annual Report 2022-23 prior to submission to the Board on 24th May 2023.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Failure to agree the reports would mean that the Health Board would not comply with Welsh Government and HM Treasury requirements.
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. The objectives will be referenced to the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. There is no Equality and Diversity impact.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Not required
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	**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 the report, however, considerations will be included in considering how the business of the Committee aligns to the WBoFG Act

AUDIT, RISK AND ASSURANCE COMMITTEE

ANNUAL REPORT FOR 2022-23

March 2023

DRAFT

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FOREWORD

I am pleased to present the Audit, Risk and Assurance Committee's (the Committee's) Annual Report for the year ended 31 March 2023.

In this report we provide an overview of the work of the Committee and describe the steps taken to strengthen audit, risk management and assurance arrangements in the last 12 months.

The Committee has welcomed the main conclusion of the Auditor General for Wales' in the Structured Assessment for 2022 which concluded that Aneurin Bevan University Health Board: 'has broadly sound arrangements in place for governance, strategic planning and use of resources'.

The Committee has also acknowledged its role in overseeing the important work that is still ongoing in a number of areas to further strengthen governance and assurance arrangements. This will be a key focus in the Committee's work in the year ahead.

Finally, I would like to express my personal appreciation to all who contributed to the audit, risk and assurance agenda over the last 12-months. Special thanks must go to Shelley Bosson for her tenure as chair of the Committee up until August 2022 and Katija Dew whose term of appointment as an Independent Member of the Health Board came to an end in March 2023.

Diolch yn Fawr / Thank you

Iwan Jones

Chair, Audit, Risk and Assurance Committee

1. INTRODUCTION TO THE REPORT AND AUDIT, RISK AND ASSURANCE COMMITTEE

1.1 The Standing Orders[1] of Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB' or the 'Health Board') state that: "*The Board may and, where directed by the Welsh Government must, appoint Committees either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*". [Section 3]

1.2 The Term of Reference of the Audit & Assurance Committee (referred to throughout this report as 'the Committee') that applied in 2022/23 were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The Committee formally adopted its Terms of Reference, following the Board's approval, on 07 April 2022.

The purpose of the Committee is to undertake scrutiny and review of matters related to audit, financial accounting, assurance and risk management. In doing so, the Committee will support the Board and the 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.

1.4 The remainder of this report describes how the Committee complied with and satisfied the requirements set out within its Terms of Reference during the period 1 April 2022 to 31 March 2023.

[1] LHB Model Standing Orders Reservation and Delegation of Powers - 25 March 2021 v5 Final (nhs.wales)

2. 2022-23 WORK PROGRAMME

2.1 ABUHB Standing Orders require the Director of Corporate Governance to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups.

2.2 When the Committee's Work Programme (see **Appendix 2**) was agreed care was taken to ensure that this was aligned to its Terms of Reference and the requirement for the Committee to 'proactively seek information to gain assurance for itself and/or on behalf of the Board'. The Work Programme is, however, a framework rather than a prescriptive agenda. This gives the Committee flexibility to identify changing priorities or any need for further assurance or information.

3. FREQUENCY OF COMMITTEE MEETINGS AND MEMBERSHIP

3.1 During 2022-23, the Committee met eight times virtually via Microsoft Teams:

- 07 April 2022
- 17 May 2022 (draft annual accounts)
- 13 June 2022 (final annual accounts)
- 02 August 2022
- 06 October 2022
- 01 December 2022
- 02 February 2023.

This met the requirement that the committee should meet at least bi-monthly.

Detail of the members and executive directors who attended these meetings is provided at **Appendix 3**.

3.2 Shelley Bosson, Independent Member, stepped down as Chair of the Committee on 02 August 2022, but remains a voting member. Iwan Jones, Independent Member (Finance), took over as Chair on 03 August 2022, and presided over his first Committee meeting as Chair on 06 October 2022.

3.3 As at 31 March 2023, the Committee comprised the following Independent Members:

- Iwan Jones – Chair
- Richard Clark – Vice Chair
- Shelley Bosson
- Paul Deneen
- Vacancy (awaiting the appointment of a new Independent Member)

3.4 Committee meetings were regularly attended by representatives from:

- Audit Wales; the Health Board's external auditor;
- Audit & Assurance Services NHS Wales Shared Services Partnership (Internal Audit) and
- Local Counter Fraud Services

3.5 In 2022-23, Committee received private briefings (without officers present) from auditors and the local counter-fraud lead as below:

- Internal Audit (*August 2022 & February 2023*)
- External Audit (*October 2022*)
- Counter Fraud (April 2022 & *December 2022*)

4. COMMITTEE REPORTING ARRANGEMENTS

4.1 The minutes of Committee meetings are routinely submitted to the Board by way of an Assurance Report, these are included in an overarching Committee Assurance Report.

All Board papers can be accessed via the following link: Audit Risk and Assurance Committee

5. COMPLIANCE WITH THE COMMITTEE'S WORK PROGRAMME

5.1 Among the key issues considered by the Committee during 2022-23, as outlined in the Committee's Work Programme, the following were also considered:

- Update on Outpatient Transformation

- Update on the Estates Efficiency Framework
- Update on Asset Verification
- Report on the Welsh Health Circular (WHC) Tracker
- Report on the Implementation of the Governance Priorities set out within the IMTP 2022-25
- Welsh Health Specialised Services Committee Governance Arrangements Audit Tracker Report (for those recommendations relating to Health Board governance arrangements)
- Audit Wales Review of Quality Governance Arrangements
- Audit Wales - Five-year Strategy 'Assure, Explain, Inspire' Report
- Audit Wales - Welsh Community Care Information System Report
- Audit Wales - Tackling the Planned Care Backlog in NHS Wales Report
- Audit Wales - Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report
- Audit Wales - Continued COVID-19 response alongside growing patient demand Report
- Audit Wales – Consultation on Fee Scales 2023 /2024
- Audit Wales - £6.5 million of fraud and overpayments identified by National Fraud Initiative in Wales
- Audit Wales - Making Equality Impact Assessments more than just a tick box exercise Report
- Audit Wales Review of Efficiency Savings Arrangements Report

6. ASSURANCE AND IMPROVEMENT

6.1 The Committee reviewed and approved the audit strategies and plans for the auditors as listed below and received audit reports produced in support of them during 2022-23:

- External Auditors, Audit Wales
- Internal Auditors, NWSSP Audit & Assurance Services (AAS)

In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile.

6.2 Where reports received a less than reasonable assurance audit rating or where there were specific areas of concern, the appropriate Executive Directors were requested to attend Committee meetings. This process provided opportunities to discuss the reports more fully, and for the Committee to satisfy itself that the findings and recommendations raised in the reports were being addressed in a timely manner and implemented to address control weaknesses or compliance issues.

Certain reports were referred to other Committees of the Board for ongoing monitoring, for example reports relating to clinical governance issues were referred for further consideration by the Patient Quality Safety and Outcomes Committee.

External Audit – Audit Wales (AW)

6.3 The Auditor General for Wales is the statutory external auditor for the NHS in Wales. Audit Wales (AW) undertakes the external auditor role for the Health Board on behalf of the Auditor General.

6.4 The WAO 2022 Structured Assessment work reviewed the Health Board's corporate governance and financial management arrangements, particularly the progress made in addressing the previous year's recommendations. Findings from the 2022 review were reported to the Committee in February 2023, prior to submission to the Board in March 2023.

Overall, the WAO report stated: "**Overall, we found that while the Health Board is strengthening its governance arrangements, there is scope to enhance them further to address the significant challenges it needs to address in the short- and medium-term."**

The report went on the say that:

- Governance – the Health Board has taken positive steps to improve the effectiveness of its governance arrangements, opportunities exist to enhance these arrangements further to address key risks and operational pressures.

- Strategic planning – the Health Board needs to revisit its clinical strategy to ensure that clinical and medium-term plans help to drive service improvement and help to shape long-term sustainable services.

- Wider arrangements that support the efficient, effective, and economical use of resources – the Health Board has a reasonably effective approach to planning, and financial controls remain generally effective but there is a need to strengthen its focus on financial performance. The Health Board Estates remains a challenge due to availability of capital finance and there needs to be stronger oversight of digital strategy and plan implementation.

6.5 The WAO Structured Assessment 2022 was subsequently received by the Board on 29 March 2023. During discussions with the Committee, Audit Wales was pleased to hear from Committee Members that they fully recognised the conclusions drawn and the key issues that required further improvement in the year ahead.

Copies of reports produced by Audit Wales can be accessed via the following link: Audit Wales Publications.

6.6 Each meeting of the Committee received a progress report from Audit Wales and during 2022-23 the Committee received one External Audit report, relating to the Health Board's External Audit Plan.

Efficiency Review Report

The review considered the high-level arrangements for planning, delivery, and monitoring of efficiency and savings and sought to address the following question: Is the Health Board putting in place effective arrangements to secure savings and efficiencies?

The review recognised that there is a good overall ethos at a senior level and that the Health Board integrates its efficiencies approach into its IMTP programmes. This had been demonstrated in the Health Board's intent to deliver financial efficiencies through a balanced approach to service transformation and value based programmes, alongside short-term savings, which is considered as a safe approach, as an over-reliance on short-term and non-recurrent transactional cost cutting can impact adversely on longer-term financial stability.

The review recommended that the Health Boards needs to focus its oversight on the risks to operational delivery of plans and better understand the impact of efficiency plans and recommended that the Health Board regularly update its forecast to provide a sense of urgency when and if the financial position deteriorates.

Internal Audit - Audit & Assurance Services NHS Wales Shared Services Partnership

6.7 During the year the Committee received Internal Audit reports in line with the agreed programme for 2021-22 and 2022-23, including the management response from the relevant Executive Director.

In total, 32 audit reviews were carried out during the year, including six that were carried over from 2021/22. These are detailed in the assurance rating sections.

The Committee will receive the following final reports from the 2022-23 Internal Audit Plan at its April meeting.

- Risk Management (Reasonable Assurance)
- Financial Sustainability (Reasonable Assurance)
- Discharge Planning (Limited Assurance)
- Monitoring Action Plans (Reasonable Assurance)
- Follow Up High Recommendations (Reasonable Assurance)
- Cyber Security (Advisory)
- Management of the Robotic Process Automation (Reasonable Assurance)
- IT Strategy (Reasonable Assurance)
- Tredegar Health & Wellbeing Centre (Limited Assurance)

The following ten reports will be presented at Committee meetings during Quarters 1 and 2 of the 2023-24 financial year.

- Clinical Futures - Care Closer to Home
- Contract Management (Urgent Care System)
- Mental Health Transformation
- Dementia Services
- Infection Prevention & Control
- Putting Things Right
- Integrated Wellbeing Networks
- Review of Bank Office & Temporary Staff
- Satellite Radiotherapy Centre
- Endoscopy Services

The assurance sections that follow provide a brief summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year 2022-23.

6.8 Substantial Assurance

In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.

The Grange University Hospital *(2021 -22)*
Executive Lead – Executive Director of Planning, Digital & IT
The review sought to provide assurance around Quality Assurance, focusing on an assessment of the delivery Grange University Hospital building against the key business case objectives.

Grange University Hospital: Financial Assurance *(2022-23)*
Executive Lead - Chief Executive
The overall objective was to determine the adequacy of information provided in support of the Stage 4 (construction) defined costs claimed by the Supply Chain Partner (through selective testing of the account)

Digital Benefits Realisation *(2022-23)*
Executive Lead - Chief Executive
The review sought to consider whether the organisation has an appropriate framework and process to ensure that benefits are gained from investment in digital solutions.

6.9 Reasonable Assurance

In the following review areas, it was reported that the Board could take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

Some matters required management attention in either control design or operational compliance and these had low to moderate impact on residual risk exposure until resolved.

Falls Management *(2021-22)*
Executive Lead – Executive Director of Therapies & Health Science
The review sought to provide assurance that the Falls Policy for Hospital Adult Inpatients was being adhered to by staff and monitored appropriately.

Flu Immunisation *(2021-22)*
Executive Lead - Executive Director of Public Health and Strategic Partnerships
The review sought to provide assurance that the flu immunisation programme in place for staff, and the governance arrangements over the community programme are working efficiently to provide maximum protection during the seasonal flu campaign.

Risk Management *(2021-22)*
Executive Lead – Director of Corporate Governance
The review sought to provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board to ensure strategic objectives are achieved.

Facilities - Care After Death *(2021-22)*
Executive Lead – Director of Operations
The review sought to provide assurance on the care after death service within the Facilities division, which commenced operations during January 2021.

Flow Centre *(2021-22)*
Executive Lead – Director of Operations
The review sought to assess the processes within the Flow Centre Team for ensuring patients are cared for in the right place, at the right time, ensuring local coordination with other partners; and providing a single point of contact for transferring patients into and between hospital sites.

Corporate Governance *(2021-22)*
Executive Lead – Director of Corporate Governance
The review sought to evaluate the Board and Risk Assurance Framework (B&RAF) process and supporting arrangements that are embedded within the Health Board governance structure.

Operational Resumption of Services *(2021-22)*
Executive Lead – Director of Operations
The review sought to evaluate the adequacy of the systems and controls in place for the operational resumption of services.

Financial Sustainability *(2021-22)*
Executive Lead – Director of Finance and Procurement
The review sought to evaluate the key financial management controls within the Health Board, including developing and monitoring the savings required for financial sustainability.

Medicines Management *(2021-22)*
Executive Lead - Medical Director
The review sought to provide the Health Board with the assurance that there are adequate arrangements in place for the management, administration, and storage of controlled drugs.

NIS Directive (Cyber Security) *(2021-22)*
Executive Lead - Director of Planning, Digital and IT
The audit sought to review the arrangements in place for the implementation of the NIS (Network and Information Systems) Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

Waste Management *(2021/22)*
Executive Lead – Director of Operations
The review sought to assess the Health Board's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Children's Community Nursing Service – Children & Young People's Continuing Care *(2022-23)*
Executive Lead - Director of Operations
The review sought to assess the robustness of Children and Young People's Continuing Care (CYP CC) governance arrangements within the Health Board's Children's Community Nursing Service (the CCNS, part of the Family & Therapies Division). With a focus on mechanisms for ensuring the quality and safety of the Children and Young People's Continuing Care provision.

Job Evaluation Process *(2022-23)*
Executive Lead - Director of Workforce & Organisational Development
The review sought to provide assurance that the Job Evaluation process meets the requirements of the NHS Job Evaluation Handbook and is being applied effectively by the Health Board. It also sought to provide assurance that all posts that are banded through the job evaluation process are done so in a fair and consistent manner to ensure there is equality for all members of staff.

Neighbourhood Care Networks (NCNs) *(2022-23)*
Executive Lead – Interim Executive Director of Primary Care, Community & Mental Health

To provide an opinion on the effectiveness of the controls in place to improve access to primary care services through the NCNs.

Integrated Audit Plans – YYF Breast Care Services *(2022-23)*
Executive Lead: Director of Operations
The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit.

Integrated Audit Plans – Newport East *(2022-23)*
Executive Lead: - Interim Executive Director of Primary Care, Community & Mental Health
The audit was undertaken to review the delivery and management arrangements in place to progress the Newport East Health & Wellbeing Centre project, and the performance to date against its key delivery objectives i.e., time, cost, and quality.

6.10 **Limited Assurance**

In the following review areas, it was reported that the Board could take **only limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively.

More significant matters required management attention with moderate impact on residual risk exposure until resolved.

Children and Young People's Continuing Care *(2021-22)*
Executive Lead – Director of Nursing
The purpose of the review was to ensure that the Mental Health and Learning Disabilities Division has robust commissioning arrangements in place, with a focus on quality and safety for the commissioning of Continuing Health Care (CHC) and Section 117 care.

Clinical Audit *(2022-23)*
Executive Lead – Medical Director
The audit was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance.

Corporate Governance (Policy Management) *(2022-23)*
Executive Lead – Director of Corporate Governance
The audit was undertaken to review the process for the management of policies throughout the Health Board.

Use of off-contract Agency *(2022-23)*
Executive Lead – Director of Nursing
To assess whether off-contract agency processes are adhered to, and related expenditure is appropriately monitored.

Records Management *(2022-23)*
Executive Lead – Chief Executive Officer
The review sought to provide assurance that the Health Board has an appropriate process for the management of records which ensures that it is compliant with legislation.

6.11 No Assurance

There were no audited areas that reported **no assurance.**

6.12 Assurance Rating Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Datix (Support of Incident Management) *(2021-22)*
Executive Lead – N/A
The review sought to provide the Health Board with an overview of testing completed within other audits that a sample of incidents entered onto Datix are being managed appropriately and in accordance with the Incident Reporting Policy.

Follow-up of High Priority Recommendations *(2021-22)*
Executive Lead – Director of Corporate Governance
The review sought to determine if a sample of high priority recommendations had been implemented or recognised as still outstanding on the Audit Recommendation Tracking Tool.

Medical Equipment and Devices *(2021-22)*
Executive Lead – Medical Director & Director of Therapies & Health Science
The audit assessed the maintenance of the electronic medical devices and equipment (EBME) database and the management of other medical equipment/devices and associated training requirements. The audit objectives were consistent with the 2017/18 Medical Equipment and Devices audit (rated 'limited assurance'), which enabled a high-level review of progress to be completed.

Agile Delivery *(2022-23)*
Executive Lead- Director of Workforce & Organisational Development
The review sought to assess the Health Board's progress in developing agile working practices and identification of good practice.

Decarbonisation *(2022-23)*
Executive Lead – N/A
To provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change.

7. MONITORING AND IMPLEMENTATION OF AUDIT RECCOMENDATIONS

7.1 At the April 2022 meeting, the Committee received a Standard Operating Procedure (SOP) that outlined the purpose of the internal and external recommendation tracker process and provided a clear rationale as to how this benefits the organisation. The Committee adopted this SOP and since April 2022, a report on audit recommendations has been submitted to each meeting. Progress continues throughout the Health Board and key relationships with service leads is progressing to close, extend deadlines or complete the recommendations.

At the April 2023 the Committee is due to receive an internal audit review of the monitoring and tracking of high-level recommendations. At the time of writing, the internal audit report has not yet been formally received by the Committee however, the report's findings concluded a ***reasonable*** level of assurance.

The Health Board acknowledges that progress on a number of outstanding audit recommendations has been difficult due to a several factors, including the impact of the COVID-19 pandemic and

the current operating environment. Furthermore, demand for primary and secondary health care services has increased considerably, putting significant strain on the Health Board's ability to implement and progress audit recommendations while addressing the backlog of patients waiting while continuing to provide a safe, quality health care service.

The Health Board recognises that further progress is required in relation to overdue audit recommendations and will make every effort to maintain the good progress made over the last year. The Committee will continue to maintain momentum on this process by providing both challenge and support.

8. RISK MANAGEMENT

8.1 Board and Risk Assurance Framework

In July 2022, the Committee received the internal audit review on the Board and Risk Assurance Framework ('B&RAF'). The purpose of the review was to "*evaluate the BAF process and supporting arrangements that are embedded within Aneurin Bevan University Health Board governance structure*." The report concluded a reasonable level of assurance could be taken and made 4 recommendations (2 medium, 2 low) to further develop, embed and strengthen the BAF to ensure Board and Committee business focused on the areas of weakest assurance and highest risk. The findings of the report were used as a baseline to inform the revised approach for 2023/24.

At the August 2022 meeting, the Committee received a presentation from the Director of Corporate Governance that outlined an updated approach to development of the BAF allowing for closer alignment and reporting with the Corporate Risk Register. It was also proposed that enhanced assurance mapping would be included to replicate the Three Lines of Defence Model [2] highlighted as best practice for evidencing sources of assurance and reassurance through the Good Governance Institute (GGI).

The Committee considered the current position, and was challenged on its understanding of the BAF, how effective it was and if it was confident that plans were in place to address gaps in assurance. In exploring this, the Committee was able to recognise that there was a lack of clarity, ownership and understanding of the BAF. A synergy needed to be developed between the BAF and the Corporate Risk Register and a system wide assurance mapping

[2] The three lines of defence for assurance and reassurance GGI

exercise needed to be undertaken to ensure the Committee was assured of the effectiveness of the internal system of control.

It was agreed that a system of assurance would be developed and would focus on the following:

- **Board Assurance Framework (Risk Based)**
  Aligned to Corporate Risk Register, focussed on Strategic Risks and Strategic Priorities
- **Assurance Mapping (Process Based)**
  Organisational assurance mapping to review system-wide internal control.

- **Quality Assurance Framework**
  To ensure a systematic, continued, and sustained improvement in the quality of care

The first steps to achieving this revised approach to the BAF have been taken and at the March 2023 Board meeting, the Board received the first iteration of the report, complete with assurance mapping and action plans identified to address gaps in assurances. Further development of the presentation of the report is expected to align with a rationalisation of the currently held strategic risks and a revised Risk Management Strategy. This is expected to be presented to the May 2023 Board.

8.2 **Frequency of Risk Reviews and Reporting**

At each meeting of the Committee, an overview of the Corporate Risk Register is provided with detailed risk assessments of the risks that receive direct oversight from the Committee. The Board then receives the overview of the Corporate Risk Register, and any areas of concerns are highlighted, as appropriate.

8.3 **Risk Management**

In April 2022 the Committee received the internal audit review on Risk Management. The purpose of the review was to "*provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board to ensure strategic objectives are achieved*."

The report made 3 medium level recommendations to strengthen risk management arrangements across the Health Board. As a result, and in response to a specific recommendation, the Committee also received at the April 2022 meeting, a Risk Management Strategy Benefits Realisation plan. This was welcomed by the Committee and

provided reassurance that plans were in place to achieve the strategic aims of the Risk Management Strategy, address the training gaps (following successful implementation of the RLDATIX risk management module) and provide enhanced clarity regarding templates and best practice.

Unfortunately, the National work taking place in relation to development of a 'Once for Wales' risk management module has not yet been concluded and is not due for implementation until April 2024. This has hindered progress in relation to a training programme for the organisation however, risk identification and risk assessment training continues to be delivered via induction courses provided by the Health and Safety Team. The Committee has and will continue to be updated in respect of this issue and will provide leadership, advice and support where appropriate.

8.4 **Community of Practice – Risk Management – Progress in 2022/23**

The Health Board has successfully established a Risk Management Community of Practice (CoP) that held its inaugural meeting in November 2021. Representation has grown consistently, and the CoP continues to meet every other month. Topics at the CoP include risk appetite and tolerances, business continuity planning, regular updates on the strategic risks reported to the Board and its Committees alongside an 'open' section for staff to share areas of good practice and wider organisational learning on risk management.

The Committee has been engaged with the inception and continued development of the Community of Practice and recognises the importance of this group in embedding the principles and objectives of the Health Board Risk Management Strategy.

8.5 **Risk Management Strategy**

The Committee received a risk management strategy benefits realisation plan in April 2022 that mapped the objectives highlighted in the Strategy with progress updates and clarity on how the Health Board will determine measurements of success. The Committee welcomed this approach to receiving assurance on the collective success related to the objectives of the Risk Management Strategy. The plan will be updated to reflect any change to strategic objectives of the revised Risk Management Strategy, following formal ratification by the Board in May 2023.

9. SELF ASSESSMENT & EVALUATION

9.1 The Board has undertaken an overall assessment of its effectiveness during 2022/23 using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews.

The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements and has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working.

From 2023/24, Committees will undertake a mid-year self-assessment of their effectiveness to inform the Board's end of year assessment.

10. KEY AREAS OF FOCUS IN 2023-24

10.1 In the year ahead the Committee will continue to focus on those matters that will strengthen audit, risk and assurance arrangements. The Committee Work Programme has been designed to ensure that in relation to all aspects of audit:

- internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- adequacy of disclosure statements (Governance Statement) which are supported by the Head of Internal Audit Opinion and other opinions;
- internal and external audit recommendations continues to be monitored, reviewed and evaluated to ensure compliance and where compliance is not evidenced, clear, agreed rationale is provided;
- the policies and procedures related to fraud and corruption; and
- that the system for risk management is robust in identifying and mitigating risks.

Thus, enabling the Committee to provide the Board with assurance that the risks impacting on the delivery of the Health Board's objectives are being appropriately managed.

10.2 The Committee Work Programme[3] is reported to each meeting for discussion.

Hardcopies of the Work Programme can be obtained from the Director of Corporate Governance, Headquarters, St Cadoc's Hospital, Lodge Road, Caerleon, NP18 3ZQ.

11. CONCLUSION

11.1 This report provides a summary of the work undertaken by the Committee over the past 12 months and demonstrates how the Committee has complied with the Terms of Reference.

[3] Audit Risk and Assurance Committee

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Appendix 1

Terms of Reference & Operating Arrangements

Version: Approved

Date: March 2022

Document Title:	Audit, Risk & Assurance Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Current version:	Approved
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

1. INTRODUCTION

1.1 Section 2 of Aneurin Bevan University Health Board's Standing Orders (referred to in this document as 'ABUHB or the 'Health Board') Standing Orders provides that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance Committee** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.

1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

2.1 The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;

- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;

- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and

- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisations activities;

- the Annual Accountability Report, which includes the Annual Governance Statement;

- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;

- the planned activity and results of internal and external audit;

- adequacy of management response to issues identified by audit activity, including external audit's management letter;

- assurances relating to the management of risk and corporate governance requirements for the organisation;

- systems for financial reporting to the Board (including those of budgetary control);

- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and

- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

- a progress report from the Head of Internal Audit summarising:

  - ✓ work performed (and a comparison with work planned);
  - ✓ key issues emerging from the work of internal audit;
  - ✓ management response to audit recommendations;
  - ✓ changes to the agreed internal audit plan; and
  - ✓ any resourcing issues affecting the delivery of the objectives of internal audit;

- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Audit Wales, for example, Value for Money reports and good practice findings);

- management assurance reports;

- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
  - use of single tender waivers;

- extensions of contracts:
- writing off of losses; or
- the making of special payments;

- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;
- the internal audit strategy;
- the Head of Internal Audit's Annual Opinion and Report;
- quality assurance reports on the internal audit function;
- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;

- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and

- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Experience, Quality & Safety Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and

- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit, Risk & Assurance Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Director of Finance, Procurement and VBHC
- Director of Corporate Governance

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and

- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Office of the Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external

members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held as a minimum on a **Bi-Monthly basis** (six times per year) and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.4 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g. interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting

any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- appropriate escalation of concerns.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

The Board and Board Committee Handbook provides detailed guidance on the conduct of the Committees business.

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a

meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix 2

AUDIT, RISK & ASSURANCE COMMITTEE

PROGRAMME OF BUSINESS 2022/23

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 2022);
- 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 arrangement

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April 2022	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb 2023
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 2022/23	Annually	Chair & Director of CG				√			
Review of Committee Programme of Business	Standing Item	Chair					√	√	√
Annual Review of Committee Terms of Reference 2022/23	Annually **(April)**	Chair & Director of CG	√						
Annual Review of Committee Effectiveness 2022/23	Annually **(April)**	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					x		√
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG						X Deferred to April 2023	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April 2022	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb 2023
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG						X Deferred to April 2023	
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		X Deferred to Dec 22	Received √	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		X Deferred to Dec 22	Received √	
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG							√
Review of Audit Recommendation Tracking Procedure	Annually	Director of CG	√						√
Audit Recommendations Tracking Report	Standing Item	Director of CG	√			√	√	√	√
Annual Review of Risk Management Strategy	Annually	Director of CG					X Deferred to Dec 22	Received √	
Report on the Implementation of the Risk Management Strategy Realisation Plan	Bi-Annually	Director of CG					X Deferred to Dec 22	Received √	
Annual Review of the Board Assurance Framework Process	Annually	Director of CG							X Deferred to April 2023
Review of the Board Assurance Framework	Bi-Annually	Director of CG				√			
Committee Risk Report	Standing Item	Director of CG	√			√	√	√	√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April 2022	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb 2023
Financial Governance and Control									
Report of the use of Single Tender Waivers	Standing Item	Director of FPV	√	√		√	√	√	√
Report of Losses and Special Payments	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									

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April 2022	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb 2023
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (2023)	Director of FPV							√
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				√			
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager		√					
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Bi-Annually	PPV Manager				√			Deferred to April 2023
Clinical Audit									
Ratify the Clinical Audit Plan to be overseen by the PQSO Committee	Annually	Medical Director				X Deferred to April 2023			
Receive an Annual Report on Clinical Audit Activity	Annually	Medical Director							X Deferred to April 2023
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services									

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April 2022	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb 2023
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						x Deferred to Feb 2023	Received √
Agree the External Audit Annual Plan	Annually	Audit Wales		√					
Receive the 2022 Structured Assessment	Annually	Audit Wales						√	√
Receive External Audit Progress Report 2022-23	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							

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April 2022	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb 2023
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

Appendix 3

Attendance at 2022-23 Audit, Risk and Assurance Committee Meetings: Independent Members and Lead Executives

Meeting dates	7th April 2022	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb 2023
INDEPENDENT MEMBERS							
Iwan Jones *(Chair October 2022 onwards)*	✓	✓	Apologies	✓	✓	✓	✓
Richard Clark (Vice Chair)	✓	✓	✓	✓	Apologies	✓	✓
Shelley Bosson *(Chair up to and including August 2022)*	✓	✓	✓	✓	✓	✓	✓
Paul Deneen	✓	✓	✓	✓	✓	✓	✓
Katija Dew	✓	✓	✓	✓	✓	✓	Apologies
OFFICERS							
Chief Executive ***(Glyn Jones up to and including August 2022*** ***Nicola Prygodzizc October onwards)***	Apologies (No representative)	✓	✓	Apologies (No representative)	Apologies (No representative)	Apologies (No representative)	✓
Director of Finance, Procurement & Value	✓	✓	✓	✓	✓	✓	✓
Director of Corporate Governance	✓	✓	✓	✓	✓	✓	✓

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Risk and Assurance Committee Work Plan 2023/24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Corporate Services Manager

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit Risk and Assurance Committee is asked to consider the draft Committee work plan appended to this report for approval. The work plan has been developed with due regard to the 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.

Cefndir / Background

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.

In line with good governance practice, a committee work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting function.

Asesiad / Assessment

The Committee is requested to approve the Committee work plan as outlined in **Appendix 1** noting that the work plan will be presented at each Committee meeting for oversight and noting.

The work plan will be used to inform Committee business alongside the Board Assurance Framework which will seek to highlight areas of limited or reduced gaps in assurance.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight.
- **AGREE** to reference and utilise the Committee work plan to inform committee meeting agendas and items for discussion in conjunction with the Board Assurance Framework.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The objectives will be referenced to the IMTP

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. There is no Equality and Diversity impact.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Not required.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Aneurin Bevan 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	**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 the report, however, considerations will be included in considering how the business of the Committee aligns to the WBoFG Act.

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			√ Deferred from 22/23 workplan			√
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG			√ Deferred from 22/23 workplan			√
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		√	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		√	√

DRAFT

Updated 12.04.23

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
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG						√
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	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			√			

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
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	-	-	-	-	-	-
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				√		
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 to be overseen by the PQSO Committee	Annually	Medical Director	√ Deferred from 22/23 workplan					
Receive an Annual Report on Clinical Audit Activity	Annually	Medical Director	√ Deferred from 22/23 workplan					√
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								

DRAFT

Updated 12.04.23

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 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						√
Receive External Audit Progress Report 203-24	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

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Update on Single Quotation and Tender Actions – 11th January 2023 to 24th March 2023**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: REPORTING OFFICER:	**Jemma Edwards – 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 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 13th January 2023 to 24th March 2023.
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 5 requests submitted which have been approved during the period with an annual value of £1,723,900.00 Ex VAT.

The largest of these relates to £1.5m for the provision of a manned security service at a number of hospitals including the GUH and RGH. Because of the timing involved the STA relates to a final extension of the existing contract. Tender documents are being worked on in preparation for a tender process later this year.

Of these 5 approved requests, 4 were classified as either licensing or maintenance/ service type arrangements. There was 1 classified as goods purchased.

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. Finance is integral to the delivery of IMTP objectives.

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 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:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

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

Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
20/01/2023	Single Tender Action	ABU-STA-52321	Security HSG Facilities Management	£1,500,000.00	HSG Facilities Management	Services	Provision of a manned security service at The Grange University Hospital, Nevill Hall Hospital, St Cadocs Hospital and Royal Gwent Hospital. The security personnel will support ABUHB to ensure safety and security of sites and support hospitals to deal with violent and aggressive behaviour, monitor and manage the access and departure of people and traffic, deal with alcohol and drug misuse at sites, deal with damage to property, report potential safety hazards, support in the event of emergencies liaising with the police and other emergency services as required, etc. This contract was awarded through a competitive tender exercise where both quality and pricing of the current provider were evaluated against others in the market. Therefore, there is confidence that the current contract provides value for money. However, the division recognises the need to either re-tender and re-test the market via a competitive exercise or seek to bring the security service in house. This service is VAT recoverable under COS Heading 60. Estates and Facilities will continue to work with Corporate Finance to reclaim VAT from HMRC.A security review was carried out by Avon and Wiltshire Mental Health Partnership NHS Trust between March and April 2022 in which a report was provided to the health board, including an action plan. The security review has enabled discussions to be had within the health board as to whether or not security services should be brought in house or continue being provided by an external source. As a result of the internal discussions, the contract is now within its final extension period (Reference: MC206) and due to time and resource constraints the health board requires a shortterm STA to be put in place due to the current extension option ending 4th February 2023. In the background, tender documents are being worked on in preparation for getting the tender out and live mid/end of 2023 if required. If the contract for security services is not extended this would present a significant risk to staff and patients, leaving the Health Board vulnerable. Carrying on with the current provider (HSG) is the best short term option as they have familiarity with ABUHB sites and processes and provides business continuity. The original contract awarded to the current provider (HSG) was procured via a competitive tender exercise. Continuing with the current provider for a short period will provide continuity of a critical service for the health board. The current provider is familiar with ABUHB sites and processes and is able to fulfil the requirement with regard to quantity and quality. The short term extension is essential to maintain the safety and minimise the potential risks to patients, staff and visitors.	Due to the risk of not having an agreement in place for this service and the short time to to implement any changes we are left with no option other than to agree a short term contract with the current provider. Can we please ensure that any future requirements are reviewed well in advance of any contract expiry dates to allow time for tendering.	Approved	03/02/2023	08/02/2023

Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
21/01/2023	Single Tender Action	ABU-STA-52322	Security HSG Facilities Management	£1,500,001.00	HSG Facilities Management	Services	Provision of a manned security service at The Grange University Hospital, Nevill Hall Hospital, St Cadocs Hospital and Royal Gwent Hospital. The security personnel will support ABUHB to ensure safety and security of sites and support hospitals to deal with violent and aggressive behaviour, monitor and manage the access and departure of people and traffic, deal with alcohol and drug misuse at sites, deal with damage to property, report potential safety hazards, support in the event of emergencies liaising with the police and other emergency services as required, etc. This contract was awarded through a competitive tender exercise where both quality and pricing of the current provider were evaluated against others in the market. Therefore, there is confidence that the current contract provides value for money. However, the division recognises the need to either re-tender and re-test the market via a competitive exercise or seek to bring the security service in house. This service is VAT recoverable under COS Heading 60. Estates and Facilities will continue to work with Corporate Finance to reclaim VAT from HMRC.A security review was carried out by Avon and Wiltshire Mental Health Partnership NHS Trust between March and April 2022 in which a report was provided to the health board, including an action plan. The security review has enabled discussions to be had within the health board as to whether or not security services should be brought in house or continue being provided by an external source. As a result of the internal discussions, the contract is now within its final extension period (Reference: MC206) and due to time and resource constraints the health board requires a shortterm STA to be put in place due to the current extension option ending 4th February 2023. In the background, tender documents are being worked on in preparation for getting the tender out and live mid/end of 2023 if required. If the contract for security services is not extended this would present a significant risk to staff and patients, leaving the Health Board vulnerable. Carrying on with the current provider (HSG) is the best short term option as they have familiarity with ABUHB sites and processes and provides business continuity. The original contract awarded to the current provider (HSG) was procured via a competitive tender exercise. Continuing with the current provider for a short period will provide continuity of a critical service for the health board. The current provider is familiar with ABUHB sites and processes and is able to fulfil the requirement with regard to quantity and quality. The short term extension is essential to maintain the safety and minimise the potential risks to patients, staff and visitors.	Due to the risk of not having an agreement in place for this service and the short time to to implement any changes we are left with no option other than to agree a short term contract with the current provider. Can we please ensure that any future requirements are reviewed well in advance of any contract expiry dates to allow time for tendering.	Approved	03/02/2023	08/02/2023
28/02/2023	Single Tender Action	ABU-STA-52647	Asbestos removal at RGH	£129,090.00	MCL Enviromental Services Ltd	Service	MCL Environmental Services Ltd will provide all necessary labour, plant, materials and transport to undertake the works in accordance with the Health and Safety at Work Act 1974 and the Control of Asbestos Regulations 2012. All waste materials arising will be disposed of in accordance with The Hazardous Waste (England & Wales) 2005 (Amendment) Regulation 2009 including the EA Hazardous Waste Consignment Note procedures. Residence Block 1 Licensed work only - £21,050.00 + Vat - Residence Block 1 Non-Licensed works - £19,550.00 + Vat Residence Block 2 Licensed work only - £6,500.00 + Vat - Residence Block 2 Non-Licensed works - £28,890.00 + Vat Removal and Disposal Of Pigeon Guano - £2600.00 + Vat - Supply scaffold for the removal of external notifiable works to both blocks 1 & 2 - £80,500.00 + Vat Total - £129,090.00 + Vat MCL Environmental Services are ABUHBs contractor for the emergency removal of asbestos and were appointed via a competitive tender exercise in 21/22. They were the most cost effective bidder during the tender process, providing both the highest quality and lowest cost out of 6 bids received. In the future, pro-active / project style asbestos removal will be tendered under the new Minor Works Framework. This framework will be awarded in October 2023 and will allow future asbestos removal requirements of this nature to be awarded quickly and compliantly. Capital funding was allocated for completion of this project in December 2022, leaving little time to complete a full tender process and meet the required Welsh Govemment funding deadlines. MCL Environmental Services have been approached as they are ABUHB's appointed contractor for the emergency removal of Asbestos and were appointed via a competitive, compliant tender process. During the tender, they were the lowest cost bidder out of 6 responses received. MCL Environmental Services have demonstrated expertise since commencing the contract for Emergency and Remedial Asbestos Removal and are familiar with the sites and rocesses of ABUHB.	Approved as there is a compatibility concern that specific equipment and skills are required to carry out the task. Also the works is follow-up, where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition).	Approved	07/03/2023	

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:**	18 April 2023
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, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Estelle Evans, Head of Financial Services and Accounting**

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.
- Annual Accounts timetable
- Technical accounting issues.
- Public Sector Payment Policy compliance.
- Payments Exceeding £100K.

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

- Approve the amendments to the following financial control procedures (FCP):

  1. General Ledger (Appendix 1)
  2. Policy and Governance approach for Commissioning Additional (External & Insourced) Non-NHS Clinical Services (Appendix 2)

Cefndir / Background

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

The FCPs presented have been reviewed 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 action taken to date to ensure compliance with the review date for 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:

- General Ledger
- Policy and Governance approach for Commissioning Additional (External & Insourced) Non-NHS Clinical Services

These procedures were presented and approved at the Executive Committee on 23rd March 2023.

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

General Ledger

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

The General Ledger (GL) is the core accounting system for the organisation and is a module of the Oracle Financial System. It records details of all financial transactions for Aneurin Bevan University Health Board (ABUHB) through a computerised double entry bookkeeping system.

The General Ledger is the database from which financial and management accounting information is obtained.

The procedure ensures that all Health Board employees, who use the General Ledger, are aware of the required controls.

The document has been circulated for comment as follows:

- Business Systems Analyst
- Assistant Head of Financial Accounting
- Assistant Head of Financial Services
- Head of Financial Services and Accounting
- Head of Business Systems and Governance
- NWSSP - Audit and Assurance Services

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.
6.1	*Roles and Responsibilities* – 'Head of Business Systems and Governance' added as being responsible for the day-to-day management of the General Ledger.
7.1.2	*General Ledger System Access* – Updated reference to delegated budget holders to reflect the budgetary control FCP.
7.2.5	*Maintenance of Account Codes & Hierarchy* – New process added, 'annual review of cost centres to ascertain if still in use or redundant.'
7.3.2	*Information Input and Processing* – Reference to 'Pharmacy – monthly' added to the processing of interface files from feeder systems.
7.3.6	*Information Input and Processing* – Responsibility change from 'Head of Governance and Controls' to 'Head of Business Systems and Governance.'
7.4	*Reconciliation of Control Accounts* – Reconciliation name change from 'ESR payments to general ledger' to 'Payroll Feeds.'

Policy and Governance Approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services

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

The procedure provides a framework and guidance for use when considering commissioning additional services to support patient care improvements, outside of the usual NHS agreements.

The scope of the procedure applies to both externally commissioned services and insourced services, where external providers operate within Aneurin Bevan University Health Board (ABUHB) premises.

The document has been circulated for comment as follows:

- Interim Assistant Finance Director – Financial Strategy and Planning
- NWSSP - Audit and Assurance Services

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.
3	*Issues – 'How do we comply with the Corporate Governance Framework?'* – Reference added for financial affordability to be confirmed by gaining approval from the budget holder.
3	*Issues – 'Why do we need to externally commission?'* - An assessment criteria added 'Are there regional solutions now or in the future to be considered.'

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

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
General Ledger	23/24	Due for review	Apr-20	02-Apr-23	Apr 23 Audit Committee
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	23/24	Due for review	Apr-20	02-Apr-23	Apr 23 Audit Committee
Capital Procedures and Guidance Notes	23/24	Due for review	Apr-20	02-Apr-23	Scheduled for Sep 23
Prepayment of Goods and Services	23/24	Y	Jul-20	13-Jul-23	
Patients' Travel Costs Policy	23/24	Y	Oct-20	22-Oct-23	
Cash and Bank	23/24	Y	Oct-20	22-Oct-23	
Petty Cash	23/24	Y	Dec-20	03-Dec-23	
Petty Cash - Mental Health	23/24	Y	Dec-20	03-Dec-23	
Accounts Receivable	23/24	Y	Feb-21	04-Feb-24	
Approval of Orders over £100K	23/24	Y	Feb-21	04-Feb-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	

2. Technical Accounting Issues

2.1 Technical updates

Welsh Government have issued technical updates 3 and 4 since the last report presented to the Audit, Risk and Assurance Committee. Technical update 3 and 4 require the submission of various returns and clarification on a number of areas including the reporting arrangements re the quinquennial revaluation figures and the indices to be applied.

Where relevant to the Health Board, the updates will be reflected in the final accounts.

3. Key Dates for Annual Accounts 2022/23

In the last Governance report presented to the Audit, Risk and Assurance Committee the dates for the draft and final 2022/23 annual accounts and associated returns had not been confirmed. We have now received the confirmed dates for the submission of the accounts and these along with other key dates are shown in the table below.

It is planned to take the final accounts for approval to the scheduled Board meeting on the 19th July

Annual Reports 2022/23 - Key Dates	**2023**	
First draft Performance Report and Accountability Report for consideration by Exec Team	Thurs	27-Apr
Unaudited accounts and associated returns to WG	Fri	05-May noon
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	Fri	12-May
Draft Reports to Audit Committee Members		16-May **Exact date TBC**
Audit, Risk and Assurance Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tues	23-May
Final Accounts & Accountability Report to Audit, Risk and Assurance Committee		11-July **Exact date TBC**
Audit, Risk and Assurance Committee meeting to Consider Final Accounts, and Accountability Report	Tues	18-July
Board meeting to approve Final Accounts and Accountability Report	Wed	19-July
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	31 July noon
Annual General Meeting – to receive the Annual Report and Accounts		**TBC**

4. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of February.

On a cumulative basis the Health Board have achieved 95.1% 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 have achieved the target of 95% in month. The cumulative percentage remains below the 95% target, but this has improved slightly in recent months with ongoing action.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	99.6 95.0	94.5 88.7
Non NHS	Value Number	96.4 94.8	95.7 95.1

5. Payments in Excess of £100K

There were no exceptional issues to report.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to approve the amendments to the following procedures.

- General Ledger
- Policy and Governance approach for Commissioning Additional (External & Insourced) Non-NHS Clinical Services

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 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Finance is integral to delivery of IMTP Objectives

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:	N/A
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure
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)	
	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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Aneurin Bevan University Health Board

Financial Control Procedure General Ledger

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/0245

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1. Introduction

1.1. The General Ledger (GL) is the core accounting system for the organisation and is a module of the Oracle Financial System. It records details of all financial transactions for Aneurin Bevan University Health Board (ABUHB) through a computerised double entry bookkeeping system.

1.2. The General Ledger is the database from which financial and management accounting information is obtained.

2. Policy Statement

Aneurin Bevan University Health Board is committed to ensuring that it has sound financial controls in place to ensure that there is good control and probity. An integral part of this is the organisation's accounting system and General Ledger (GL), which is therefore subject to a Financial Control Procedure.

3. Aims

To ensure that all Health Board employees that use the General Ledger are aware of the required controls.

4. Objectives

The objectives for the General Ledger Financial Control Procedure are:

- There should be sufficient controls to ensure segregation of duties is adequate.
- Adequate physical security should exist.
- There should be a clearly defined audit trail from all information in the General Ledger to the source input documentation giving rise to it.
- Access to the General ledger is restricted to authorised personnel only.
- Feeder systems are appropriate and operated in a controlled environment.

5. Scope

This procedure details the controls underlying the ABUHB's General Ledger. This Financial Procedure should be read in conjunction with the Health Board's Standing Orders and Standing Financial Instructions.

6. Roles and Responsibilities

6.1 The Director of Finance, Procurement and Value

The Director of Finance, Procurement and Value is ultimately responsible for the security, integrity and accuracy of the General Ledger. The day-to-day responsibility and management of the General Ledger is delegated to the Assistant Director of Finance (Financial Systems and Services) who in turn delegates to the Head of Business Systems and Governance

6.2 System Administrator

The Business Systems Finance Analyst (System Administrator) is responsible for the integrity of the hierarchical coding structure and ensuring that the General Ledger is in balance.

The System Administrator is responsible for ensuring all daily, weekly and monthly feeds from sub ledgers and feeder systems are received and processed in Oracle in accordance with the ABUHB timetable.

The System Administrator will run month end close routines as per their standard operating procedures and adhere to the ABUHB month end close deadlines.

ABUHB Accounts Receivable manager will run month end close routines as per their standard operating procedures and adhere to the ABUHB month end close deadlines.

NHS Wales Shared Services Partnership (NWSSP) Accounts Payable will run month end close routines as per the Accounts Payable FCP and adhere to the ABUHB month end close deadlines.

The System Administrator is responsible for user maintenance.

7. Main Body

7.1 General Ledger System Access

7.1.1 Access to the General Ledger will be controlled via access levels. Access levels will be determined, for each individual user or groups of users, dependent on their position and level of responsibility.

7.1.2 Access to the system will be by way of a username for each individual user. A new user form must be completed and signed by the appropriate delegated Budget Holder for access to be granted to the General Ledger System. On receipt of this form, the System Administrator will set up access and inform the user.

7.1.3 Generic usernames / accounts are sometimes used to enable system processes where there is no human interface. Such generic usernames and/or accounts will only be set up if absolutely necessary and only after approval by the Assistant Director of Finance (Financial Systems and Services). The Assistant Director of Finance (Financial Systems and Services) will ensure that where such generic accounts exist, they will be configured, or other controls will be in place to minimise the risk from damage of misuse.

7.1.4 In addition to the username, the General Ledger will also be protected by a password system. Where possible, controls will be built into the General Ledger System to automatically aid users in meeting the Health Board's Password Management Policy, e.g.

- An appropriate interval (60 days) is set in Oracle to force the user to change their passwords.
- Users will only be allowed a limited number (3) of log in attempts before the account is disabled.
- The password must be the required length of 8 characters, must be alpha/numeric and contain no consecutive repeating characters. These rules will be set in the system to force users to enter a password that meets the minimum requirements.

7.2 Maintenance of Account Codes and Hierarchy

7.2.1 The ABUHB's coding structure consists of five elements:

- Entity
- Cost Centre
- Subjective
- Analysis
- Other

When linked, all five elements form a valid financial code.

7.2.2 All requests for the creation, amendment or deletion of one of these five elements must be sent to the System Administrator. If requesting a new element, the requestor must specify where the new element fits into the segment hierarchy. Before creation, amendment or deletion, the System Administrator will check the validity of the request. The System Administrator must maintain the appropriate documentation relating to these requests.

7.2.3 A common subjective chart of accounts is maintained across all Health Boards and Trusts in Wales. Any new or amendment to codes therefore has to be actioned via the All Wales Oracle team.

7.2.4 The System Administrator is responsible for maintaining the hierarchical coding structure and, prior to month and financial year end, must run control reports to ensure the integrity of the hierarchical coding structure.

7.2.5 The System Administrator will annually perform a review of cost centres to ascertain if still in use or redundant.

7.2.6 Financial codes will be automatically validated, i.e., linking all five elements detailed in paragraph 7.2.1, when they are used in combination for the first time. Where possible, validation rules will be set in the system to help check the validity of the financial code e.g. that revenue codes are not being linked to capital subjective codes and vice versa.

7.3 Information Input & Processing

7.3.1 There are four methods of inputting financial information into the General Ledger:

- The processing of interface files from feeder systems.
- The processing of feeds as part of an integrated system (e.g. AP/AR, Procurement)
- Manual Journal Entry.
- File upload from a PC or linked system tool.

7.3.2 The processing of interface files from feeder systems forms part of the monthly input carried out by the System Administrator. The following feeder system financial information is fed into the General Ledger through interface files:

- Payroll – Weekly and Monthly

- Stock – Monthly
- Pharmacy - Monthly

The System Administrator will be notified electronically when a feeder file is ready for processing.

It is the responsibility of the Litigation Accounting Higher Officer to ensure that the payroll files transferred to the GL reconcile to the ESR gross to net and costing reports. Checks to the feeder control totals will be made by the System Administrator to ensure that no data has been lost or corrupted during the import process.

7.3.3 The General ledger is part of an integrated Oracle system, which includes modules such as Accounts Payable and Accounts Receivable. The system will be set up to generate feeds either on a daily basis, weekly basis or at month end. The System Administrator will check at each month and year end that all the relevant system generated feeds have been imported and posted in the General Ledger.

The Head of Financial Services and Accounting is responsible for reconciling each module to the General Ledger Control Account Balances

7.3.4 Manual accounting entries (journals) can be input into the General Ledger by individuals who are authorised. Access to manual journal entry will be controlled via access security levels, as detailed in Section 7.1.1. Every manual journal input into the General Ledger should be uniquely identifiable, either by a unique header name for the journal or by a sequential number. Each journal should be balanced, should have valid financial codes and should contain adequate narrative.

7.3.5 Journals can be entered via a file upload (spreadsheet), either directly from the PC or using a software application tool linked to the General Ledger. Access to spreadsheet journal entry will be controlled via access security levels, as detailed in Section 7.1.1. Each journal should be uniquely identifiable, either by using a unique header name for the journal or by a sequential number. Each journal should be balanced, should have valid financial codes and should contain adequate narrative.

Control checks on journals include:

- All budget reports are reviewed monthly in detail by the Business Partner Accountants and Corporate Finance Teams.
- The organisation's balance sheet is subject to monthly review to understand significant movements.

7.3.6 The Head of Business Systems and Governance is responsible for ensuring a month end checklist of controls to ensure the completeness of data, posted to the General Ledger, is maintained. The checklist will contain all the tasks that need to be undertaken and the officer who is responsible. The responsible officer will sign off that the task has been completed on a monthly basis.

7.4 Reconciliation of Control Accounts

A reconciliation of Balance Sheet control accounts will be carried out on a monthly basis by the appropriate officer. Reconciliations are reviewed and authorised by a senior officer set out in table 1 below:

Table 1

Reconciliation	Prepared by	Authorised by
Bank account statements to cash books	Treasury Officer	Treasury Manager
Cash books to the general ledger	Treasury Officer	Treasury Manager
Accounts receivable (debtors) to general ledger	Accountancy Manager	Assistant Head of Financial Accounting
Accounts payable (creditors) to general ledger	Losses & Litigation officer	Head of Financial Services & Accounting
PAYE, NI, pension to the general ledger	Treasury Manager	Assistant Head of Financial Services
VAT return to general ledger	Financial Services Manager - VAT	Head of Financial Services & Accounting
Payroll feeds	Losses & Litigation officer	Head of Financial Services & Accounting
Primary care control accounts for dentists, doctors, pharmacists and opticians	Accountancy Manager	Assistant Head of Financial Accounting

7.5 Reporting timetables

Annually, an agreed standardised processing and reporting timetable will be developed and published. In order to ensure that the Welsh Government

and Aneurin Bevan University Health Board financial reporting deadlines are met, the timetable will define cut off dates for input into the General Ledger and output dates for the ABUHB Budget Reports.

8. Further Information

Enquiries regarding this procedure should be directed to either the Head of Business Systems and Governance or the Principle Finance Manager – Business Systems.

9. Audit

The procedure will be subject to internal audit review from time to time.

10. Review

The procedure will be reviewed every 3 years.

Aneurin Bevan University Health Board

Policy and Governance Approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services

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1 Introduction

This policy provides a framework and guidance for use within Aneurin Bevan University Health Board (ABUHB) when considering commissioning additional services to support patient care improvements. It is specifically applicable when engaging non NHS providers and suppliers of health services.

2 Application

This policy should be used for commissioning additional service capacity from outside of the usual NHS agreements.

The scope applies to both externally commissioned services and insourced services, where external providers operate within ABUHB premises.

3 Issues

There are several elements to consider before the service proposal is commissioned. This policy sets out the main areas which need to be considered in commissioning *external or "insourced" services.* These can be summarised over 4 key headings:

- **A.** Why do we need to externally commission? (Led by Division)
- **B.** What are the key Clinical Governance issues? (Led by the Medical Director, with input from the relevant service lead clinician)
- **C.** How do we comply with the Corporate Governance framework? (Led by Commissioning) - the financial affordability also needs to be confirmed by gaining appropriate approval from the Budget Holder (either Commissioning or Divisional lead depending on the situation
- **D.** What are the Operational Management factors to consider, including involvement of the Community Health Council? (Jointly Led by Division/Commissioning)

A. Why do we need to externally commission?

The current position of the internal service to be commissioned needs to be reviewed to establish the need to commission, this assessment will be used to gain executive approval to consider external commissioning to include:

- Current waiting times & lists,
- Demand profile & trends on the service,
- Delivery against planned resourced activity – can this be improved,
- Resource limitations (workforce, facilities, equipment),
- Which elements of the patient pathway are struggling to deliver,
- Target delivery position,
- Future internal development/improvement plans,
- Is it a recurrent or non-recurrent issue to resolve,
- Are there financial resources delegated already,
- Is there additional funding available internally or new Welsh Government funding,
- Are there national trends and factors affecting ABUHB,
- Does the proposal reflect value based commissioning,
- Are there regional solutions now or in the future to be considered,
- Proposed outcomes and measures, and
- Impact on & fit with the Integrated Medium Term Plan (IMTP) and strategic plans.

B. What are the key Clinical Governance issues?

This should include an assessment of what minimum standards we want to commission against and the clinical patient pathway, as part of a specification:

- Provider registration accreditation (eg HIW, CQC),
- Workforce accreditation appropriate to service (eg. Royal College Surgeons). Registration checks to be undertaken for all named individuals,
- Quality & Safety Standards expected,
- History of past performance against clinical performance indicators (eg. national joint registry),
- Service access criteria – what types of patients we want to be seen and treated (eg. simple, complex),
- Best Practice clinical patient pathway expected (Agreed and approved by the Medical Director and relevant lead specialty clinician),
- How to deal with unforeseen events, continuity of care, complaints and redress, and
- Productivity and outcomes expected from provider & reporting.

C. How do we comply with the Corporate Governance Framework?

This is relatively straight forward for NHS providers where contract LTAs or ad hoc activity can be agreed through the Commissioning Team &/or Execs, subject to the budget delegation, financial resources and operational arrangements being clarified, the CEO will approve the LTA. The usual commercial Procurement rules do not apply by special dispensation.

As an ABUHB 'informal policy' there is an escalation of service commissioning thus:

1. Can we deliver internally,
2. Can we commission extra through existing NHS Long Term Agreements (LTAs),
3. Can we commission through new NHS LTAs in Wales,
4. Can we commission through new NHS LTAs in England,
5. Using the All Wales Procurement Framework, can we commission through NHS Treatment Centres (requires Procurement where privately owned), and
6. Using the All Wales Procurement Framework, can we commission privately (requires Procurement)?
7. If 1 to 6 are not achievable, then the contract should be re-tendered through the UK national framework or on an open market basis.

The above approach has been influenced by the Welsh Government/political expectations of Health Boards to have optimised their local service delivery before looking outside of the organisation. It is also something that is explicitly requested in ministerial briefings, along with clarifying local development plans to deliver internally in the long term.

When commissioning external services where 'Procurement' is required, the approach varies depending on the estimated value of the contract. The ABUHB budget, Standing Orders and Standing Financial Instructions delegation limits apply, but also the need to involve the Commissioning team to lead or support the commissioning plan and the support of the Procurement team to support the overall procurement process to ensure compliance with guidance/legislation.

The steps are relevant to the value of the service being commissioned and the Standing Orders and Standard Financial Instructions Scheme of Delegation applies:

General Delegated Financial Approval Limits

Body / Committee / Post	**General Financial Limit £'000**	**Individual Patient Placements (Including CHC) Annual Contract Limit £'000**
Welsh Government	>1,000	N/A
Board	1,000 (note 1)	N/A
Chief Executive and Chairman / (Deputy Chief Executive / Vice Chairman in their absence)	500	N/A
Chief Executive / Deputy Chief Executive	100	500
Executive Team Members	75	250 (note 2)
Divisional Directors / General Managers / Assistant Directors	50	50
Other Delegated Budget Holders	25 and below	N/A

Note (1): urgent issues between scheduled Board meetings should be referred to the Board Secretary to seek approval via chairs action.
Note (2): this relates specifically to the Director of Primary, Community and Mental Health Services.

Prior to these limits influencing the ultimate decision to award a contract, a management approval approach needs to be undertaken to ensure the Board is sighted on decisions of high value.

The Board should be consulted on issues of significant service and financial impact. Ideally the IMTP consultation and approval process will act as the mechanism to undertake external & insourced commissioning activities. In this way the Board is aware of the implications and financial resource required and gives approval to commission, go to procurement and follow the required process.

During the financial year, if external or insourced commissioning is required to deliver an improved level of performance or for other reasons, the Executive Team should consider the proposal and the Board should be made aware of the proposal and considered in formal

committee – subject to delegated authority (e.g. in excess of £100k where this is the delegated CEO general financial limit).

The Board can authorise contracts up to £1m, thereafter Ministerial approval is required, in addition there are monitoring arrangements to be complied with:

The expected value of a contract guides the Ministerial monitoring requirement:

- For individual contracts with a value exceeding £250k and up to £500k, the Minister needs to be 'Informed'.
- For individual contracts with a value exceeding £500k and up to £1m, the Minister needs to be 'briefed' and adequate time allowed for the Minister to review the contract particulars before awarding the contract.
- For individual contracts with a value exceeding £1m the Minister/Welsh Government must give written approval to enter into the agreement.

When a procurement process is agreed, the mechanism needs to be worked through in terms of tender type (open market, framework agreement, etc), action points, documentation and timescales to receive bids, award contract and implementation. The procurement process should ensure that tender details submitted have been checked properly, including relevant references. The process should include undertaking interviews with potential suppliers/providers to ensure that tender information is tested robustly.

An example of a timeline for a contract value between £500k and £1m is included below:

Contracting Stage	Anticipated Date/Timescales
Briefing paper to Minister	Usually 1 week.
Receive Minister comments and 'Note'	Day 0
Issue PIN via OJEU mechanism	Day 1
Formal responses received	Day 20
Evaluation/Assessment to ensure award criteria being met – Pre Qualification	Day 28
Evaluation/Assessment to ensure award criteria being met – Final Evaluation and Selection	Day 36
Prepare ABUHB Board Report	Day 38
Update Minister of outcome and intention to award	Day 39
Execute Agreement	Day 40

Contract Start	Day 45

The above demonstrates the steps and how long a relatively 'quick' procurement can take to comply with regulations.

D. What are the Operational Management factors to consider?

There are several very significant implementation and operational issues to be dealt with as part of external or insourced commissioning. These include a range of patient related, directorate operational and commissioning monitoring aspects.

Potential Conflicts of Interest

Consideration also needs to be given to any related party issues with potential providers.

As part of any procurement process, potential providers will be asked to document the following:

- Whether the organisation employs or engages any current Health Boards employees and whether these individuals have personal financial interests in the organisation
- Whether the organisation intends to use any current Health Board employees to deliver the contract
- Whether the organisation employs Board members or others holding positions of influence or other interests in ABUHB
- Whether there are any other influential interests or relationships or connected parties.

This information will be reviewed by the Executive Team before a decision is made whether to proceed with that potential provider.

A Project group should be established with relevant experts to support the delivery of the actions listed below and as a minimum should include a Specialty Clinician, Commissioning Lead, Directorate Manager, Workforce, Informatics representative (every effort should be made to involve a Specialist doctor in the process, with final approval signed off by the Medical Director). An Independent Member (IM) of the Board will be invited to sit on the group, including the supplier interview panel. The Aneurin Bevan Community Health Council should be involved in agreeing the full clinical pathway. Therefore, it may be appropriate to consider inviting the Community Health Council to sit on the group.

- Internal and external implementation issues,

- Contract Management resources (led by Commissioning team),
- Patient Communication mechanisms and messages,
- Identification of the relevant patient cohort to offer the service to (eg. long waiters or everyone),
- Divisional and Commissioning Team resources to deliver the project aims,
- Workforce, facilities, diagnostics and equipment requirements if delivered within ABUHB venues,
- Registration checks for all named individuals,
- Provider Responsible Officer for provider medical staff to be confirmed,
- Ensure the patient pathway is monitored to meet the specification,
- Distance to travel and patient transport arrangements,
- Project monitoring – activity, outcomes, performance (including Clinical lead),
- IT and information sharing interfaces and document control,
- Adverse incidents and emergency patient event management arrangements, escalation & patient continuity of care processes,
- Risk register & decision record,
- Potential for joint working and learning, and
- Financial management arrangements.

4 Conclusion

This report has outlined the multiple factors and issues to be considered when externally commissioning or insourcing health services for ABUHB patients, the 'checklist' of issues is applicable to both 'in-sourcing' services and 'out-sourcing' services. This policy should be used within ABUHB to ensure that these services are commissioned appropriately and effectively.

5 Queries and Clarifications and Updating

Matters of clarification and queries on this policy should initially be directed to the Director of Finance, Procurement and Value

This procedure will be reviewed on a three yearly basis.

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Counter Fraud Work Plan for 2023/24.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Michelle Morris – Head of Counter Fraud

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

An Executive overview has been prepared for Aneurin Bevan University Health Board (ABUHB) Audit Risk & Assurance Committee. It highlights Counter Fraud work which is proposed to be undertaken by the Local Counter Fraud Specialists for 2023/24.

This workplan encompasses all the components of Government Functional Standard GovS 013: Counter Fraud, which took effect over the NHS Counter Fraud provisions on 1st April 2021.

Cefndir / Background

This document has been prepared by the Aneurin Bevan Counter Fraud team to facilitate mapping the provisions of the Government Functional Standard GovS 013: Counter Fraud and the recommendations of the NHS Counter Fraud Authority.

Asesiad / Assessment

There are no inherent risks associated with this Workplan, however; the plan will form the basis of the annual Quality Assurance Self-Review, as evidence that ABUHB has complied with the aforementioned Government Functional Standards.

Argymhelliad / Recommendation
The Audit, Risk & Assurance Committee is asked to APPROVE the Counter Fraud Workplan 2023/24.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The monitoring and reporting of Counter Fraud activity is a key element of the Health Boards assurance framework.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Counter Fraud is integral to delivery of IMTP objectives.
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:	Not applicable
Rhestr Termau: Glossary of Terms:	Not applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not applicable

Effaith: (rhaid cwblhau)

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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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD, BRIBERY & CORRUPTION WORK-PLAN 1st APRIL 2023 to 31st MARCH 2024

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

WORKPLAN 2023-2024

1 Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6 NHS Counter Fraud Authority (NHSCFA) has also published detailed information on how the new Government Functional Standard 013 will be applied across the NHS and wider Health Group. The Health Board's 2023-24 Work-Plan for Local Counter Fraud work will therefore closely mirror this Standard and Provider's Guidance, which in turn supports the objectives set by the Welsh Government.

1.7 The total number of suggested **Pro-Active days** to be allocated in 2023-24 is **312** (out of a total of resource of 535 workdays) this *excludes* the resource required for undertaking 'Reactive' Local Counter Fraud work (Hold to Account). This reactive resource is required to conduct detailed investigations into allegations received by the Health Board in relation to NHS Fraud, Bribery and Corruption. The total

number of **Reactive days** to be allocated in the 2023-24 Work-Plan is **223** (including proactive investigations).

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

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

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

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

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

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

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

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

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

2.5 The LCFS should have effective liaison with the Local Risk Manager and Risk Group. It is recommended that frauds that have occurred within the organisation

and beyond be brought before this group to ascertain the risk to the Health Board from the same type of fraud. Once identified, the fraud can be proactively addressed.

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

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

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

3 Focusing on outcomes and not merely activity

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

Risk Assessment of Counter Fraud Arrangements

Approach

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

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

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

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

1.5 The overall risk assessment of organisational Counter Fraud Arrangements on 31st March 2023 was rated **Green** (Score- 100%) in all areas.

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

Suggested Response to Summary Outcomes

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

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

Summary of risk assessment outcome

1.7 The summary assessment by the ABUHB Counter Fraud Team of each Key Section at 31st March 2023 is shown in the table below:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1

Number of Days agreed for 2023/24 ***535 Days***

Agreed/signed by

Signature: **Date:**

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Plan 2022/24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, 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 continually 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 guideline defined standards of care. It also improves the quality of care and patient outcomes.

The Health Board has four priorities:

- That there is scrutiny of national clinical audit performance at directorate and divisional level (overseen by the Clinical Standards and Effectiveness Committee) with robust development, monitoring, and completion of improvement plans.
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risks identified from datix, complaints and outcomes of care.

- Trainees are supported to participate in high quality clinical audits that support clinical governance.
- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

Cefndir / Background

Clinical audit is one tool in a wider Quality Improvement Strategy aimed at providing assurance with respect to delivery of best practice care. Aneurin Bevan University Health Board complied with Welsh Government requirements by participating in all mandatory National Clinical Audits (NCAs). The Health Board's clinical audit team are updating the following organisational documents, as suggested by the Healthcare Quality Improvement Partnership (HQIP). They must be linked and read together to ensure the effective management of clinical audit:

- The 'Clinical Audit Policy' describes the use and conduct of clinical audit: the document sets out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice and improving the quality of services to meet the needs of patients.

- The 'Clinical Audit Strategy 2022-25' sets out the principles of how an audit is identified as required, planned and linked with the Quality Management System under development in Aneurin Bevan University Health Board. It describes how the Health Board will implement the strategy and increase the impact of audit on improvement in clinical services. The strategy was launched in October 2022 and implementation is underway.

- A clinical audit plan/ programme is being developed for the next two years. This will provide a prioritised summary of planned clinical audit activity and outcomes. This will be regularly updated and scrutinised in accordance with the above clinical audit policy and strategy.

- A clinical audit report template has been developed in a web-based Audit Management and Tracking system (AMaT). This will provide consistency in the reporting of clinical audit and will allow completion of audit actions to be visible to the corporate and divisional team.

In its review of clinical audit, HQIP suggested that clinical audit should be integral to Board assurance of quality and improvement. To be able to provide this assurance a clinical audit programme should provide confirmation that clinical practice compares favourably with evidence of guideline defined practice and where this is not the case, that changes are made to improve the delivery of care.

Our clinical audit programme will reflect national and local drivers for quality improvement. It will aim to balance key drivers with directorate/division/service/ clinician priorities. The programme will assess if the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual plan.

Asesiad / Assessment

Development of 2023/24 Programme

In developing the Aneurin Bevan University Health Board audit programme the Clinical audit team considered the following:

- Ensure directorates participate in all national clinical audits, national confidential enquiries and service reviews relevant to its service provision.
- Ensure all clinical audit activity within directorates is registered on AMaT.
- Mandatory participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).
- Participate in national audits, not on NCAPOP, but are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls, pressure ulcers).
- Clinical audits identified or required for Board Assurance Framework.
- NICE guidance and HTW adoption. Audit is not mandatory but implementation and audit of NICE guidance can be subject to external review.
- Projects requiring re-audit after changes in practice.
- Work with clinicians, service managers, divisional governance and quality managers and clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- 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).
- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include 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.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads will identify projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits from clinical incidents, complaints or risks. Engagement meetings with Divisions to facilitate implementation of the Clinical Audit Strategy and develop a clinical audit plan are scheduled for the next two months. The programme will commence from April 2023.

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by the Welsh Government (WG) annually. This plan is one of the foundation cornerstones in the drive to improve the 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 the healthcare provided to patients and to assess year on year improvements. The plan also details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided.

Full participation is mandatory in all NCAs and are registered on AMaT. The identified Clinical Lead, in conjunction with the Divisional Triumvirate will review the audit reports and develop an action plan to address any requisite improvements. The NCA programme and Clinical Outcome Review Programmes (CORP) will be shared with Directorates for 2023/24 and clinical audit leads to allow planning for attendance at Clinical Standards and Effectiveness Group (CSEG).

The introduction of AMaT will make auditing easier, faster, and more effective. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. This will allow tracking of results and an action plan to be produced with measurable improvements within a specified timeframe. Using AMaT, Clinical Directors will be empowered to undertake audits more effectively and enable presentation of data using a dashboard and easy-to-read graphical presentations. The clinical audit team are training staff to use AMaT, currently there are over 90 users trained.

Creation and delivery of actions plans arising from audit are an opportunity to improve safety and patient experience. Use of AMaT will ensure there is a system for prioritisation of clinical audit and enable monitoring and tracking of actions. AMaT will facilitate effective clinical audit and provide an oversight of audit data. For future meetings, Clinical Leads are asked to ensure that Audit reports include a summary of areas of practice that already meet guideline/audit standards and an action plan for areas requiring improvement that are specific, measurable, achievable, realistic and time bound so that their implementation can be tracked.

Divisional governance teams are required to oversee the production of audit action plans by directorates for approval at CSEG. This will improve accountability for clinical audits, visibility of action plans and allow tracking of actions, providing assurance to the Committee and Executive Board. Future reports will include 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.

CSEG will develop a process to enable shared learning from audits across the organisation and communicated to staff and patients. Results from clinical audits will be triangulated with other quality measures to inform future Quality Improvement plans.

AMaT is seen as the solution to local improvement and the implementation and monitoring of NICE guidance and of HTW adoption. We have aspirations that using the AMaT platform will be a reliable and comprehensive system for monitoring local compliance with evidence-based guidance prioritising NICE and HTW guidance in the first instance. This new system will allow improved clarity, oversight and assurance of compliance and mitigation.

The Health Board's clinical audit programme will provide a list of all the clinical audit projects planned or undertaken. The clinical audit programme will be updated every month to ensure the rolling nine-month NCAORP plan is reflected in the programme. See Appendix One for current 2023 NCAs and CORP. The scheduling function on AMaT will be utilised to develop this plan and will align with

CSEG meetings and include dates for Operational Groups and Outcome Committees. This will be evaluated after six months. See example of Excel Gantt Chart until an AMaT audit schedule is developed.

The Health Board's clinical audit intranet page will host a link to the HQIP site. The regular publication of a National Clinical Audit and Outcome Review e-bulletin highlighting developments and findings from recent reports will be made available to clinicians via CSEG. The aim of the clinical audit team is to raise the profile of clinical audit with boards, patient groups, clinicians and all staff working within the health board. AMaT is enabling closer partnerships working with health boards/trusts clinical audit teams to improve knowledge and understanding of national and local audit/review activities.

For the year 2022/23, the clinical audit team will produce an annual audit report. Our ambition is to ensure full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.

The Terms of Reference for CSEG have been updated. CSEG oversees the governance relating to Clinical Audit and reports biannually to Patient, Quality and Safety Outcomes Committee, the outcomes and improvements plans relating to National Audit. This is part of the assurances processes required by Welsh Government to be taken internally by all Welsh Health Boards.

Identification of relevant risks from audits will be incorporated onto the Divisional risk register going forward. There is work underway to review the assurance framework for Committees and Operational Groups. The development of a Risk Management Strategy and Board Assurance Framework will ensure the appropriate governance structures and arrangements are in place for clinical audit and address how risks are escalated.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team to develop a clinical audit programme for the next 12-24 months.

Note work is underway to implement the clinical audit strategy, update the Health Board policy on clinical audit, produce a clinical audit programme and produce an annual Health Board audit report. AMaT is being implemented. Engagement with Divisions on clinical audit is planned.

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):	3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Clinical Audit is integral to achieving IMTP objectives.
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 Choose an item. Choose an item. Choose an item.

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

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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

APPENDIX ONE
NATIONAL CLINICAL AUDIT AND PATIENT OUTCOMES PROGRAMME (NCAPOP)
9 MONTH PUBLICATION SCHEDULE

Please see the nine-month publication schedule for the National Clinical Audit and Patient Outcomes Programme (NCAPOP) – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP). This will form part of the Clinical Audit Plan which will be updated every three months to ensure the programme updates are constantly planned for a rolling nine-month programme.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Publication date
304	NACAP – National Asthma and COPD Audit Programme	National Asthma and COPD Audit Programme – Airways Report	NCA	Royal College of Physicians	Thu 12/01/2023
352	FFFAP – Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLDSB) Annual Summary Report	NCA	Royal College of Physicians	Thu 12/01/2023
370	NPCA – National Prostate Cancer Audit	National Prostate Cancer Audit Annual Report	NCA	Royal College of Surgeons	Thu 12/01/2023
372	SSNAP-Sentinel Stroke	SSNAP – Sentinel Stroke Data Report	NCA	Kings College London	Thu 12/01/2023
378	GI-NOGCA – Gastro-Intestinal Cancer Audit Prog. – National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit Annual Report	NCA	Royal College of Surgeons	Thu 12/01/2023
379	GI-NBoCA – Gastro-Intestinal Cancer Audit Prog. – National Bowel Cancer Audit	National Bowel Cancer Audit Annual Report	NCA	Royal College of Surgeons	Thu 12/01/2023

246	NDA – National Diabetes Audit	National Diabetes Audit Core: Complications and Mortality Report	NCA	NHS Digital	Thu 12/01/2023
384	NDA – National Diabetes Audit	National Diabetes Audit (Data only)	NCA	NHS Digital	Thu 12/01/2023
392	NELA – National Emergency Laparotomy Audit	NELA Annual Report	NCA	Royal College of Anaesthetists	Thu 09/02/2023
246	NDA- National Diabetes Audit	National Diabetes Audit Core: Complications and Mortality Report	NCA	NHS Digital	Thu 09/02/2023
377	NLCA – National Lung Cancer Audit	National Lung Cancer Annual Report	NCA	Royal College of Surgeons	Thu 09/03/2023
353	FFFAP – Falls & Fragility Fracture Audit	Falls & Fragility Fracture Audit Annual Report (Wales only)	NCA	Royal College of Physicians	Thu 09/03/2023
371	PICANet – Paediatric Intensive Care Audit	Paediatric Intensive Care Audit Annual Report	NCA	University of Leeds	Thu 09/03/2023
376	CVD Prevent- Cardiovascular Disease Prevention Audit	Cardiovascular Disease Prevention Audit Annual Report	NCA	NHS Benchmarking Network	Thu 09/03/2023
395	NCISH – Mental Health CORP	Mental Health CORP Annual Report	CORP	University of Manchester	Thu 09/03/2023
397	NPDA – National Paediatric Diabetes Audit	National Paedatric Diabetes Audit Core Report	NCA	Royal College of Paediatrics and Child Health	Thu 09/03/2023
376	CVD PREVENT – Cardiovascular Disease Prevention Audit	Cardiovascular Disease Prevention Audit Annual Report	NCA	NHS Benchmarking Network	Thu 13/04/2023

387	NDA – National Diabetes Audit	National Diabetes Audit (Data only)	NCA	NHS Digital	Thu 13/04/2023
373	SSNAP – Sentinel Stroke	SSNAP – Sentinel Stroke(Data only)	NCA	Kings College London	Thu 13/04/2023
373	NDA – National Diabetes Audit	NDA Core Annual Report – Care Processes and Treatment Targets	NCA	NHS Digital	Thu 08/06/2023
386	NDA – National Diabetes Audit	NDA Diabetes Prevention Programme (DPP) Annual Report	NCA	NHS Digital	Thu 08/06/2023
262	NPDA – National Paediatric Diabetes Audit	National Paediatric Diabetes Audit Admissions report	NCA	Royal College of Paediatrics and Child Health	Thu 13/07/2023
380	NACEL – National Care at the End of Life Audit	National Care at the End of Life Audit Annual Report	NCA	Kings College London	Thu 13/07/2023
388	NDA – National Diabetes Audit	National Diabetes Audit Type 1 State of the Nation report (Y1) 2021-2022	NCA	NHS Digital	Thu 13/07/2023
389	NDA – National Diabetes Audit	National Diabetes Audit Young Type 2 State of the Nation report (Y1)	NCA	NHS Digital	Thu 13/07/2023

https://www.hqip.org.uk/ncapop-9-month-publication-schedule/

Aneurin Bevan University Health Board

Clinical Audit Policy

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

Status: Issue 1.1 (review date extended to April 2024) Issue date: 11 April 2019
Approved by: Clinical Standards & Policy Group Review by date: 11 April 2024
Owner: Assistant Director for Quality & Patient Safety

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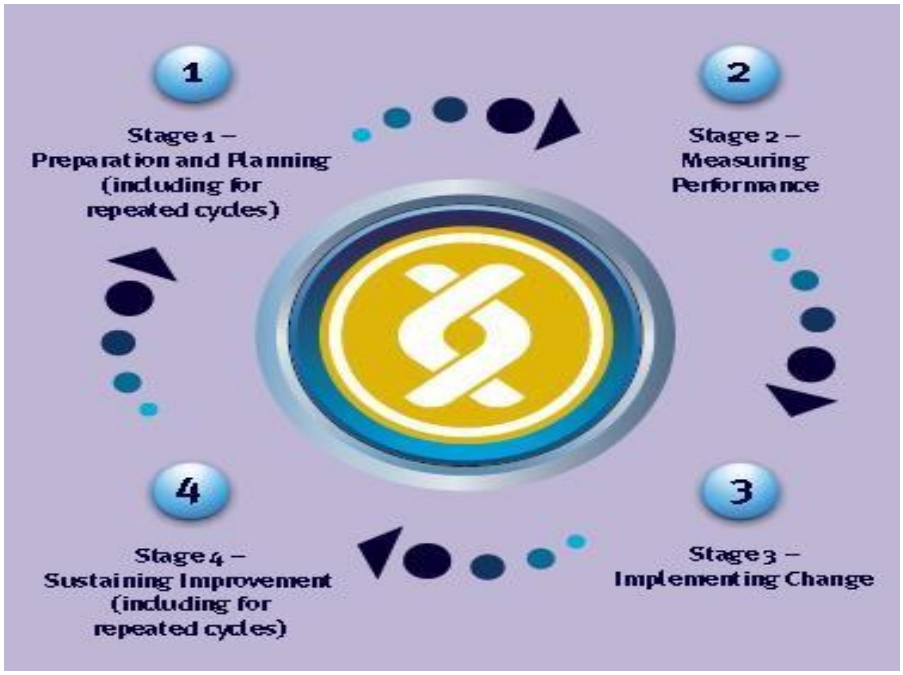
1. Introduction and Definitions

Clinical audit is at the forefront of Welsh Government's drive to improve patient care in Wales. The results of clinical audit provide an invaluable insight into the quality of care being provided by a service and over time can be used to monitor how well improvements are being taken forward. National Clinical Audit also benchmarks our clinical services against similar services in other Health Boards and Trusts in England and Wales.

NHS organisations in Wales are expected to participate in clinical audit as part of the requirements of Standard 3.3 of the *Health and Care Standards 2015*. The standard requires healthcare organisations to have a cycle of continuous quality improvement that includes clinical audit.

In this Policy and in the Clinical Audit Strategy, the definition of clinical audit adopted by ABUHB is that used by the Healthcare Quality Improvement Partnership (HQIP):

"Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."



There are four stages in the clinical audit cycle:

- **Stage 1 – Preparation and Planning:** to agree required standards and clinical audit methodology
- **Stage 2 – Measuring Performance:** data collection in order to evaluate performance against required standards
- **Stage 3 – Implementing Change:** using action planning where shortfalls are identified
- **Stage 4 – Sustaining Improvement:** through monitoring and service development, with repeated clinical audit cycles as required

2. Policy Statement

Aneurin Bevan University Health Board (the Health Board) is committed to using Clinical Audit, including National Clinical Audit, as a key quality improvement methodology, in conjunction with other quality improvement methodologies like 1000 Lives/IHI Model for Improvement. As part of this process, Clinical Audit provides assurance about compliance with accepted clinical standards within the services provided by the Health Board. It is expected that this Policy, working with the Clinical Audit Strategy, aligns with the Health Board's wider governance and assurance mechanisms, and its value and outcomes work, that will inform and enhance the process of improving clinical services.

3. Purpose

The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures. It also outlines the support available from the Medical Director's Support Team for National Clinical Audits on the National Clinical Audit and Outcome Review (NCAOR) Programme, for Health Board wide clinical audits and for the development and design of other clinical audit projects taking place within the Divisions and Directorates.

This policy aims to support a culture of best practice in the management and delivery of clinical audit, and to clarify the roles and responsibilities of all staff involved.

4. Scope

This Policy applies to anyone engaged in the clinical audit process within Aneurin Bevan University Health Board, in primary, community and

hospital care. This includes all staff, clinical or non-clinical, and students and trainees.

Within the Health Board, there are three broad areas of clinical audit:

- National Clinical Audits that are part of the Welsh National Clinical Audit and Outcome Review Programme, and it is mandatory for the Health Board to participate in these audits.
- A small programme of Health Board wide clinical audits, that are determined annually to review the standard of service in relation to issues highlighted through complaints and serious incidents, mortality reviews, external reports and patient experience surveys.
- Programmes of local audits within Directorates that are determined by clinical staff within the services or the Division, and often carried out by doctors in training as part of their training.

5. Roles and Responsibilities

The table below sets out the key leadership roles and responsibilities for clinical audit activity and the role of key committees and groups in relation to clinical audit:

Lead	Responsibilities
Chief Executive	The Chief Executive is the Accountable Officer of the Health Board and as such has overall accountability and responsibility for ensuring it meets its statutory and legal requirements in relation to clinical audit.
Medical Director	The Medical Director is the Executive Lead for clinical audit and is responsible for ensuring that the Health Board Clinical Audit Strategy and annual programme of clinical audit are aligned to the Board's strategic interests and concerns and support assurance to the Board on the clinical services.

Assistant Director of Quality & Patient Safety	The Assistant Director is responsible for leading the development of Health Board Policy and Strategy in relation to the practice of clinical audit. In addition, the Assistant Director is also responsible for the co-ordination and monitoring of participation in the NCAs on the NCAOR Programme and in ensuring a programme of clinical audits is agreed and carried out annually.
Divisional Directors	Divisional Directors are responsible for ensuring that the services within the Division are participating in and implementing changes based on the results of the NCAs on the NCAOR

Lead	Responsibilities
	programme. They are also responsible for maintaining the overview of local clinical audits within the Directorates, to ensure they comply with this Policy.
Clinical Directors	Clinical Directors are responsible for ensuring a programme of local clinical audits is planned and carried out. They are also responsible for having the structure and processes in place so that the audits are reported and presented locally, and that changes are made based on the results of the audits, and that the full audit cycle is completed to ensure that the changes have made an improvement to the services. This responsibility may be delegated to a Directorate Lead for Clinical Audit. Clinical Directors are responsible for appointing a clinical lead for the NCAs on the NCAOR Programme for services in their Directorate, and supporting them in participation in the full audit process.
Clinical Leads for National Clinical Audits	The NCA Clinical Leads are responsible for having systems and processes in place to facilitate full participation in their NCA, and for ensuring the results of the audit are considered locally and changes are made to improve the service against the standards within the NCA.

Quality & Patient Safety Lead for National Clinical Audit	The QPS Lead for NCA is responsible for day-today operational matters in relation to delivery of the National Clinical Audit and Outcome Review Programme and putting in place effective systems and processes with other members of the Medical Director's Support Team to support this, and the overall dissemination and reporting of the results of NCAs within the Health Board.
Medical Director's Support Team	The members of the Team support the Clinical Leads in respect of providing relevant reports and assurance documentation on their NCAs in a timely manner.
Quality and Patient Safety Operational Group	The QPS Operational Group is responsible for reviewing the results of all the NCAs on the NCAOR Programme and escalating any concerns to the QPSC. It also will review the
Lead	**Responsibilities**
	audit reports for all of the health board wide audits and agree the action plans.
Quality & Patient Safety Committee	To monitor that the outcomes in clinical audits for the services in the Health Board are improving.
Divisional Quality and Safety Groups	To review participation in and results from NCAs for services in the Division and support the Clinical Leads and Directorates in taking forward the agreed changes where they are outside the control of the Directorate.

6. Processes and Procedures

6.1. Process for National Clinical Audits: Participation, review of reports, dissemination of results, escalation and improvement actions

The Welsh Government National Clinical Audit and Outcome Review Committee publish the National Clinical Audit and Outcome Review Annual Plan (The Plan) which lists the NCAs that all Health Boards and Trusts are expected to participate in. The Plan also confirms that the the findings

from audits and reviews must be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.

In ABUHB a Clinical Lead for each NCA on the NCAOR Programme will be appointed by the Clinical Director for the service. All NCAs will be supported by one of the members of the Medical Director's Support Team.

The Plan requires 100% participation, in terms of case ascertainment and submission of complete data, where applicable, with audits listed as part of the Annual Programme, and completion of the full audit cycle, including the implementation of changes to improve the results.

The Clinical Lead for each NCA will ensure that there are systems and processes in place for participation in the audit, review of the results within the Directorate, identification of the priority areas for improvement and agreement of the changes that can be made to make improvements to the outcomes for the service.

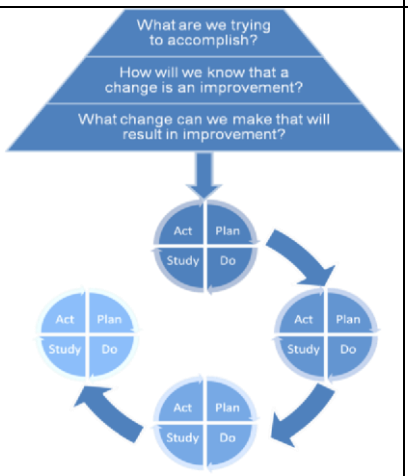
The Quality and Patient Safety Lead for NCA will maintain an overview of all the NCAs on the NCAOR Programme in an excel spread sheet, and work with all the members of the Medical Director's Support Team to ensure that the spread sheet is up dated. The MDST will work with the Clinical Leads to achieve the full audit process for each NCA. In particular, they will draft Headline Data slides that summarise the key results for each NCA. The slides will be used to disseminate the results of the NCA across the Health Board and at key Groups and Committees. This will mean there is an overview of the results of all the NCAs at all levels in the Health Board. The MDST will also co-ordinate the reporting to the WG of the 2 part Assurance Proforma: Part A (key findings) and Part B (action plan).

The Quality and Patient Safety Operational Group will receive a report at each meeting of all the Headline Data Slides for the NCAs published since the last meeting. Any concerns will be escalated to the QPSC. An NCA Annual Report will be published each year, showing the development of the overall processes for NCA and summarising for each NCA the key findings for ABUHB, improvements in outcomes as a result of the changes that have been made, the actions that are being implemented to address the key findings and the progress with those actions.

The steps in this process and the responsibilities for the main actions are summarised in the table below:

Step in NCA process	National Audit Clinical Lead Responsibilities	Medical Director's Support Team Responsibilities
Registration for NCA	Clinical Director appoints Clinical Lead, Clinical Lead registers to participate in National Clinical Audit on NCAORP, sign off by Caldicott Guardian where necessary	Allocate member of Team to liaise with and support Clinical Leads for each NCA
Identification of all cases that meet audit criteria		Support for identification of cases/access to records
Data entry	Identify who will complete data capture and data entry for 100% cases and 100% audit fields, with ability to track case ascertainment	Limited data entry as clinical knowledge often required

Step in NCA process	National Audit Clinical Lead Responsibilities	Medical Director's Support Team Responsibilities

Analyse results and disseminate	On publication of National Clinical Audit Report – analyse report and local results. Amend and agree Part A and Headline data slides.		Draft Headline Data Slides and draft part A Summary of key findings for ABUHB). Reporting of headline data slides to QPS Operational Group. Dissemination of Headline data slides. Submit Part A to WG
Agree priorities for improvement	Identification of local Priorities for Improvement from the report and agreement of changes to be made with Directorate. Complete Part B and return to MDST		Send Part B (summary of actions) to Clinical Lead. Submit completed Part B to WG.
Set up and monitor change programme	Initiation of Improvement Programme to put in place and monitor impact of changes (Directorate level/Divisional level/Board level)		Support for Improvement Process in Clinical Specialty/Directorate as required.
Step in NCA process	**National Audit Clinical Lead Responsibilities**		**Medical Director's Support Team Responsibilities**

	Reaudit	Annual Report on NCA

6.2. Process for agreeing and carrying out the annual Health Board wide clinical audit programme

Each year, the Health Board will agree and carry out a number of clinical audits on issues that have been highlighted through the Health Board's surveillance mechanisms. These include: complaints, serious incidents, claims, mortality reviews, external inspections.

The Medical Director's Support Team will collate the issues that have arisen, and suggest a programme of about 6 clinical audits to the Quality and Patient Safety Operational Group for discussion and agreement. The Group will discuss and amend the list, drawing on the knowledge of all the members of the Group across the Divisions and Corporate Departments. Some issues will have a one off audit, others may be a routine annual audit (record keeping).

Once agreed by the QPSOG, the MDST will develop a plan for each audit. This will be agreed with the relevant corporate lead for the issue. The MDST will co-ordinate the completion of the audit and a report on the results of the audit. An action plan will be developed with the Corporate Lead and the report and action plan will be taken to the QPSOG.

6.3. Divisional/Directorate Clinical Audit Programmes

The Clinical Director is responsible for ensuring that the directorate agrees an annual clinical audit plans, which address local clinical issues in the Directorate. The Directorates are also responsible for having the structure and processes in place so that the audits are reported and presented locally, and that changes are agreed and implemented, based on the results of the audits, and that the full audit cycle is completed to ensure that the changes have made an improvement to the services.

Clinical Audits undertaken by doctors in training will usually be part of the Directorate Audit programme and should be agreed with the doctor in Trainings Consultant and/or the Audit Lead for the Directorate. These audits do not need to be registered with the Medical Director's Support Tea. If the doctor in training requires a certificate to demonstrate that they have completed the audit satisfactorily, this should be provided by their consultant or the Audit Lead for the Directorate.

7. Conduct of Clinical Audit

7.1 Distinguishing Between Clinical Audit, Data Collection and Research

Clinical audit and research have complementary roles to play in ensuring clinical effectiveness. However, there is sometimes some confusion as to the distinction between the two activities.
Most commonly the difference is described in terms of research determining the right thing to do and that the role of audit is to determine whether the right thing is actually done *(Smith, R, 1992, Audit and research – BMJ 305: 905-906).* The purpose of research has also been described as 'to add to a general body of scientific knowledge which has universal application', and the purpose of clinical audit as 'to enable practitioners to monitor and improve practice in specific situations' *(Closs SJ, Cheater FM, 1996, Audit or research – what is the difference? Journal of Clinical Nursing 5: 249-256).*

If a project is deemed as research then it should be progressed in accordance with the Research and Development Policy.
Collection of baseline data will not normally be classified as 'clinical audit'. However, such exercises will be regarded as part of the clinical audit process if the aim is not just to define standards but to follow on with a full clinical audit cycle including re-audit.

7.2 Good Practice

The Health Board encourages all staff to develop and design clinical audits that are multidisciplinary and that are undertaken across the whole ABUHB service, rather in one site. Partnership working with other local and regional organisations is also encouraged where improvements to the patient journey may be identified through shared clinical audit activity.

Patients and carers view the quality of care differently to healthcare professionals and provide a unique perspective based on their personal experience. Involvement in the focus of clinical audits and in the development and design of clinical audits is therefore encouraged.

7.3 Use of standards (or criteria) in clinical audit

Audit standards are formal statements about how patients or service users should be managed or services delivered. They define the aspects of care to be measured in order to find out whether what is being carried out is correct. Standards may already exist locally or nationally in the form of guidelines or protocols. National standards are available for certain treatments and conditions in the form of NICE or Royal College /

professional body guidelines and are also incorporated into large-scale service delivery documents such as the National Service Frameworks.

If there are no recognised standards available from these sources, audit specific standards need to be developed working with the Clinical Audit Lead. The standards should relate to the audit objectives and should always be based on the best available, most up-to-date evidence of what constitutes best practice. A literature search will need to be undertaken to identify relevant evidence from which to develop the standards.

7.4 Reporting and Dissemination

Once an audit is completed an audit report must be written detailing what was done, the findings, any recommendations and action plans. A successful audit in one area may be transferable to other parts of the organisation, and so it is recommended that the Directorate should maintain a database of their audits so that they can be used by other areas as a basis for an audit there.

Once a round of data collection has been completed and the data has been analysed, the results should be presented at specialty governance/audit meetings where the findings should be discussed, action plans agreed and a commitment to re-audit made in a designated timeframe.

7.5 Action plans for improvement

One mechanism for the Health Board to improve its services and clinical care is by developing and implementing action plans in response to the clinical audit results. Action plans should be specific, measurable, achievable, realistic and timely (SMART). They must have clear implementation timescales with identified leads for each action. Action plans should also have been approved by the relevant head of service or lead manager.

Not all clinical audits will require an action plan e.g. where an audit shows that standards are being met or guidance followed. For such audits there should be an explicit statement saying 'no further action required' in the audit summary report and a reason given for no re-audit.

The relevant divisional governance/audit groups will monitor the implementation of actions, ensuring that any identified changes are incorporated into relevant business plans as appropriate.

7.6 Re-Audit

It is important to ensure that the audit cycle is completed. The Directorate should ensure that re-audits are planned as part of their audit plans, allowing enough time for changes to be implemented.

8. Information Governance

Collection, storage and retention of data and Confidentiality and Ethics

All clinical audits must adhere to NHS Information Governance policies and standards. Audits should pay special attention to the Data Protection Act (1998) and the Caldicott Principles (1997). This means that data should be:

- adequate, relevant and not excessive
- accurate
- processed for limited purposes
- held securely
- not kept for longer than is necessary.

9. Training

Clinical Professionals receive training on the audit methodology as part of their professional education. Where this is not the case, guidance on completing a clinical audit is available on the ABUHB intranet site. Support and advice for individuals undertaking an audit can be provided by the members of the MDST.

10. Health and Care Standards

This policy supports the implementation of standard 3.3. which requires healthcare organisations to have a cycle of continuous quality improvement that includes clinical audit.

11. Review

This policy will be reviewed in 3 years or earlier if there is a significant change in guidance or the Welsh Government approach to Clinical Audit.

Clinical audit: 10 simple rules for NHS boards

1. Use clinical audit as a tool in strategic management as part of the broader quality improvement programme; obtain assurance that the strategy for clinical audit is aligned to broader interests and targets that the board needs to address
2. Consider the full range of quality improvement tools and choose clinical audit if its methodology is best suited to assess the issue at hand and develop an improvement plan
3. A clinical audit strategy must include a combination of national and local priorities with sufficient resources to complete the cycle for each element of the programme
4. Agree on the timescale and resources required for each clinical audit activity upfront but have a process in place to deal with variations and additional requirements
5. Operate a rolling clinical audit programme that covers the different stages of individual projects on a continuous basis focused on outcome improvements for each area
6. Ensure the professionalism of clinical audit by agreeing what constitutes unacceptable variation in clinical audit results compared to evidence based standards, outcomes at similar organisations, or with standards developed within the organisation where national guidelines are not available
7. Ensure with others that clinical audit crosses care boundaries and encompasses the whole patient pathway
8. Develop a clear strategy to ensure patient and stakeholder engagement at the different stages of the clinical audit cycle, make clinical audit reports patient-friendly and publicly available, and disseminate summaries of results to stakeholders and patients in a variety of ways
9. Share clinical audit results with other providers, commissioners, regional clinical networks and local patient networks. Publish outcome statistics and evaluations
10. Provide sufficient education and training in clinical audit beyond the clinical audit team, and use junior doctor clinical audit and quality improvement projects as a valuable resource

Appendices:

1. national-clinical-audit-and-outcome-review-plan-2018-19 2. www.hqip.org.uk

Aneurin Bevan University Health Board

Clinical Audit Strategy 2022-2025

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

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1. Introduction/Overview

Looking forward to our future - Our Strategic Direction: 2022-25 sets out the vision for clinical audit for the Health Board. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve and to abide by our Health Board values.

The values we aim to show are:

Clinical audit is one tool in the wider quality improvement strategy aimed at providing assurance of delivery best practice. This strategy sets out the principles of when clinical audit should be used and will clarify how the development of the clinical audit plan can be achieved, placing patients first. The application of the strategic direction to clinical audit is described in this strategy, contributing to the range of quality improvement activities and governance arrangements of the Health Board.

What is Clinical Audit?
The National Institute for Health and Clinical Excellence (NICE) describe clinical audit as:

> "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery" (NICE 2002)

2. Statement

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

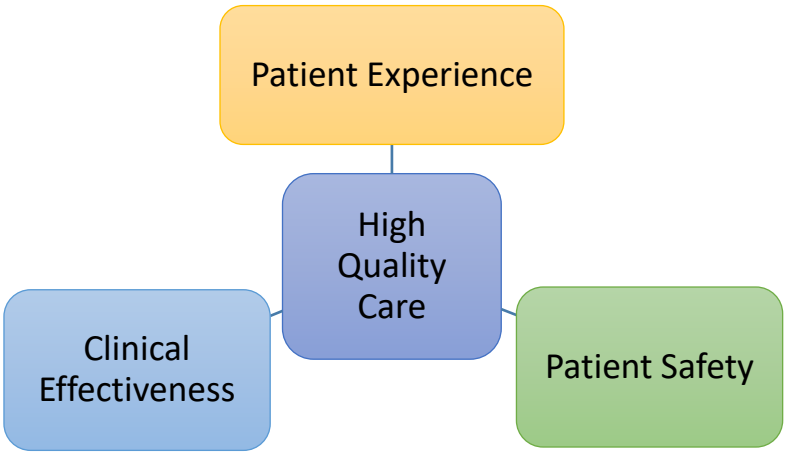
When conducted in accordance with best practice standards, clinical audit:

- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste, and variation
- Improves the quality of care and patient outcomes

ABUHB has adopted a policy on the governance and practice of clinical audit which applies to all staff

3. Aims/Purpose

- This strategy sets out the Health Boards commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness.



- Cost-effective clinical services to ensure that care is both sustainable and effective
- National Audit engagement at a local level.
- The Trust Quality Account as part of the Trust Annual Report.
- Compliance to regulatory requirements from NHS Improvement and the Care Quality Commission.
- Reports on the compliance with clinical standards that can be used for assurance.

- Quality improvement as part of the national and local Commissioning for Quality and Innovation (CQUIN) targets and local Clinical Commissioning Group initiatives.
- Quality improvement projects and local audits that are aligned to the Trusts priorities for improving care.
- Demonstrable NICE compliance and best practice evidence implementation.

4. Objectives

Achieving the objectives set out in this strategy will ensure that the Health Board Clinical Audit Policy is implemented and effective, resulting in sustained improvements and the delivery of safe care.

The Health Board has Four Priorities:

- There is scrutiny of national clinical audit performance with robust development, monitoring, and progression of Improvement plans
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- Trainees are supported to participate in meaningful clinical audits that support clinical governance
- Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

5. Scope

Our strategy is relevant to:

- The Board
- Divisional Management Teams
- Clinical Directors
- Chairs of Health Board groups and committees
- Clinical Audit Leads
- Education Leads

6. Roles and Responsibilities

Responsibility for the implementation of this strategy is with the Divisional Triumvirate, Clinical Leads and Clinical Directors and presented to the Clinical Standards Effectives Group.

7. Main Body

Priority 1
There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

The National Clinical Audit and Outcome Review Plan is a comprehensive programme of clinical audit that allows the Health Board to bench mark their delivery of care associated with a broad range of evidence-based guidance against health organisations across the UK. The National Audit plan can be accessed here .

To ensure an effective and robust approach to considering national audit outcomes and implementing the requisite improvements a systematic approach to the governance of these audits is required.

- On Publication of each national audit the national report and local results will be uploaded to AMaT, and the Divisional Triumvirate and the Clinical Lead will be notified of the publication.
- On Publication, all national clinical audits will be reviewed by the Division in partnership with the Clinical Director and Clinical Audit Lead
- An action plan will be developed by the Divisional Triumvirate in partnership with the Clinical Director to support the requisite improvements and uploaded onto AMaT.
- The national audit results and Improvement will be presented to the Clinical Standards and Effectiveness Group within two months of publication by an individual agreed between the Divisional triumvirate and the Clinical Director
- The Divisions will ensure the necessary scrutiny and monitoring of National Audit improvement plans in a Quality and Patient Safety Forum
- All associated risk will be reviewed and where appropriate recorded on the Divisional risk register

Priority 2
Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

Quality is the endeavour of continuously, reliably, and sustainably meeting customer, patient, or service user needs. This definition places quality at the centre of the health service and as the organisational strategy, not merely a component of the strategy. The Duty of Quality

applies to all health service functions in Wales and applies to both clinical and non-clinical functions and the people that deliver those functions.

NHS organisations will be required to ensure that they are routinely using data and information about quality at every layer of the organisation as part of their Quality Management Systems and clinical audit will be a valuable tool in supporting this function.

Divisional Triumvirates will be required to develop a programme of Clinical Audit that support governance and assurance aligned to the quality and safety priorities of the Division. The quality and safety priorities will include:

- Nationally reportable Incidents
- Patient safety incident themes
- Clinical outcomes
- New Evidence Based Guidance including NICE
- Themes from mortality reviews and M&M

Each Division will be required to present an overview and update of their clinical audit plans at each Clinical Standards and Effectiveness Groups meeting.

- All clinical audits will be registered on AMaT and will have an identified lead.
- All Clinical audits will be monitored at an appropriate and pre-defined quality and safety forum.
- All results will be reported on AMaT
- Where required all actions plans will be recorded on AMaT
- The Divisional Triumvirate will have oversight of all clinical audits and their results and will ensure that the required actions plans are progressed and monitored.
- Clinical Audit will be a standing agenda item on Divisional Quality and Patient Safety Group agendas
- Divisions will be asked to produce a report on a bi-annual basis detailing clinical audit activity, results and improvements and present this at the Clinical Standards and Effectiveness Group.

Priority 3
Trainees are supported to participate in meaningful clinical audits that support clinical governance

Where trainees are required to undertake clinical audit as part of their ongoing development, the Directorate and Division have a responsibility to ensure that the necessary arrangements are in place to ensure that they have oversight of these projects, that the results are considered and

that were necessary action plans are developed to support the requisite improvements.

Trainees should be supported to undertake meaningful clinical audits that support quality and safety priorities and participate in the resulting quality improvement.

- All clinical audits undertaken by trainees should be agreed by a clinical supervisor and should contribute to the Divisional Quality and safety priorities
- All clinical audits must be registered on AMaT with the audit supervisor specified.
- All audit results must be uploaded to AMaT if the data is not collected directly onto the AMaT system
- The clinical supervisor will review all results
- Where required an action plan will be developed with the support of the Clinical Director with oversight from the Divisional Triumvirate and uploaded to AMaT
- All clinical audits and action plans will be monitored at an appropriate and pre-defined quality and safety forum.
- All trainees must receive the appropriate acknowledgement of their participation in clinical audit and will be provided with a certificate of participation generated through AMaT.

Priority 4
Groups and Committees across the Health Board will commission clinical audit to support effective assurance as required.

Clinical governance is the systems, processes, and behaviours by which organisations lead, direct, and control their functions to achieve organisational objectives, safety, and quality of service, and in which they relate to patients and carers, the wider community, and partner organisations

The Health Board Quality Assurance Framework Structure comprises a range of groups, each of which forms an essential element of the overall system and controls that are in place within the Health Board; their purpose is to mitigate and manage risk which may occur regarding the achievement of ABUHB strategic objectives and priorities as set out in the Health Board's Integrated Medium-Term Plan.

The groups ultimately report to the Patient Quality Safety and Outcomes Committee, a sub-committee of the Board.

- The Quality Assurance Framework support the delivery of a quality management system including
- Quality Planning – the Health Board priorities and plans for the delivery of high quality and safe services

- Quality Improvement – The systematic process to implement the improvements required within our services
- Quality Control – The processes in place to ensure that the care being delivered
    - Every group that forms part of the quality assurance framework will review the evidence available to support its function in overseeing the quality-of-care provision
    - Consideration will be given to implementing clinical audit where no existing evidence is available
    - Clinical audit should be considered to provide evidence of improvements here required.
    - Clinical audit will be implemented to meet mandated national requirements e.g., DNACPR audits

8. Resources

Welsh Health Boards and Trusts are required to ensure sufficient resources are available to undertake participation in all audits, reviews, and national registries. Undertaking Clinical audit is mandatory and should be incorporated into existing job plans.

9. Training

Training on how to use AMaT will be conducted by the Corporate QPS team. This will involve training sessions that will be delivered virtually by AMaT and organised by the QPS team. The following training plan will be implemented throughout ABUHB.

Recommendation	Action	Responsible group / Individual	Completion Date
Priority 1	All Clinical Directors, Directorate and Divisional Management Teams, Senior Nurses, Clinical Governance and Quality and Safety Leads will register with AMaT	Divisional Triumvirates	July 2022
	All national audit reports and local data will be disseminated to the Divisions using AMaT	Quality and Patient Safety Team	July 2022
	National audit action plans developed to address requisite improvements will be saved, monitored on AMaT	Divisional Triumvirates	August 2022
	All audits and Improvement plans will be presented at the Clinical Standards and Effectiveness Group	Divisional Triumvirate and Clinical audit lead	September 2022
Priority 2	Divisions will register two local clinical audits on AMaT that address a current Divisional quality and safety priority	Divisional Triumvirates	July 2022
	Implement the two registered audits and record the results on AMaT and present the outcomes of these	Divisional Triumvirates	August 2022

	audits at a Divisional Quality and Patient Safety meeting		
	Present overview of local audit activity in Clinical Standards and Effectiveness Groups	Divisional Triumvirates	September 2022
Priority 3	Provide each cohort of Medical Trainees with registration and training information for AMaT	Medical Education	August 2022
	All clinical supervisors to register with AMaT	Divisional Triumvirates	July 2022
	All clinical audits undertaken by medical trainees to be registered on AMaT and results to be uploaded to AMaT	Directorate Management Teams	From August 2022
	All clinical audits completed by medical trainees to be presented at a clinical audit meeting or quality and patient safety meetings	Directorate Management teams	From August 2022
	All medical Trainees to be issued with a certificate to evidence their involvement in the clinical audit	Directorate Management teams	August 2022
Priority 4	All groups and committees that form part of the ABUHB Quality Assurance Framework should review the evidence available to them to identify gaps in assurance and consider commissioning clinical audits to address these gaps.	Chairs of ABUHB groups and Committees	October 2022

10. Implementation

Clinical Directorates should ensure that all relevant staff are aware of the Policy, especially those who are involved with Clinical Audit.

There will be standardised approach to reporting audit findings. These will be reported under the headings

- Areas where good practice has been identified
- Areas of where practice requires improvement

- Actions to be taken - using SMART objectives

11. Equality

The policy does not require an Equality Assessment Impact Assessment (EqIA).

Adherence to this policy will identify opportunities to replicate or improve equitable health-care delivery across Aneurin Bevan University Health Board.

12. Audit

This policy will be subject to the formal auditing process to ensure it is fit for purpose, has been implemented effectively and to assess compliance.

13. Review

This policy will be reviewed every three years, or sooner should the author or legal requirements deem it to be relevant or required.

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

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 April 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Activity Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Joanne Stimpson – Clinical Audit Lead

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

National Clinical Audit Reports are presented to the Clinical Standards 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 local data against the report recommendations, ensuring alignment to services, detailing Health Board results using SMART goals.

Cefndir / Background

Clinical Standards Effectiveness Group (CSEG) is held bi-monthly, the meeting held in November 2022 included the following reports:

- National Audit for Percutaneous Coronary Intervention (NAPCI) 2022 Summary Report
- National Maternity & Perinatal Audit – Clinical report 2022
- National Clinical Audit of Psychosis - National report for Wales - Early Intervention in Psychosis Audit
- Myocardial Infarction National Audit Project (MINAP) 2020-2021

The January 2023 CSEG meeting included presentations from:

- National Hip Fracture Database (NHFD) annual report
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Vascular Audit (NVA)
- National Diabetes Audit (Care Processes and Treatment Targets)
- New Procedure Policy request: Orbital atherectomy
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews, encompassing: testicular torsion study, transition from child to adult health services, Crohn's disease, epilepsy hospital attendance, community acquired pneumonia hospital attendance.

For future meetings, Clinical Leads have been asked to ensure that Audit reports include a summary of areas of practice that already meet guideline/audit standards and an action plan for areas requiring improvement that are specific, measurable, achievable, realistic and time bound so that their implementation can be tracked. Divisional governance teams are required to oversee the production of audit action plans by directorates for approval at CSEG.

Asesiad / Assessment

Additional information can be found in the attached CSEG meeting notes

National Audit for Percutaneous Coronary Intervention (NAPCI) 2022 Summary Report

Report Recommendations
During COVID-19 there was a 70% fall in elective PCI activity during the first wave, with less of a fall for patients being treated for NSTEMI (35%). The smallest reduction in activity was for primary PCI to treat STEMI (14%). Day case PCI for elective procedures: we continue to identify wide variation in practice determined by local logistic issues and not patient characteristics. Use of drug eluting stents instead of bare metal stents: almost all Hospitals perform well, with a high proportion of drug eluting stent use across all clinical syndromes.

Key points:
PCI activity has increased in Aneurin Bevan University Health Board after Cardiology Services were centralised at GUH. Elective PCI cases are gradually increasing in Aneurin Bevan University Health Board following the peaks of the Covid pandemic. Left main PCI cases have good outcomes when compared with national and worldwide benchmarks. The proportion of Intravascular Ultrasound (IVUS) use in left main PCI cases is at 89% which follows the British Cardiovascular Intervention Society (BCIS) Guidelines.

The majority of day case PCI patients are discharged the same day. Drug eluting stents are universally used in all stenting cases. Data capture remains incomplete leading to inaccurate representation of Aneurin Bevan University Health Board PCI practice. Compliance has improved with the appointment of Cardiology PACS Manager and regular submission of data to NICOR. Aneurin Bevan University Health Board PCI services comply with national guidelines in delivering a safe and effective

PCI service. Data report is 2020/2021 and Aneurin Bevan University Health Board outcomes have improved since this data capture.

Actions:

- Internal audits required to review operator compliance.
- Work in progress to have Primary PCI delivered to Aneurin Bevan University Health Board patients in GUH.
- In the process of recruiting scrub nurses' staff, radiographers, Cardiac Physiologists and ANP's.
- Plan to appoint consultant.

National Maternity & Perinatal Audit – Clinical report 2022 based on data from 2018/2019

Report Recommendations:
There was improved availability & quality of information regarding interventions. There is a need to offer episiotomy following instrumental birth. Reviewing cases for post-natal admissions. Epidural/spinal GA / analgesia should be separated for data collection. A request to review meaningful data such as skin to skin.

Key points:
Using Apgar <7/ Post-Partum Haemorrhage rates and readmission rates comparable with other Health Board's. There is a higher rate of spontaneous vaginal births and lower rate of caesarean and instrumental birth. Obstetric anal sphincter injury rates compare favourably (use of OASI trial) now on Part 2 of the trial. There is a lack of data for birth without intervention and higher rates of birth weight <10th centile.

Actions:

- BRAN - Benefits, Risks, Alternatives, do Nothing used in Aneurin Bevan University Health Board and expanding antenatal education working with early years framework to put in place.
- Moving to digitalised of maternity health records to improve data capture (delayed) to 2023.

Outcomes:

- Maternity services using the acronym in antenatal care and for communication, working to embed this work in the early year's framework for antenatal education.
- Go live date is aimed for 2nd May 2023.

National Clinical Audit of Psychosis - National report for Wales - Early Intervention in Psychosis Audit

Report Recommendations:

- Screen and intervene – better access.
- Think family – better links with families.

- Equitable access – reaching out to communities possibly experiencing FEP.
- Outcome focused – ARMS – At Risk Mental State, working to prevent people slipping into psychosis, Aneurin Bevan University Health Board does not have the capacity currently to work with people with ARMS.

Key Points:

- Aneurin Bevan University Health Board had higher compliance in 6 out of 8 Total National Standards (TNS) than comparators.
- For 3 standards Aneurin Bevan University Health Board was the highest in Wales
- Aneurin Bevan University Health Board services were higher than comparable English standards in 5 out of the 8 standards despite England having had established EIP longer than Wales.
- In Aneurin Bevan University Health Board every patient is seen within 2 weeks.
- Training Cognitive Behavioural Therapy for Psychosis (CBTp) therpists is quite specialised and currently only one clinician in Wales meets the criteria, however Aneurin Bevan University Health Board is training ALL EIP staff to deliver CBTp.
- The pandemic accounted for a lower than desired Family Intervention outcome at 57% as these are preferred face to face.
- Prescribing of Clozapine – for people who have tried 2 other anti-psychotic drugs with limited success, approx. 20% not offered in Aneurin Bevan University Health Board.
- Employment and education programmes were affected by the pandemic, Aneurin Bevan University Health Board has a full time Occupational Therapist (OT) developing vocational opportunities.
- Physical health screening – previously scored poorly but have hugely improved at 85%, physical health interventions is reactive to the screening at 48%.

Actions/Outcomes:

There is a national steering group which monitors activity and service development of FEP teams across Wales. Aneurin Bevan University Health Board is a part of this group and standards continue to be monitored via this group.

Myocardial Infarction National Audit Project (MINAP) 2020-2021

This reports data period was during the pandemic and the Health Board was without a MINAP Coordinator for some time. Appointment of a new Coordinator has seen an increase in case ascertainment (CA). Previous CA has been 85-100% however due to the issues above, for this period, only 46-58% was achieved. NICOR also had issues with Aneurin Bevan University Health Board data and this should be re-aligned in the next report. This report covers the period of transition from RGH to GUH.

- RGH has 100% compliance for patients seen by a Cardiologist, and patients admitted to a Cardiac Unit/Ward, RGH is the best performing Site across Wales at 92.11%.
- RGH % of NSTEMI patients undergoing angiogram during admission is 89.19% which is below the average for Wales and patient receiving the angiogram with 72 hrs of admission rate for RGH is 57.58%, most hospitals in Wales are not recording enough cases.
- Almost 100% of Aneurin Bevan University Health Board patients are discharged on all secondary prevention medication. Post cardiac event referred to Cardiac Rehab, the pandemic has given an opportunity to reflect on how the service is delivered. There are offers of virtual or F2F service, which has improved the compliance which is 92% take up from 76%.

Key Points:

There was a significant fall in activity reflected in the data as a result of:

- Significant disruption due to COVID-19 in 2020/21 and staff absence.
- Possible confusion NICOR as mid-year switch in hospitals – under ix (J Kerr, NICOR).
- What limited data there is for RGH prior to centralisation on GUH site is reassuring.
- New appointment – of Registered Nurse.
- Directorate planning strategies to improve performance for NST-ACS and BC for repatriation of PPCI (element of) to address delays in transfer patients who present to GUH.

Argymhelliad / Recommendation

The Audit, Risk, and Assurance Committee is asked to note the contents of the report, as well as the assurance provided by all Clinical Leads presenting specialty data that Quality Improvement work is always at the forefront, and to improve the quality of care for patients across the localities.

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):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Clinical Audit is integral to achieving IMTP Objectives.

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 Choose an item. Choose an item. Choose an item.

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

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

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:**	18 April 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Counter Fraud Bribery & Corruption Report 2022/23.
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Morris – Head of Counter Fraud

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 This document has been prepared by the Health Board Counter Fraud Team in order to comply with legal directions and the requirements/components of Government Functional Standard 013: Counter Fraud.
Cefndir / Background To comply with the above standards, the LCFS is required to provide a written report to the LHB (at least annually) on Counter Fraud work to illustrate compliance, outcomes and learning.
Asesiad / Assessment There are no inherent risks associated with this report, however; the report will form the basis of the annual Quality Assurance Self-Review, as evidence that ABUHB has complied with the aforementioned Government Functional Standards.
Argymhelliad / Recommendation

It is recommended that the Audit & Risk Assurance Committee NOTE the contents of the Annual Counter Fraud Bribery & Corruption Report 2022/23 report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The monitoring and reporting of Counter Fraud activity is a key element of the Health Boards assurance framework.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Counter Fraud is integral to delivery of IMTP objectives.
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:	Not applicable
Rhestr Termau: Glossary of Terms:	Not applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

On behalf of

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD BRIBERY & CORRUPTION REPORT

1st April 2022 to 31st March 2023

Martyn Edwards
Head of Counter Fraud
Aneurin Bevan University Health Board

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1. Management Summary

1.1. The annual report for the period 1st April 2022 to 31st of March 2023 has been written in accordance with the provisions of the WG Directions on Counter Fraud Measures (WHC 095 of 2005) which require Local Counter Fraud Specialists (LCFS) to provide a written report, at least annually, to the LHB on Counter Fraud work. The report content and style used complies with the model prescribed by the NHS Counter Fraud Authority (NHSCFA).

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

1.3. In relation to the current support LCFS, Louisa STEELE was appointed in August 2022 and Sara MORRIS was appointed in October 2022.

1.4. Martyn Edwards completed his Counter Fraud training in February 2009 and was accredited in March 2009. Louisa STEELE completed her Counter Fraud training in 2020 and became accredited the following year. As a replacement team member, Sara MORRIS was appointed on the above stated date and is scheduled to undertake National Counter Fraud Foundation Training in May 2023. The successor Head of Counter Fraud, Michelle MORRIS, was appointed on 1st March 2023, and has held Counter Fraud Specialist accreditation since October 2017. These accreditations gain University recognition, as a Counter Fraud Specialist, with the Professional Accreditation Board. Subsequent to this, nomination was gained as a Counter Fraud Specialist with the NHSCFA. These credentials are mandatory requirements for the professional role.

1.5. In total, 480 Counter Fraud days were provided for Aneurin Bevan University Health Board during 2022/23. This breaks down across the standards key framework as follows: strategic = 174 days, proactive counter fraud engagement = 150 days, reactive counter fraud engagement = 156 days.

1.6. The aforementioned provision of counter fraud days was devoted to a workplan which contained 535 days spread across the key framework, which was provided by 2.8 WTE LCFS's, as defined in the corporate structure outline. Therefore the actual number of days provided by the LCFS for 2022/23 underachieved the expectation of the workplan by 55-days. The reason for this deficit was due to the unexpected departure of 2 x LCFS's for reasons of promotion/retirement. Consequently, the Fraud Team was reduced to one-third capacity for half of the financial year. The workplan itself was approved by the DoF in accordance with the legal directions and the NHS counter fraud manual and the workplan was ratified by Audit Committee.

1.7. During the period 1st April 2022 to 31st March 2023, Aneurin Bevan University Health Board Counter Fraud team handled **thirty-five (35)** investigations into potential fraudulent or corrupt activity, which included cases brought forward from 2021/22. These cases are listed at **Appendix 2** (index of investigations).

1.8. **Thirty-one (31)** of those cases involved instances of staff related issues, which for the most part, the main categories were working whilst on sick leave, falsification of timesheets/expenses and dishonest retention of erroneous salary overpayments. The remainder of the cases involved alleged fraud on the part NHS primary care contractors and members of the public.

1.9. The aforementioned investigation's have resulted in **four (4)** files of evidence being forwarded to the Crown Prosecution Service for charging decisions. The LCFS investigations have also resulted in **six (6)** disciplinary sanctions during

2022/23, predominately resulting in employer derived sanctions by ABUHB and/or sanctions by a professional body.

1.10. Furthermore, investigation number **(10)** is an impending criminal prosecution, whereas investigation's number **(4)** & **(21)** resulted in a non-court based criminal sanction.

1.11. Financial recoveries stemming from LCFS investigations during 2022/23 stand at **£121,728.21,** plus a potential fraud prevention saving amounting to £9.8 million from a spurious supplier invoice, which is dealt with in greater detail, later in this report.

1.12. Appendix 2 (schedule of investigations) depicts that, similar to previous years, overpayment of salaries for personnel who have terminated employment with the organisation (which have potential implications for criminal proceedings) remains at a low level. This report incorporates a total of six such investigations of that nature. It was deemed that audio recorded interviews under caution were necessary on two of those six instances, one of which, investigation number **(6)** resulted in a criminal conviction. This may possibly be viewed as assurance, insomuch as despite overpayments occurring in high volume for existing staff, long term salary overpayments for terminated staff remain low. As in previous years, the LCFS has continued to work in close liaison with NWSSP Payroll Services, NWSSP Accounts Payable staff and ABUHB Accounts Receivable Staff from Corporate Finance. Guidance is repeatedly reiterated to managers to remedy this, emphasising the crucial requirement for timely and accurate staff termination forms and staff changes forms to be disseminated to Payroll Services for actioning. One such example of a reminder to this effect was to all staff members on payslip messages via ESR, in November 2022 & March 2023. These messages highlighted the requirement on staff to immediately report any overpayment of salary. The implementation of the ABUHB Recovery of Overpayments Policy is promoted by Corporate Finance and the LCFS alike and is rigidly adhered to. All high value overpayments, regardless of origin, are notified to the LCFS by Corporate Finance/Payroll Services/Accounts Receivable staff. The ABUHB Recovery of Overpayments Policy is up-to-date and fit for purpose. This Policy, in conjunction with the Counter Fraud, Bribery & Corruption Policy, acts as a sanction and redress policy on behalf of the organisation. Counter Fraud guidance features throughout the Recovery of Overpayments Policy and in the action flowchart which is incorporated within the policy.

1.13. the LCFS has considered the implementation of a speculative alert on ESR to electronically highlight staff payslips which go unopened on the system for a prolonged period of time. The purpose of such an alert is it could be an indicator that the staff member no longer works for the organisation yet is still being paid due to a failure in submission of a termination form to Payroll Services. ESR Support advise that this may not be an accurate outlier due to the sheer volume of staff who customarily, do not review their payslips on ESR. This option will be subject of periodical review and consideration.

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

1.15. During year 2022/23, the ABUHB LCFS conducted **two (2)** tape recorded interviews under caution with **two (2)** alleged offenders. This number of interviews is reduced from previous years as a by-product of Covid and the effect the pandemic had on the number of fraud referrals.

2. Strategic Governance

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

As of April 2021, the Government Functional Standard for Counter Fraud (GovS 013) replaced the previous NHS specific Standards for Fraud, Bribery and Corruption. Together with stakeholders the NHSCFA have developed new NHS Requirements to meet the Government Functional Standards. These changes are reflected in the ABUHB Counter Fraud Bribery & Corruption Workplan for 2023/24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The NHSCFA initiated the replacement of the investigation management system formerly utilised by the LCFS changes to a system titled *'Clue-3'.* This is a restricted and confidential which has the capacity for integration with the Police and other domains of law enforcement. The ABUHB LCFS's have undergone training on the replacement system which was rolled out on 1st April 2021. Due to technical complications, existing active investigations on *'First'* have not been migrated over to *'Clue-3'* but both systems are being used in tandem until the cases on *'First'* reach their conclusion and are closed on that system. Legacy cases on *'First'* have been effectively managed and there are only 3 such cases

remaining on the system which are awaiting the outcome of sanctions from the regulatory bodies for the professions in question.

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

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

2.3 The Counter Fraud Bribery & Corruption Policy was extensively re-written in November 2022, in order to align to the Government Functional Standards for Counter Fraud. The policy was approved by the Executive Team on 5th November 2022 and ratified by Audit Committee on 2nd February 2023.

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

2.5 Since April 2011, the LCFS has acted in a consultation role to the Workforce and OD Policy Group and has received notification of all policies, terms of reference guidance notes that are subject of review by the group. This ensures that the policies are robust and 'Fraud Proofed' at concept or review stage. Further information is provided on this topic at paragraph 4.23 regarding the **twelve (12)** policies reviewed by the LCFS during 2022/23.

2.6 With reference to the aforementioned policy entitled 'Appearing in Court', although this policy is not owner by Counter Fraud, the ABUHB LCFS has maintained a rolling review of this document, due to the fact it is inextricably linked to the Counter Fraud provision. Tri-fold leaflets have been developed, based on the spirit of the policy, which can be provided to members of ABUHB staff should the event arise whereby they become a Crown witness in a prosecution case.

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

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

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

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

bribery and corruption. The Counter Fraud staffing level has been increased from 2.8 WTE on the Corporate Structure to 3.0 WTE, which will have a marked impact on the Counter Fraud provision for 2023/24.

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

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

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

2.11 This also demonstrates that the Board has a clear remit to reducing losses to fraud and corruption to an absolute minimum by the appropriate application of counter fraud resources. The new Counter Fraud staffing level of 3.0 WTE LCFS' is ingrained in the LHB formal organisational structure.

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

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

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

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

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

2.13 On a reporting perspective, the LCFS has unrestricted access to the DoF and customarily has quarterly meetings scheduled to appraise and update on Counter Fraud work and identify and manage risk. The LCFS met with the DoF in this capacity on the following dates: 04/05/22, 20/07/22, 13/10/22, 17/01/23 & 08/03/23. These meetings were supplemented by telephone and

email contact maintained with the DoF, together with MS Teams collaboration on 15/12/22 & 24/01/23.

2.14 Furthermore, to consolidate the reporting process, the LCFS met with the Medical Director & the Director of W&OD on 15/12/22 & 24/01/23.

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

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

2.17 Additionally, Counter Fraud reporting is a standing agenda item for the Audit Committee meetings. In compliance with legal requirements, the LCFS attended and delivered reports to 4 Audit Committees on 7th April 2022, 2nd August 2022, 1st December 2022 & 2nd February 2023.

2.18 All aspects of Counter Fraud strategic governance is incorporated in the Audit Committee Self-Assessment Checklist. There is a requirement that as part of compliance and professional probity, the LCFS has a right of direct access to the Audit Committee Chair and its Independent Members. This entails private, pre-Audit Committee meetings with said members. The LCFS held such meetings with IM's on 7th April 2022 & 1st December 2022, plus one-to-one meetings with the Audit Chair on 12th May 2022 & 6th March 2023 respectively.

2.19 With reference to further reporting, as part of quality assurance requirements, the LCFS submitted the self-review report based on the Government Functional Standard for Counter Fraud (GovS 013) to the NHSCFA by the deadline date of 31st May 2022. The submission was authorised by the DoF and ACC and a rating of green was recorded against all components/requirements.

2.20 In order to retain core skills and maintain best practice, the LCFS's have kept up to date on legislation and working practices through attendance at various training sessions. As part of continuing professional development, these inputs included training sessions from the NHSCFA. These sessions are more fully outlined in para 6.3, 6.5 & 6.6 of this report.

Additionally, on 13th February 2023, both ABUHB LCFS investigators were attendees of the Band 3-6 Development Programme Module 4 Presenting and Influencing.

Furthermore, the LCFS attended the All-Wales LCFS Forum on 22/11/2022, which was also attended by NHSCFA Senior Development and Quality & Compliance Managers, who incorporated training inputs.

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

3.1 The Health Board has worked with the LCFS and NHSCFA to promote an anti-fraud culture within the NHS. The LCFS's and Director of Finance (DoF), identified target audiences for fraud awareness activities, with the following objectives:

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

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

In ABUHB, for PADR purposes, Counter Fraud awareness input at Corporate Induction remains a mandatory requirement.

Quarter 3 Counter Fraud Service performance report statistics for 2022/23, indicate that ABUHB continues to have a high staff uptake figure for Counter Fraud e-Learning with a culminative figure of 3,098 staff having completed the e-learning programme.

The year-end Counter Fraud Service performance report further illustrates that ABUHB is the national leader and has the highest number of fraud awareness presentation uptake figures to the Corporate Induction programme of all the Health Bodies in Wales with 1,669 members of staff completing the programme during 2022/23.

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

On the aspect of staff fraud awareness training, such training is a standing agenda item on every staff Corporate Induction in ABUHB. Whereas this training was normally delivered in person, to adapt during Covid restrictions, Counter Fraud have made a 20-minute video film of the training to provide virtual staff training until it is safe to resume conventional classroom training.

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

To comply with legal requirements, the video film is equipped with Welsh language sub-titles for viewers who wish to avail themselves of that facility. This fraud awareness video film went 'live' as part of the virtual Corporate Induction programme at the beginning of November 2020 and is still in place to-date. The staff uptake figures only identify staff numbers who complete the full Corporate Induction programme, not staff numbers who go through the programme, over a period of time, in a piecemeal fashion, making multiple logon sessions. During the 2022/23 timeframe, the LCFS received 24-fraud

referrals which is a further indication that the raising fraud awareness strand of LCFS work is reaching its target audience.

Furthermore, the LCFS has made a video film to Career Wales which is being used as a public awareness information film. This video film is unrelated and distinct from the aforementioned fraud awareness video film currently utilised by ABUHB on the mandatory Corporate Induction programme.

3.3 To promote fraud awareness, in addition to attending every Corporate Induction session, the LCFS's customarily attend major events such as the AGM, the annual HCA Conference and ABUHB careers fairs. In addition to this, Counter Fraud portable display stands are periodically sited at conspicuous locations in hospital environment's on a rotational basis. Covid lockdown curtailed these activities on the part of the LCFS, however; the activities have now fully resumed.

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

Examples of LCFS work carried out to develop and promote an anti-fraud culture includes the delivery of 'live' fraud awareness presentations to the following audiences consisting of 123 attendees:

- Managers Core Skills Module-7 Taking the Lead x 7
- Payroll Services x 2

3.4 During February & March 2023, a staff fraud awareness survey was published on the Health Board intranet via Microsoft Forms which was accessible to the entire workforce board-wide. The responses are attached to this report as **Appendix 3**. Following commencement of the survey, to support and promote its uptake by staff, a reminder from the Communications Team was broadcast to all Managers on this topic. Early indications from the survey are that the pandemic has not impeded staff from making fraud referrals should they have occasion or are mindful of doing so.

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

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

Examples of this are investigations listed as **(29)(31)(32)(33) & (34)** which stemmed from the 0800 National Fraud & Corruption Reporting Line. The remainder of the investigations on **Appendix 2,** are a combination of paper based anonymous fraud referrals using referral forms downloaded from the ABUHB Counter Fraud Team web-pages, or direct personal contact from whistleblowers. This is a clear indication that all mediums are being used by 'whistleblowers' to report suspicions of fraud. The NHSCFA on-line reporting tool is also promoted by the LCFS, but no referrals have ever been received via

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

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

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

3.8 On an all-Wales basis, ABUHB personnel have consistently rated as the top scoring of all NHS Health Boards in Wales for having completed the fraud awareness aspect of Corporate Induction on ESR. This is due to the fact that Corporate Induction is a mandatory prerequisite training dimension for all Health Board personnel. The LCFS is now endeavouring to consolidate this figure by initiating the all-Wales Counter Fraud e-learning training as a mandatory compliance dimension on ESR. An organisational consideration for this is that currently, new members of staff have to complete circa 19 mandatory dimensions on ESR, of which, circa 13 are renewable dimensions thereafter. The consideration is that personnel could become overwhelmed by mandatory training. The LCFS has met with the Assistant Director of W&OD to discuss this aspect. The Assistant Director of W&OD has confirmed that a Multi-Disciplinary Team will be assigned to be the gatekeepers for statutory and mandatory training. Although this has yet to be actioned, when the group convene, it will be tasked to consider Counter Fraud as part of the overhaul for mandatory training.

3.9 Fraud Awareness month (FAM) which was a national NHS initiative was customarily orchestrated/managed by NHSCFA. This initiative has been reinitiated by the NHS Counter Fraud Service, following several years absence due to funding restrictions. The initiative is now called fraud awareness week. This initiative not only serves to create an anti-fraud culture but heightens the awareness of a high footfall number of employees of all grades and the general public alike. The Health Board participated in FAW in November 2022, and it was promoted in the Health Boards Newsletter for that month. The Fraud Team set up display boards and attended hospital sites for this initiative, presenting week-long roadshows at the Royal Gwent, Nevill Hall and Grange University Hospitals. These roadshows incorporated providing information on fraud awareness to staff, distribution of fraud referral forms, promotional giveaways such as post-it pads, pens, key rings etc. which bear the corporate identity of the LCFS.

Aside of fraud awareness week, the LCFS intends to maintain this initiative on a rolling programme, potentially one or two days each month, presenting roadshows at all ABUHB sites, including smaller venues such as Chepstow, Monmouth, St Woolos and County Hospitals.

3.10 Fraud information has been updated on the Aneurin Bevan University Health Board intranet website, which has advertised the outcomes of investigations and guidelines to staff for reporting fraud in addition to fraud notices. The ABUHB website was regularly updated and the LCFS web-pages and ancillary platforms received 377 'hits' during 2022/23. Articles placed on the

organisation's intranet site front page comprised of national press releases, local sanctions and general fraud awareness messages from the LCFS. The LCFS has maintained the implementation on the ABUHB website the video entitled 'Taking the U out of Fraud' on the aforementioned web-pages. The format of the web-pages has been amended to meet corporate design.

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

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

3.12 A Counter Fraud newsletter was distributed to Health Board Primary Care Contractors during 2022/23 with various counter fraud articles and successful NHS fraud cases. In total there are 383 Primary Care Contractors that provide NHS services to ABUHB which consist of GP's, Optometrists, Dentists and Pharmacists. The newsletter promotes the NHS Fraud and Corruption Reporting Line and LCFS contact details. The newsletter is bespoke and topical for primary care contractors.

3.13 Three staff orientated Counter Fraud Newsletters/bulletins were also publicised on the ABUHB intranet during 2022/23 and was accessible to the entire workforce.

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

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

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

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

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

3.18 Further evidence of partnership working is case **(1)** on **Appendix 2** which resulted in a gateway taxation request being made by the LCFS to HMR&C and case **(10)** which involved passport data from HMPO.

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

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

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

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

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

4.2 In order to ensure that they remain current, effective and up-to-date, the LCFS has a rolling-programme for reviewing the following polices/protocols which were initially created in 2011. These policies were extensively revamped again during 2014/15. This is necessary in order to reinforce the infrastructure of directives and the framework of organisation guidelines necessary to support the Counter Fraud provision. The Counter Fraud Bribery & Corruption Policy is up-to-date and fit for purpose having been extensively re-written in November 2022. Similarly, the Communication Strategy was updated in March 2021 and Counter Fraud and Workforce & OD Protocol and the Internal Audit & Local Counter Fraud Services Joint Working Protocol were updated in October 2021. All policies received Executive approval and Workforce & OD Policy Group input where necessary. These policies continue to be reviewed in compliance with target dates to ensure they are maintained up-to-date and fit for purpose. The Appearing in Court Policy, in respect of which, the Legal Services Directorate has ownership, is also current.

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

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

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

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

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

4.5 The LCFS has developed relationships with individuals whose role within the LHB has an impact on counter fraud work to identify local areas of risk. The LCFS also meets regularly with External Organisations such as the Police,

NWSSP-Primary Care Services, UK Borders Agency and the Department for Work and Pensions (DWP) to gather intelligence and identify Local and National risks. The LCFS also engages with HMR&C in this capacity and also engages with the Counter Fraud Operations Team of the H.M. Passport Office.

4.6 As part of working in partnership with the Police, the ABUHB LCFS has provided criminal intelligence reports to them, whereby the information would be deemed to be of value to law enforcement. In addition to this, the LCFS has also provided witness statements and documentary evidence to Gwent Police for use in an impending criminal prosecution. Furthermore, the LCFS routinely provides NHS Drug Alerts to the Gwent Police Controlled Drugs Liaison Officer and works in close collaboration with the CDLO. Conversely, this information sharing practice has resulted in the LCFS being afforded access to Police held intelligence which was pertinent to the NHS.

Further evidence of partnership working with the Police are investigations **(10) & (12)** on **Appendix 2,** which are collaborative investigations.

4.7 The LCFS also liaises regularly with the PPV Team and all PPV reports which form part of the standing agenda item at Audit Committee are disseminated to the LCFS. Any concerns of fraud highlighted at a PPV visit are discussed immediately with the LCFS and the appropriate action is agreed. The PPV team reports their findings directly to the DoF. The LCFS has input to a current project conducted by NWSSP-PCS PPV in relation to data set trend analysis in the General Ophthalmic Services domain designed to identify inappropriate claiming in that primary care arena. The ABUHB LCFS attends quarterly all-Wales Fraud Team meetings with the PPV Senior Managers. Such meetings were attended on 25/05/22, 09/09/22, 08/12/22 & 07/03/23.

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

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

On **two (2)** occasions during 2022/23 the LCFS has utilized ABUHB Primary Care Team resources to alert all Gwent GP Practices/pharmacies of immerging fraud threats which targeted the primary care GMS/pharmacy dispensing domains.

4.10 Fraud prevention notices can be issued by NHSCFA under the WG directions for Countering Fraud. Any such circulars include the request for specific action to highlight and minimise any known fraud risk. These fraud prevention instructions referred to as FPN's emanate from the Central Intelligence Unit (CIU) of NHSCFA. During 2022/23 the LCFS has actioned **ten (10)** such circulars, which are outlined in further detail later in this report.

4.11 Additionally, the ABUHB LCFS generated a further **five (5)** self-generated alerts on banking mandate fraud throughout the Corporate Finance and Procurement communities.

4.12 Current indicators from the WG, the Government Counter Fraud Function and the NHS Counter Fraud Authority is that fraud risks remain high and economic attack against the NHS and other public sector bodies will continue.

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

Due to the threat level, the ABUHB LCFS has continued to focus on banking mandate and invoice fraud in the Procurement Services domain. During 2022/23, nationally within the NHS, banking mandate fraud has remained a high-risk fraud threat and ABUHB has been subject to attack from this type of high risk/high value fraud.

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

The ABUHB LCFS has maintained ongoing collaboration with NWSSP Procurement Services on preventative measures focussing on banking mandate fraud, which had been implemented a number of years previously.

The following directives were reinforced to mitigate this area of fraud:

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

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

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

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

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

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

4.14 An area of managed risk within Procurement Services follows arrangements to support supplier businesses during Covid which was highlighted by the Cabinet Office in March 2020. NHS Wales moved to support businesses during Covid with the aim of paying suppliers more speedily, improving their cash flow. This was the catalyst to a variation in the 3-tier procurement protocol for the payment of invoices under £500.00 in value. These type of invoices are of low individual value but extremely high in volume.

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

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

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

The LCFS has confirmed that retrospective receipted verification has been carried out and that spot checks have been done on samples of invoices which have been paid without being receipted and very few issues or areas of concern have been identified. This arrangement remains in place moving forward for the future and is subject of ongoing review.

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

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

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

4.16 In an effort to raise workforce awareness on these fraud threats, the LCFS uses permutations of intranet news items, staff newsletters and via the ABUHB intranet carousel.

4.17 The LCFS has worked in collaboration with Procurement Services and the wider NHS finance community as part of local proactive exercises stemming from fraud prevention guidance generated by the NHSCFA during 2022/23.

Fraud Prevention Guidance

The FPN's are as follows:

- NHS CV fraud
- Mandate fraud – hacking of NHS mail accounts
- Fake supplier invoice fraud
- Cyber enabled mandate fraud x 3
- Payment usage mandate fraud
- Bogus Consultant
- Salary diversion fraud
- Payment terminal fraud

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

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

1. Service specification review for Community Pharmacists – Pharmacy Independent Prescriber Service claims (PIPS).
2. Security, governance and control of hospital controlled drugs and WP10HP medical prescription forms.
3. Cyber enabled mandate fraud.

RISK ASSESSMENT 1 – PHARMACY INDEPENDENT PRESCRIBER SERVICE CLAIMS

The LCFS has engaged with the Community Pharmacy Advisor to review general financial governance vulnerabilities with the PIPS service specification and perceived difficulty for the NHS in the verification & reconciliation of pharmacy contractor claims.

PIPS took effect in April 2022, as a WG promoted service, which enables community pharmacies to prescribe medicines on occasions when there is an Independent Prescriber in situ on the premises. There is a sliding scale of standing payments to pharmacies, dependent on the number of hours that the Independent Prescriber is on site, to a maximum of £3.2k per month for 150 hours Independent Prescriber attendance. This figure is then enhanced with prescribing activity payments.

Difficulties were initially encountered on the launch of the service as the prescription pads were not available for use for several months. It was identified that at least one ABUHB pharmacy contractor claimed the maximum standing payment for that initial period, despite being unable to provide the service due to the absence of prescription pads. Following collaboration between the LCFS and Primary Care Pharmacy Lead, agreement was reached that this fell outside of the spirit of the service specification and in excess of £10k was recovered from that contractor, by installment, over a 3-month timeframe.

Circa one third of ABUHB Pharmacies have currently taken up on this service provision and it is anticipated that this number will increase to in excess of 100, by year end 2023.

Potential financial risk surrounding the service, is difficulty in verification of standing payment claims with the reconciliation of the number of hours an

Independent Prescriber was in attendance on the premises. Further vulnerability is the potential for a contractor, who has more than one pharmacy, in close proximity, to claim standing payments for both pharmacies, when there was an Independent Prescriber at one premises only. This again, would fall outside the spirit of the service specification.

These risks have been highlighted to the Community Pharmacy Advisor and will be subject to on-going scrutiny and review.

A recommended verification control is the reconciliation of claims under this service against the daily pharmacy responsible pharmacist duty record (held at the pharmacy) and confirmation that the responsible pharmacist details tally, followed by confirmation that the duty responsible pharmacist holds Independent Prescriber status/credentials.

Additionally, the LCFS has raised these vulnerabilities, with PPV Leads, at the all-Wales Counter Fraud & PPV meeting, with the suggestion that PIPS should be considered as part of the PPV service provision.

RISK ASSESSMENT 2 – SECURITY OF HOSPITAL CONTROLLED DRUGS AND MEDICAL PRESCRIPTION FORMS

Following repeated incidents of reported theft, relating to the security, handling & governance of controlled drugs and medical prescription forms at the Grange University Hospital, the LCFS carried out a risk assessment in collaboration with the Urgent Care Divisional Pharmacist. This assessment included Omnicell vending cabinets, which are used for the secure storage of drugs and medical prescription pads alike. The review additionally incorporated ward practices and use of controlled drug cabinets and controlled drug registers. Security of patients own drugs (brought in on admission) was also subject of review.

The following areas of weaknesses were identified:

- CD medicines stored in patient lockers and not in Omnicell/CD cabinets
- Same drug cabinet access code used on a number of wards
- Access code not changed frequently or following Datix incident, which highlighted that the access code had potentially been compromised
- Drug cabinet doors left open as staff unaware of access code
- Patient lockers and medical cupboards all using the same access code
- Access code written on stickers and placed on outside of drug cabinets for ease of access by staff
- Prescription pad removed from Omnicell cabinet and left on table, close to patient occupied area
- Potentially dangerous drugs left in unlocked cupboard (potassium)
- Drugs requisitioned from pharmacy left on unmanned desk in open plastic envelope carrier, not placed in Omnicell cabinet
- Unused medicines left on desks/work stations etc.
- Bag of patient medicine left in carrier bag on unmanned workstation

The LCFS has liaised with the Head of Internal Audit in respect of these findings and also the Clinical Director of Pharmacy who has delegated the Divisional Nurse to take ownership of and manage said risks.

RISK ASSESSMENT 3 – CYBER ENABLED MANDATE FRAUD

A risk assessment was initiated as a consequence of a fraud prevention notice distributed by NHSCFA. The contents and recommendations of the FPN were endorsed and is supported by the Department of Health and Social Care Anti-

Fraud Unit, NHS Counter Fraud Authority, NHS England and NHS Digital. The NHSCFA was alerted to several breaches to the NHS email system which revealed that cyber criminals had gained access to NHS email accounts which the criminals then monitored to gather information for the purposes of committing fraud against the NHS. The cyber criminals were attempting to divert high value payments by assuming the identity of legitimate suppliers/NHS personnel and then inserting themselves within existing email chains between NHS organisations and their suppliers. Email flow rules were changed by the cyber criminals in order that they would be copied into all future emails that were sent between NHS organisations and their suppliers. This was initially achieved by cloning a legitimate email address and creating a very similar one with a subtle difference which was very difficult to spot. As a consequence, high value payments were diverted into bank accounts controlled by the cyber criminals and NHS funds were successfully stolen.

The LCFS has complied with all the recommended actions attached to this FPN. The notice has been distributed to all divisions of the finance community and the NHS Cyber Security teams alerting greater vigilance to this type of fraudulent attack. The LCFS has actioned the FPN on *'Clue'* case management system.

The LCFS will also maintain an ongoing collaboration with the NHS Cyber Security Team to assess the robustness of existing cyber security tools and consider adopting such tools recommended by the NHSCFA. To date, there has been no successful attack of this nature in NHS Wales.

PROACTIVE DETECTION ACTIVITY – OVERPAYMENTS OF SALARY

Currently, overpayments of salary arguably account for the highest percentage of invoices raised by the Corporate Finance Team.

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

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

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

As a remedial measure, the LCFS has incorporated payslip messages to all ABUHB staff on two occasions during 2022/23, reminding the workforce of their obligation to immediately report any salary errors.

Additionally, case listed as investigation **six (6)** on Appendix 2, was referred to the LCFS, via the protocol with Accounts Receivable, as described previously in

this section. This is evidence of positive collaborative working, which subsequently resulted in a criminal conviction at court.

It is worthy of note that Counter Fraud have two separate work streams relating to overpayments of salary, undertaken in line with the Counter Fraud Standards. Firstly a requirement to investigate potential fraud offences within the NHS and secondly to undertake detection activity and reduce the risk of fraud losses. It was considered that there was a divergence in the approach to the risk and detection element between the Health Board's Counter Fraud Teams in relation to the parameters for highlighting individual instances of overpayment of salary.

To consolidate local protocols, the Lead LCFS's for the Health Boards in Wales, collaborated and guidance has been presented, as a proposal, to NWSSP Payroll Services, as an all-Wales recommended standardised best practice. The guidance is as follows:

- The overpayment relates to a staff member whose employment has been terminated;
- The overpayment persisted for a period of 3-months or more and/or is of a value of £5k or more following termination;
- Payroll have received no contact regarding the overpayment of salary from the terminated staff member, hence there has been no effort by the staff member to remedy the situation;

To satisfy the detection activity and risk element, data that reflects individual overpayment details should be provided, to enable Counter Fraud to assess potential criminal activity. This data should be provided to Local Counter Fraud Teams, on a monthly basis. This would streamline such referrals and alleviate the need for Payroll Services to refer the majority of overpayments to Counter Fraud individually.

This overpayment problem is not unique to ABUHB. From collaboration with counterparts in other Welsh Health Boards, it is evident to the LCFS that this is a national issue for NHS Wales.

PROACTIVE DETECTION ACTIVITY – PROCUREMENT INVOICE FRAUD

Evidence of the success of the collaborative working between Counter Fraud and Procurement Services (as highlighted previously at paragraph 4.12 of this report) is borne out by the interception of a fraudulent invoice which claimed payment for the purported the delivery of 1,400 ITU beds at a cost of £9.8 million. This enquiry involved ABUHB Procurement Services and the National Administration Team of NHS Supply Chain. The conclusion was the invoice originated from one company in the guise of a different company which ended their NHS agreement from when the new framework was launched. This activity was alerted to NHSCFA Central Intelligence Unit for national circulation and payment of the invoice was declined. The wider NHS finance community was also alerted to this activity.

4.19 The LCFS has engaged with the Medical Director with a view to establishing directives regarding the appropriateness of displacement of job plan contracted SPA sessions by Consultant Doctors in order to uptake additional productivity sessions elsewhere, such as NFI/backfill sessions. This is subject to ongoing review.

4.20 The LCFS is a permanent attendee of the Gwent Local Intelligence Network (LIN). The Medical Director is the Accountable Officer for the LIN which has Police representation, representation from neighboring county LIN's and also representation from HoPMM, Pharmacy, GPhC, Health Inspectorate Wales, Care

& Social Services Inspectorate Wales and this allows for exchanges of information. A primary function of the LIN relates to the security of and addressing risk factors attributed to controlled drugs (CD's).

The LCFS attend all LIN meetings during year 2022/23, which took place on 10/05/22, 01/08/2022, 25/10/2022 & 24/01/23 respectively.

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

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

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

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

These rules have previously been distributed to all 131 Pharmacies in the LHB. During year 2022/23, ABUHB has made payment on **five (5)** Pharmacy Reward Scheme claims.

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

The LCFS has reviewed and has initiated inclusions on **twelve (12)** documents which have been implemented by ABUHB during 2022/23. These policies are:-

- Annual Leave & Statutory Holidays Policy
- Annual Leave Policy for Consultants & Senior Medical & Dental Staff
- Employer Pension Contributions - Alternative Payment Policy
- Paternity Leave Policy
- Home Working Policy & Guidelines
- Trade Union Recognition & Partnership Agreement Policy
- Adverse Weather Conditions Policy
- Accessing NHS Pension & Re-Engagement Guidelines
- Counter Fraud, Bribery & Corruption Policy
- Health & Care Professional Council - Registration & Checking Policy
- Long Service Award Policy
- Rebanding Policy

4.24 A frequent concern raised by NHSCFA is the upholding of pre-employment checks and maintaining NHS employment standards, insomuch as any relaxation in pre-employment checks, may result in the NHS employing staff,

who have dubious or spurious credentials, or whose identity may not be verified as rigorously as usual. Pre-employment checks need to remain robust in this domain and the LCFS is monitoring this area both within Health Board processes and on the National Fraud Initiative. An example of this is case **(10)** on **Appendix 2** which pertains to a person who gained employment as a HCSW and who had been previously imprisoned for drug trafficking offences.

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

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

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

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

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

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

4.30 During year 2022/23, where legally permissible, the LCFS has continued with the practice of publicizing national media reports of individuals who have been convicted at Court of defrauding the NHS. This positive counter fraud reporting is with a view to maximizing the deterrent impact of such cases.

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

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

4.33 The Counter Fraud newsletters and circulars that were circulated during 2022/23, highlighted local and national cases of fraud against the NHS that have been successful in court. These sources of information also provided details on the correct way to report fraud and all the relevant Counter Fraud

contact details. The communiqués sent out a clear deterrent message to readers that fraud in the NHS is unacceptable, indefensible and will not tolerated and that action will be taken against any known perpetrators.

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

Feedback questionnaires are customarily distributed at face-to-face presentations and the results of these questionnaires are retained and analysed by the LCFS. Any areas of perceived deficiency are addressed.

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

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

4.37 In order to ensure the effectiveness and staff awareness of the Standards of Business Conduct for Employees Policy, the Board Secretary continues to pursue the submission of declaration of interest forms or a nil return, whichever applies. Furthermore, the LCFS has access to DOI data for the purposes of investigating data matches on the National Fraud Initiative (NFI).

In order to reinforce the obligation for staff to submit declarations of interest, the aspect is included on ESR as part of PADR (staff appraisal) core documents. By this means, the topic potentially reaches the largest audience of staff members. A question on this document asks whether the postholder has a declaration of interest and if the answer is 'yes', a second question asks whether the appropriate form has been sent to the Board Secretary. The document also contains a link to guidance on DOI.

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

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

5.2 The Audit Commission is responsible for running the National Fraud Initiative (NFI). This commenced in 1996 and runs every two years. The NFI is an exercise that matches electronic data both within and between some 1,200 public sector bodies and participating private sector bodies to prevent and detect fraud. This includes the NHS, DWP, HMR&C, Police Authorities, Local Probation Boards, Fire and Rescue Authorities as well as Local Councils and number of private sector bodies. Cumulative detected and prevented savings identified from NFI data matching since 1996 are cited to exceed £2 billion across the UK and £49.4 million in Wales. The NFI data collection operated in 2022/23. By the deadline date of October 2022, the LCFS facilitated the downloading of the Trade Creditors payment history and Trade Creditors standing data to the Wales Audit Office in compliance with the NFI mandate.

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

The payroll data matches were received by ABUHB on 27th January 2023, whereas trade creditor data matches were received on 6th February 2023. The matches total 7,441 in number, of which, 6,916 relate to trade creditors standing data.

The ABUHB LCFS continues work on these NFI data matches and outcomes will be reported back to the Cabinet Office by the deadline date. The work into trade creditors standing data matches, is undertaken by NWSSP Procurement Services Account Payable Section. Payroll to payroll and kindred matches are investigated by the LCFS.

5.3 The LCFS has maintained the following proactive investigation exercises:

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

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

5.5 Investigations are anonymised in reports to the Audit Committee. Internal Audit and External Audit receive copies of the LCFS report to the Audit Committee and vice versa. Incorporated in **Appendix 2** are details of the LCFS counter fraud investigations conducted between 1st April 2022 and 31st of March 2023.

5.6 CFS Wales carry out high value complex investigations. If an investigation is linked with the area in which the LCFS operates they may be required to assist the CFS Wales by taking witness statements, assisting in the search of a premises or carrying out interview of witnesses and suspects.

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

5.8 The LCFS actively promotes working in partnership through collaboration and interaction with other agencies. A demonstration of this are cases listed as **(10)(12) & (21)** on **Appendix 2,** which in this instance pertains to Police collaborative investigations.

5.9 On the aforementioned cases, information sharing occurred between the LCFS and Police. The LCFS provided a witness statements and documentary evidence to support a joint LCFS/Police prosecution in case **(12)**. Additionally, the LCFS provided statements of evidence to HR to support the disciplinary process in relation to investigations **(1)(3) & (6)** on **Appendix 2**.

5.10 Additionally, on investigations **(1)(2) & (3)** on **Appendix 2** the LCFS provided evidential support to the professional bodies and actually provided witness statements to the NMC & GMC in these instances.

5.11 The LCFS is committed to pursuing every line of enquiry during an investigation and this includes employing every available investigative technique and resource. A further demonstration that the LCFS utilizes the full range of investigative resources, applies to investigation **(30)** on **Appendix 2**. This case demanded a financial investigation under the Proceeds of Crime Act 2002, which was undertaken by an Accredited Financial Investigator attached to Counter Fraud Service (Wales). Additionally, as part of the investigation, for evidential purposes, it was necessary to identify the level of funds held in a bank account.

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

5.13 During 2022/23 the ABUHB LCFS disseminated **five (5)** Data Protection requests to external bodies i.e. Police, DWP & UKBA etc., whereby information was sought by the LCFS to progress investigations.

Similarly, **ten (10)** Data Protection requests were received by the LCFS from the Police and other agencies, whereby information was sought by law enforcement. This resulted in the release of information by the LCFS and from probity and information governance best practice, the Head of Information Governance was party to all the disclosure.

5.14 Liaison was effected with HMR&C on investigations **(1)** on **Appendix 2** and a gateway authority was utilised to obtain taxation records as part of this LCFS investigation.

5.15 Automated number plate recognition evidence (ANPR) was requested from Heddlu Gwent Police on **two (2)** occasions in relation to investigations **(1) & (20)** on **Appendix 2**.

In addition to this, as a stopgap, the LCFS collaborated with Gwent Police to facilitate PNC checks on persons & vehicles following the protracted loss of this resource by the NHSCFA. This facility was restored to NHSCFA in February 2023 and is now fully functional and available to the LCFS.

5.16 During 2022/23, the LCFS conducted **two (2)** interviews under caution with **two (2)** alleged offenders.

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

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

5.18 **Four (4)** investigations on **Appendix 2** have resulted in prosecution files of evidence being submitted to the Crown Prosecution Service (Paragraph 1.9 above refers).

5.19 **Four (4)** of those cases **(4)(6)(12) & (21)** on **Appendix 2** have resulted in criminal convictions/sanctions.

5.20 **Six (6)** cases **(3)(14)(9)(15)(18) & (19)** on **Appendix 2** have resulted in disciplinary action. These generally pertain to dismissal from employment for gross misconduct but include formal written warnings or where staff members have resigned prior to the conclusion of the disciplinary process. Case **(21)** is an ongoing disciplinary matter.

5.21 Investigations **(1)(3)(4)(6) & (13)** on **Appendix 2** are ongoing matters with the GMC & NMC which have potential impending sanctions from professional bodies.

5.22 Case **(2)** on **Appendix 2** has received a professional sanction from the professional body the GMC.

5.23 The LCFS has sought to maximise the deterrent value of criminal sanctions by publicising them and exploiting media coverage of cases. Case **(6)** on **Appendix 2** received extensive regional media reporting following conviction at Court. Additionally, case **(13)** also received regional media attention during its hearing at the NMC. This media coverage amplified the deterrent message to any would-be NHS fraudsters.

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

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

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

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

Investigations listed as case numbers **(1)** & **(2)** on **Appendix (1)** received declined charging decisions by the CPS under public interest considerations.

Pre-Covid, such cases would have undoubtedly resulted in criminal court proceedings. Following meetings between the Manager for Counter Fraud Service (Wales) and the Head of the CPS Specialist Fraud Division, the balance has been restored and the successful prosecution of case number **(6)** is testament to this.

The Audit Committee tasked the LCFS to establish if this was exclusive to ABUHB cases. It has been confirmed that this was an emerging pattern across Wales and was not unique to ABUHB. Information on all rejected cases across Wales was collated and the Manager of Counter Fraud Service (Wales) who is the liaison point with the CPS, met with the Head of the CPS Specialist Fraud Division to discuss concerns. Consequently, the balance has been restored and the successful prosecution of case number **(6)** is testament to this.

5.27 The criminal investigations conducted by the LCFS are continuing unhindered throughout their evidential gathering phases, following emergence from the Covid pandemic. Towards the conclusion of any such investigations, following the evidence gathering stages, if areas of concern are found to be prevalent, there is the requirement to conduct an audio recorded interview under caution, with the defendant, in the presence of their Solicitor. Such interviews are now progressing as normal following emergence from the pandemic.

5.28 Fraud whistleblowing referrals have continued to be received by the LCFS but the dynamic for raising fraud concerns has favoured the 0800 NHS National Fraud & Corruption Reporting Line. The previous most common method of this type of referral was by means of the fraud referral form downloaded from the Counter Fraud web-pages on the ABUHB intranet site.

5.29 In all cases, the LCFS, in agreement with the DoF, seeks to recover monies lost to the Health Board as a result of fraud and corruption. Recoveries totalling **£121,727.21** were made against investigations listed as numbers **(5)(6)(11)(16)(24)(28)** & **(30)** on **Appendix 2** of this report. Additionally, the NHSCFA are currently driven to fraud prevention savings as a result of counter fraud intervention and such savings are arguable as outlined in paragraph 4.18 of this report. The LCFS also seeks to maximise possible sanctions against the perpetrator. Effective recovery can benefit from other work performed by the LCFS to professionally investigate, to seek to apply sanctions and develop an anti-fraud culture.

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

6 Counter Fraud Arrangements

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

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

6.3 During 2022/23, an all-Wales LCFS meeting was held on 22nd November 2022, which was preceded by an LCFS Leads meeting on 9th September 2022. These meetings were attended by Senior NHSCFA Q.A. Managers. Additionally, the Lead LCFS met with Senior NHSCFA Q.A. Managers on 11th October 2022, in relation to quality and assurance and local proactive exercises on behalf of ABUHB.

6.4 The Lead LCFS has regularly met/liaised with the DoF during 2022/23 to monitor the progress against the Counter Fraud workplan. The LCFS has regular interaction with the DoF relating to fraud investigations, to highlight potential fraud risks and to circulate fraud notices. These meetings are customarily scheduled on a bi-monthly basis.

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

6.5 The Counter Fraud team consistently takes action to develop new skills for Counter Fraud, and where necessary attends the relevant training courses and workshops. In addition to the all-Wales forums referred to at paragraph 6.3 above, the LCFS attended training sessions delivered by NHSCFA Q.A. on 25/26th January 2023 & 29th March 2023.

6.6 Further to the above, the ABUHB LCFS undertook the following training sessions during 2022/23:

- NHSCFA training - CPIA, AG guidelines 2022 updates, CLUE-3 training
- NHSCFA training - Disclosure, AG guidelines 2022 updates, CLUE-3 training
- NHSCFA forum training - AG guidelines/new bail changes
- NHSCFA Webinar - mid-year performance review
- RL Datix Cloud IQ incident review training x 2
- Women in leadership workshop
- Learning & development platform & competency training
- AB pulse training
- Creating video links on pulse
- Roster training
- Menopause awareness training
- Band 3-6 Development module 4 - Testing & influencing
- Employee investigation - Looking after process & people
- Difficult conversations workshop
- Influencing skills workshop

6.7 The Lead LCFS has ongoing liaison throughout the financial year with CFS (Wales) with regards to ongoing measures that the Counter Fraud Team has to adhere to. During 2022/23 the Counter Fraud Team has submitted quarterly statistics to CFS (Wales) which included Counter Fraud work and risks identified. This data was presented to the Counter Fraud Steering Group and contributed to the all-Wales Counter Fraud Performance Report. The LCFS presented the 2022/23 performance report to Audit Committee.

6.8 The Lead LCFS presented the Counter Fraud workplan for 2022/23 which was duly agreed by the DoF and Audit Committee. The LCFS identified areas of greatest risk that needed addressing. The workplan is a dynamic document and is regularly updated to ensure that it is reflective of the LHB's needs.

6.9 By the submission deadline date of 30th April 2023, ABUHB Counter Fraud will submit a standards self-assessment review to NHSCFS, Quality Assurance. This review is based on Government Functional Standard for Counter Fraud (GovS 013) and will reflect the ABUHB Counter Fraud provision for 2022/23. The NHSCFA Quality Assurance Team scrutinise the counter fraud provision and assess for embedded counter fraud arrangements and evidence of qualitative outcomes. The resulting report will be presented to Audit Committee for its recommendations to be implemented accordingly.

6.10 Counter Fraud work is a standing item on the Aneurin Bevan University Health Board's Audit Committee meeting agenda. During 2022/23, the LHB Lead LCFS was required to attend and report at **four (4)** such Audit Committee meetings

for the LHB i.e. 7th April 2022, 2nd August 2022, 1st December 2022 & 2nd February 2023. Additionally, the LCFS met privately with Independent Members on 7th April 2022 & 1st December 2022. The LCFS also held one to one meetings with the Audit Committee Chair on 12th May 2022 & 6th March 2023 respectively.

6.11 Historically the LCFS referred primary care general dental service and general ophthalmic service cases to the Counter Fraud Service (Wales) for investigation, in relation to potential fraud in those domains.

Appendix 1

1. Reporting lines

Chief Executive	Mrs. Nicola PRYGODZICZ Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: nicola.prygodzicz@wales.nhs.uk
Director of Finance	Mr. Robert HOLCOMBE Aneurin Bevan University Health Board H.Q. St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ Email: robert.holcombe@wales.nhs.uk
Head of Counter Fraud	Martyn EDWARDS Counter Fraud, Corporate Finance Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: martyn.edwards3@wales.nhs.uk
Succession Head of Counter Fraud	Michelle MORRIS Counter Fraud, Corporate Finance Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: michelle.morris9@wales.nhs.uk
Local Counter Fraud Specialist	Louisa STEELE Counter Fraud, Corporate Finance Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: louisa.steele@wales.nhs.uk
Local Counter Fraud Specialist	Sara MORRIS Counter Fraud, Corporate Finance Aneurin Bevan University Health Board 2nd Floor, Block C, Mamhilad House Mamhilad Park Estate Pontypool NP4 0YP Email: sara.morris5@wales.nhs.uk

2. Further Information\Mix of cases

Number of cases as at 31st of March 2023, including those brought forward from previous year:

Area (based on Initial reported category)	Number of Cases	Closed	Ongoing
Contractor – GP (Falsify application for performers list)	1	1	0
Member of public – (Compensation fraud)	1	0	1
Member of public – (Prescription fraud)	1	1	0
Member of public – (Illegal distribution prescription meds)	1	0	1
Staff – Doctors (Private work in NHS time/WLI)	1	0	1
Staff – (Falsify CV to obtain post)	1	0	1
Staff – (Falsify hospital appointments)	1	1	0
Staff - (Working on sick leave)	7	3	4
Staff – (Dishonest retention of salary overpayments)	8	5	3
Staff - (Falsified expenses/timesheets)	7	1	6
Staff – (Overtime fraud)	3	3	0
Staff – (Theft of NHS property)	1	0	1
Staff – (Theft of prescription medication)	2	0	2
Totals	**35**	**15**	**20**

3. NHS Counter Fraud Authority Website

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

Appendix 2

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2023					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
1.	WARO/19/00145	ABUHB	NHS Staff	Falsify WLI claims.	CPS declined charging decision, NFA criminal aspect. Civil recovery and GMC action impending.
2.	WARO/19/00122	ABUHB	General Practitioner	Falsify information on application for Welsh G.P. performers list.	Subject was interviewed under caution. CPS declined to charge, NFA on criminal aspect. On 03/03/2023, GMC tribunal found that the Defendant's fitness to practise was impaired. Subject struck off medical register & will not be able to work as a Doctor in the UK for a minimum of five years. Sanction effective from 10/04/2023. Case closed 07/03/2023.
3.	WARO/20/00020	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Dismissed from employment on 21/10/2020 following disciplinary action. NMC sanction impending.
4.	WARO/21/00003	ABUHB	NHS Staff	Theft of medication.	Dismissed for gross misconduct on 10/08/2021 following disciplinary action. Police sanction Women's pathway. NMC sanction impending.
5.	INV/21/00267	ABUHB	NHS staff	Dishonest retention of salary overpayment.	NFA on criminal aspect. Subject no longer employed by ABUHB. Civil recovery of £33,920.00 implemented. Case closed 12/08/2022.
6.	INV/21/00276	ABUHB	NHS staff	Dishonest retention of salary overpayment.	At Merthyr Tydfil Crown Court on 6th September 2022, the defendant was sentenced to 8-months imprisonment, suspended for 12-months, was ordered to pay £1,124.69 investigation costs, pay £156.00 victim surcharge

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2023					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					and perform 100 hours of unpaid work. (The defendant had already repaid ABUHB in advance of the court hearing on 25th August 2022, against a fraud loss value of £21,389.69. NMC sanction impending.
7.	INV/21/00294	ABUHB	NHS Staff	Falsification of hospital appointments.	NFA on criminal aspect. Disciplinary action not pursued. Case closed 22/11/2022.
8.	INV/22/00060	ABUHB	Member of public	NHS compensation claim.	Investigation ongoing.
9.	INV/22/00110	ABUHB	NHS staff	Timesheet fraud.	NFA on criminal aspect. Written warning on fast track disciplinary on 01/12/2022 and restricted from bank duties. Case closed 01/12/2022.
10.	INV/22/00123	ABUHB	NHS staff	False declaration on job application form.	Investigation ongoing in joint venture with Gwent Police. Criminal prosecution impending.
11.	INV/22/00388	ABUHB	NHS staff	Dishonest retention of salary overpayment.	NFA on criminal & disciplinary aspect. Recovery of £3,567.81 implemented. Case closed 30/11/2022.
12.	INV/22/00529	ABUHB	Member of public	Illegal supply of prescription drugs.	Joint investigation with Police. Defendant convicted at Newport Crown Court on 28/10/2022. 6 x firearms offences & 1 x possession controlled drugs offence. Sentencing hearing impending.
13.	INV/22/00690	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. NMC imposed 18-month interim order on 27/05/2022. Restricted to work in Private Nursing

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2023					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
					Home in Tredegar. NMC action continuing.
14.	INV/22/00691	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal & disciplinary aspect. Case closed 27/03/2023.
15.	INV/22/00692	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Fast track disciplinary on 21/12/2022, written warning. Case closed on 22/12/2022.
16.	INV/22/00693	ABUHB	NHS staff	Dishonest retention of salary overpayment.	NFA on criminal aspect. No disciplinary issues identified. Financial recovery of £28,328.68 implemented. Case closed 01/08/2022.
17.	INV/22/00899	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
18.	INV/22/00925	ABUHB	NHS staff	Overtime fraud.	NFA on criminal aspect. Informal resolution disciplinary sanction. Case closed 08/03/2023.
19.	INV/22/00926	ABUHB	NHS staff	Overtime fraud.	NFA on criminal aspect. Informal resolution disciplinary sanction. Case closed 08/03/2023.
20.	INV/22/01183	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.
21.	INV/22/01195	ABUHB	NHS staff	Theft of hospital prescription medication.	Police caution on 14/01/2023 as criminal sanction. Disciplinary action impending.
22.	INV/22/01184	ABUHB	NHS staff	Timesheet fraud.	Subject interviewed under caution. Financial recovery impending.
23.	INV/22/01201	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.

INDEX OF LCFS INVESTIGATIONS AS AT 31st March 2023					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
24.	INV/22/01391	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Subject interviewed under caution. NFA on criminal & disciplinary aspect. Recovery of £24,000.00 implemented.
25.	INV/22/01353	ABUHB	Member of public	Prescription fraud.	NFA on criminal aspect. Case closed 07/11/2022.
26.	INV/22/01702	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect & disciplinary aspect. Case closed 23/11/2022.
27.	INV/22/01354	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal & disciplinary aspect. Case closed 23/11/2022.
28.	INV/22/01389	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	NFA on criminal & disciplinary aspect. Recovery of £5,357.34 implemented. Case closed 04/01/2023.
29.	INV/22/01522	ABUHB	NHS Staff	Overtime fraud.	NFA on criminal & disciplinary aspect. Case closed 30/11/2022.
30.	INV/23/00285	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	NFA on criminal & disciplinary aspect. Recovery of £4,040.00 implemented. Case closed 22/02/2023.
31.	INV/23/00254	ABUHB	NHS Staff	Theft of NHS property.	NFA on criminal & disciplinary aspect. Case closed 27/03/2023.
32.	INV/23/00258	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
33.	INV/23/00265	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
34.	INV/23/00332	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
35.	INV/22/01414	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Investigation ongoing.

Appendix 3

ABUHB Counter Fraud Staff Survey

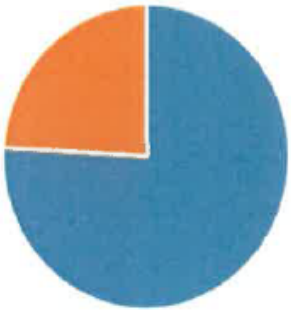
75	03:18	Active
Responses	Average time to complete	Status

1. Have you ever attended a NHS fraud awareness session?

Yes	29
No	46

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

Yes	57
No	18



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

Yes	42
No	32

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

In the last 6 months	8
In the last 12 months	13
Longer than 12 months ago	25

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

Yes	55
No	20

6. Have you read the policy?

Yes	26
No	49

7. Are you aware of the Health Board's *Standards of Business Conduct Policy* and behaviours expected of all Health Board Employees?

Yes	51
No	24

8. Have you read the policy?

Yes	21
No	53

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

Counter Fraud Newsletter	14
Counter Fraud Specialist Posters	14
Counter Fraud Leaflets	12
Bulletins & Videos our Health B...	50
Other- Please add details in Q.10	3

10. Other - Answer here to Q.9

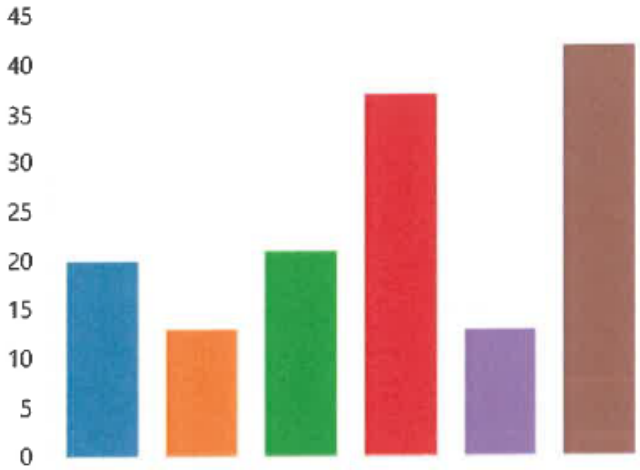
5

Responses

Latest Responses

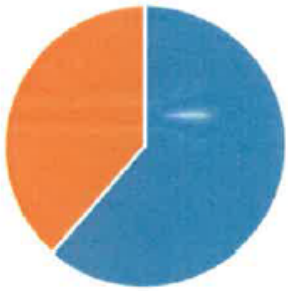
11. How would you like to be informed of Counter Fraud work within the Health Board? (PLEASE TICK ALL THAT ARE APPLICABLE)

Counter Fraud newsletter	20
Fraud Awareness Presentation	13
E-learning module	21
Information on HB intranet/ AB...	37
Videos and Interactive content	13
A bit of everything	42



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

Yes	46
No	29

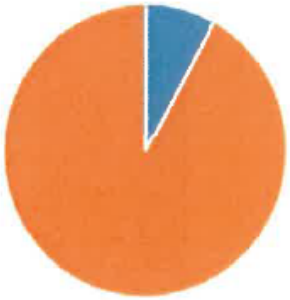


13. Do you know how to report a suspicion of fraud?

Yes	42
No	33

14. Have you had concerns around fraud, bribery and/or corruption in your Team or Department in the last 12 months?

Yes	6
No	68

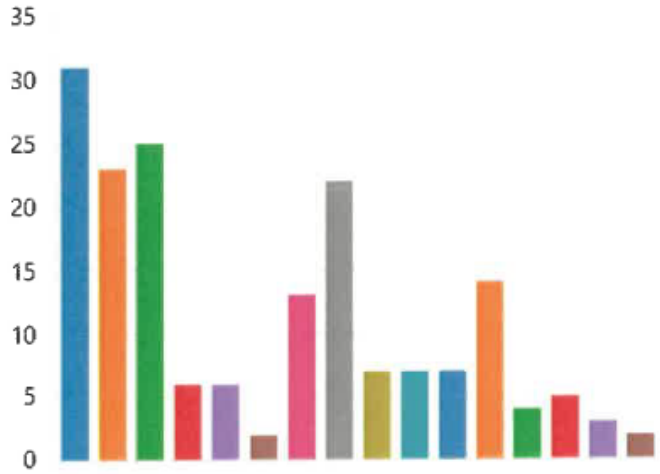


15. Do you feel that your Team/ Department is at risk of fraud?

Yes	16
No	58

16. From the list below, please specify what you believe to be the top three types of frauds your department is most at risk of? (You can select more than 1 answer)

Timesheet fraud	31
Working elsewhere whilst on sick	23
False expenses	25
False employment history	6
False qualifications	6
Falsely inflating costs	2
NHS Equipment	13
Supplies for personal use	22
Private work in NHS time	7
False/duplicating invoicing	7
False prescriptions	7
Abuse of Position	14
Overseas visitors giving false inf...	4
Bribery or corruption	5
Other - Please add details to Q.17	3
Other	2



17. Other - Answer here to Q.16

5
Responses

Latest Responses

18. To ensure we provide appropriate training to the right audience, please provide your Primary area of work. (For example: Primary Care, Clinical Support, Estates & Facilities etc.)

45
Responses

Latest Responses

"Finance"

"Corporate"

"Unsheduled care"

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategic Risk Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Services, Risk and Assurance

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

Er Sicrwydd/For Assurance

This report seeks to provide a summary of the current risks which comprise the corporate risk register and therefore form the strategic risks for the Health Board.

The report also provides a first iteration of a proposed new format of report that maps the entire risk profile for the Health Board across a diagram. This would provide the Committee with a view of the risk exposure of the organisation and allow for greater scrutiny of the system of internal control.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an overview of all **26** strategic risks described within the corporate risk register and which, therefore, represent the most significant risks to the Health Board in potentially impacting the delivery of its IMTP objectives (5 life course priorities).

The sustained demand for services, compounded by the residual impact of the pandemic and significant workforce constraints continue to represent the most significant risks to the Health Board's delivery and the achievement of the objectives outlined within the IMTP. A high-level overview of the risks currently captured on the corporate risk register are attached to this report at ***Appendix 1***.

The role and function of the Audit, Risk and Assurance Committee as articulated in the Committee Terms of Reference (ToR) is to:

"***... support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report... provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.***"

In recognising the breadth of the function and purpose of the Committee, the Director of Corporate Governance has recently initiated an Organisational Change Policy (OCP) process, which has been supported by the Executive Committee. Through this review, the requirement to increase capacity within the Governance team to address the deficits to take this work forward, has been identified. Additional capacity and resource are expected from Summer 2023 when sustainable progress can be made to ensure the revised approach to the Board Risk and Assurance Framework becomes embedded and used to inform and drive Board and Committee business and allow for the Committee to take an active role in evaluating assurances and the internal system of control.

Internal Audit has recently undertaken a review into Risk Management arrangements within the Health Board. The result of this audit was a *reasonable level* of assurance however, further improvement actions have been identified and are addressed in the management actions of the report itself.

Cefndir / Background

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy and 'risk decision' processes.

At the March 2023 Board meeting, members received an updated version with enhanced risk assessments for each risk profile. The report included an assessment of the internal controls used to manage each risk and an assessment on levels of assurance that could therefore be taken.

Internal controls were identified and rated (red, amber, green[1]) RAG in relation to their effectiveness. Where gaps were identified, clear actions aligned to SMART methodology were developed and tracked through respective Executive risk owners. Sources of assurance could then be established and similarly, where gaps are identified, clear SMART actions were developed to address the gaps to drive progress to mitigate the risk and reduce either the likelihood, consequence, or both. Committees are then responsible for the active monitoring and review of all risks which receive oversight from each respective committee.

Risk Management ensures that the Health Board focuses on the risks and concerns that may impact on the Health Board's ability to deliver its objectives as stated within the agreed IMTP. Whilst active risk management is performed daily at an

[1] For clarity, Red would indicate no assurances available, Amber would indicate satisfactory sources of assurance available, and Green would indicate a considerable level of assurance with clear evidence that the risk is being managed effectively.

operational level, the Health Board's risk management strategy and process ensures that the Board is informed, engaged, and assured about the approach that Health Board uses to identify and manage perceived risks.

Risk Management Approach, Methodology and Strategy Update

The risk management approach outlined within the current risk management strategy remains theoretically sound and allows for risks to be escalated through the system, as well as strategic risks to be identified by the Executive Team and the Board. When agreed criteria are met for inclusion on the Corporate Risk Register, a recommendation is then made to the Board for inclusion. The Health Board approach contains principles of evidenced-based risk management methodologies and aligns with enterprise risk management (ERM), ISO ISO 31000:2018 - Risk management Guidelines and COSO risk management standards COSO's enterprise risk management framework | ACCA Global.

At the recent Board Development Session on Risk Management, a refreshed approach to utilisation of risk appetite was agreed. This will subsequently change the way in which risk is reported to the Committees, and the Board, and enable greater clarity and consistency of risk scoring, definitions and appetite levels.

A particular focus on internal escalation and clarity on reporting hierarchies is also being developed to fortify the objectives within the strategy. To provide absolute clarity on the system of assurance and risk escalation across the Health Board, the revised Risk Management Strategy will propose a clear escalation structure with agreed trigger criteria for inclusion and escalation on each level. This will support the avoidance of inconsistency of reporting, inconsistency of risk scoring and over inflation of risks for funding purposes.

The revised risk appetite development work that is currently underway with NHS Providers and the Board, will underpin the strengthened escalation framework and promote consistency of risk scoring, based on risk appetite levels. This will enable the Board and its Committees to take assurance that risks are being managed effectively at the most appropriate level. It will also help to empower our staff to apply the principles of risk management effectively within their respective service areas. A diagrammatical depiction of how the escalation framework would become operational is included below:

An Executive Committee session is planned for 27th April 2023 to provide an opportunity for Executives to rigorously review the Corporate Risk Register and potentially reframe, de-escalate and redefine risks already captured. The proposed risk escalation framework will also be reviewed and discussed as part of the report for that meeting.

At the time of writing, a further Board Development Session is scheduled to take place on 26th April 2023, focused on defining and setting the Board's risk appetite, based on feedback received at the last session. The outcome of this work will be pivotal in informing the updated Risk Management Strategy, due to be presented to the Board in May 2023.

Risk Management Community of Practice - Update

The Health Board has successfully established a Risk Management Community of Practice (CoP) that held its inaugural meeting in November 2021. Representation has grown consistently, and the CoP continues to meet every other month. Topics at the CoP include risk appetite and tolerances, business continuity planning, regular updates on the strategic risks reported to the Board and its Committees alongside an 'open' section for staff to share areas of good practice and wider organisational learning on risk management. Further development work has also commenced in relation to assurances, what it is and how it can be evidenced. The Health Board is positive that the community of practice remains a key change agent for a cultural shift in relation to risk management and is pivotal in embedding the objectives within the current and future Risk Management Strategy.

A comprehensive work programme will be developed for the community of practice for 2023/24 and presented to the next meeting scheduled for 9th May 2023.

Asesiad / Assessment

Current Organisational Risk Profile:
There are currently **26** Organisational Risk Profiles, of which **19** are classified as high risks due to the scoring being 15 or greater. The following table provides a breakdown of the risks and level of severity:

High	**19**
Moderate	**7**
Low	**0**

In preparation for the March 2023 Board meeting, the risks that comprise the corporate risk register were subject to Executive risk owner scrutiny, challenge, and review. Robust assessments of the Health Board's internal control system were undertaken, alongside a review of all sources of assurance related to each risk. Based on a calculation of averages methodology, an initial indication on each risk was given a **RAG** rated assurance level. This is in line with Internal Audit methodology when determining assurance levels for audit reviews.

An over-arching, high-level indication of the level of assurance the Committee could derive from the assessment is set out below:

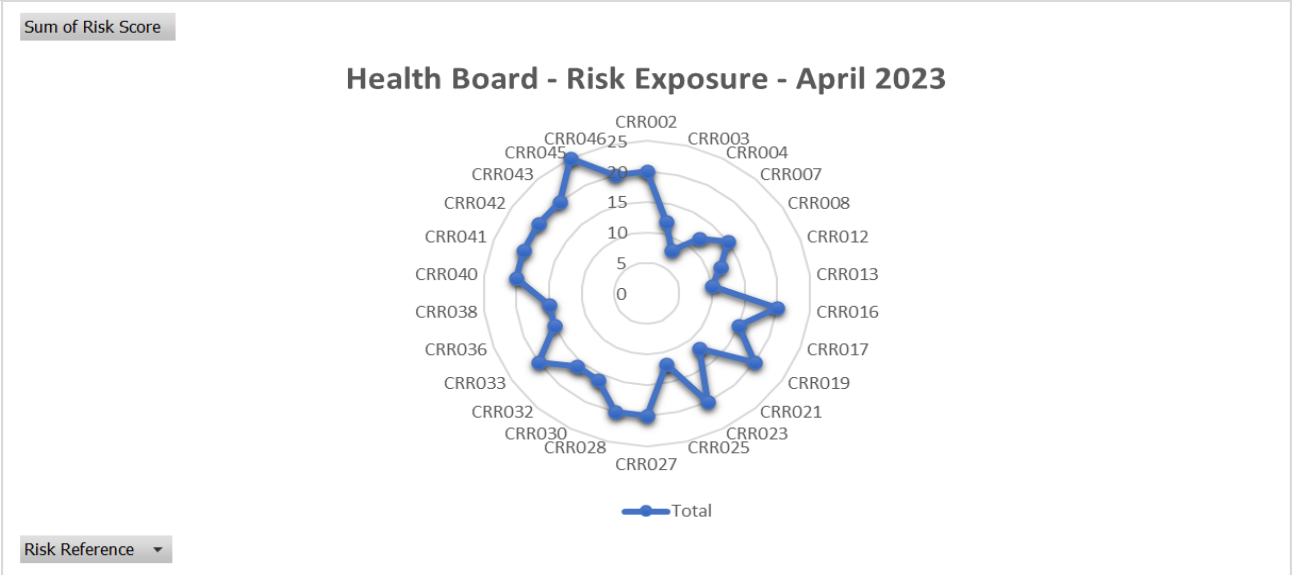
Nil	Satisfactory	Considerable
	X	

This meant that the Committee could take an overall level of ***satisfactory*** assurance that the Strategic risks which comprise the corporate risk register, and which represent significant risks to non-delivery of the IMTP, were being managed effectively. The Committee could also take assurance that the system of internal control to manage these risks was deemed to be ***satisfactory***.

Risk Profile and Risk Exposure [2]

Following the Risk Management Board Development Session on 22nd March 2023, it was agreed that for future reporting, Board members would like the opportunity to review the Health Board's risk exposure as a visual representation. The following diagram has been developed for this purpose and is informed by the current risk scores which comprise the corporate risk register:

[2] The result of the risk analysis process can be used to produce a risk profile which gives a significance rating to each risk and provides a tool for prioritising risk treatment efforts. This ranks each identified risk so as to give a view of the relative importance. **Institute of Risk Management** (IRM)



The diagram clearly demonstrates that the current risk exposure features heavily in the upper limits of the scoring matrix. This is not unusual for strategic level risks and best practice indicates that we would expect to see corporately reported risks as high/significant level as they pose the most significant threat to the organisation.

Changes in Risk Status Since Last Reporting Period

The Committee is requested to note that 4 risks on the Corporate Risk Register continue to be actively managed within an approved and agreed risk appetite/tolerance level, through achievement of a target score; these are:
CRR023 – Avoidable harm to the population
CRR008 – Health Board estate being fit for purpose.
CRR013 – Infection Prevention and Control (IPC)
CRR027 – Vaccination programme.

Escalation of New Risks

The Board agreed at its last meeting for the inclusion of the following risk on to the corporate risk register:

> "**Risk of**: significant dilapidation of Health Board estate
> **Due to**: the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures."

A full risk assessment on this specific risk will be presented to the Board at the May 2023 meeting, once all contributing factors (internal and external) have been considered. The Board will then consider at its July 2023 meeting, how the Health Board will manage the presence of RAAC in its buildings. The outcome of this will then be submitted to Welsh Government for formal review.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE** the overview of the Corporate Risk Register
- **NOTE** that the Board has endorsed a revised approach to risk management including the application of the risk appetite levels, and;
- **NOTE** the revised Risk Management Strategy will be presented to the Board at its meeting in May 2023 in addition to a revised and rationalised corporate risk register.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix 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 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	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	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Respective committees of the Board have considered risks contained within the Corporate Risk Register

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. N/A

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**March 2023 Board**	**PQSO**	**Director of Operations**
CRR002 Failure to recruit and retain staff across all disciplines and specialities leading to adverse impacts on delivery of care to patients across acute and non-acute settings and non-compliance with safe staffing principles and standards. Nursing and	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles.	**No**	**Treat** the impact of the risk by using internal controls.	**March 2023 Board**	**PCC**	**Director of Workforce and OD**

HCSW agencies refusing to contract with the Health Board. **[1](re-framed Nov 2022)**								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PQSO**	**Director of Nursing**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**March 2023 Board**	**PQSO**	**Director of Operations**
CRR007*re-framed July 2022* The Health Board's inability to meet the changing demographic need for its population.	12	8	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.	**March 2023 Board**	**PPHPC**	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships &CDM**
CRR027 'Effectiveness of COVID	20	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of	**Yes**	**Treat** the potential impact of the risk with mitigations.	**March 2023 Board**	**PQSO**	**Director of Public Health**

[1] Links to **CRR016** financial position due to impact of this part of the risk being realised.

vaccination and booster programme compromised resulting from the emergence of a Variant of Concern[2]			the potential of variants of concern as recognised by Welsh Government in its Winter Modelling Update for 2022-23. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.		**Tolerate** the unpredictable element of the VoC and other mutations.			**and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PQSO**	**Director of Operations**
CRR003 – Inadequate and clinically unsafe Mental Health Service provision due to operational impact of WCCIS	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**March 2023 Board**	**PQSO/PPH PC**	**Director of Primary, Community and Mental Health Services**
CRR004 (re-framed Feb2023) Failure to comply with WBoFG Act	8	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**March 2023 Board**	**ARAC**	**Director of Public Health and Strategic Partnerships and Board Secretary**

[2] This risk to incorporate CRR001 to describe an overarching population health vaccination risk for the next Board meeting.

CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**FPC**	**Director of Planning, Performance and ICT**
CRR016 Achievement of Financial Balance [3]	20	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However, responding to COVID 19 implications and maintaining safe services take precedence.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**FPC**	**Director of Finance and Procurement**
CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PPHPC**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position	**March 2023 Board**	**FPC/PPHPC**	**Director of Operations**

[3] Links to **CRR002** – workforce risk.

			Moderate risk appetite with regard to innovation and developments across the Health Board estate.		with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence should the risk be realised, is significant.***			
CRR032 Failure to achieve underlying recurrent financial balance	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**FPC**	**Director of Finance and Procurement**
CRR033 (Dec 2021) Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PPHPC**	**Director of Planning, Performance and ICT**
CRR021 Inability to comply with the Welsh Language Standards as a result of the Welsh Language (Wales) Measure 2011, resulting in Welsh speakers	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**P&C**	**Director of Workforce and OD**

will not being able to receive services in their language of choice. ***(re-framed Jan2023)***								
CRR025 Lack of mental and psychological staff preparedness will have a negative impact on absenteeism and could result in long term sickness with PTSD & other forms of emotional traumatisation. High work-related industrial injury claims and compensation pay-outs. ***(re-framed Jan2023)***	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**P&C**	**Director of Workforce and OD**
CRR036 Clinically unsafe and inappropriate inter-site patient	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PQSO**	**Director of Operations**

transfers and into communities								
CRR038 Increased levels of patient acuity presenting resulting in an inability to staff appropriately and provide acceptable levels of care in line with best practice and guidelines.	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PQSO**	**Director of Nursing/Director of Operations**
CRR040 Putting Things Right (PTR) – Continued and sustained non-compliance with The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011	20	8	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PQSO**	**Director of Nursing**
CRR041 Industrial Action – Failure to sustain current levels of staffing due to industrial action following 2022 pay round and ballots, leading to adverse impacts	20	8	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**March 2023 Board**	**PCC**	**Director of Workforce and OD**

on delivery of care for patients across acute and non-acute settings and non-compliance with safe staffing.***(re-framed Jan2023)***								
CRR042 (re-framed Jan23) Inability to continue provide adequate quality of care to asylum seekers, migrants populations and Unaccompanied Children Asylum Seekers (UCAS)	20	10	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** and acknowledge that some contributing factors are outside of the Health Board's control.	**March 2023 Board**	**PPHPC**	**Director of Primary, Community and Mental Health Services**
CRR043 Cost of living crisis – impact on population of Gwent and staff Levels of staff absence may increase due to the costs associated with travelling to and from work, increased demand for services as population unable to heat their homes adequately, especially	20	12	**Moderate (cautious risk taking) Risk Appetite Level 3**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**March 2023 Board**	**PPHPC**	**Director of Public Health/Director of Workforce and OD**

impacting the elderly population of Gwent.								
CRR045 LINC Programme – IF the new LIMS service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	25	5	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**March 2023 Board**	**FPC**	**CEO**

Safeguarding ***CRR030 – (re-framed Nov 2022) *this risk has interdependencies with CRR002 Workforce Risk**** **Risk of:** 'Hidden Safeguarding Harms' experienced by patients in their homes and communities due to the COVID-19 pandemic and significantly increased demand on Health Board services.	16	8	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PQSO**	**Director of Nursing**

CRR046 – New Risk - "Risk of: significant dilapidation of Health Board estate Due to: the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures."	20	12	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls and eventually **Terminate** the risk.	**March 23 Board**	**FPC**	**Director of Operations**

ABUHB Ref. No.	Audit Type	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	No. of months past original agreed deadline	No. of months past Agreed Revised deadline	If closed and not complete, please provide justification and ensure evidence is available upon request	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 reccomendation?	Reporting Date	Date Added to Tracker	
	External	Structured Assessment 2019	Not Rated	Board Secretary		Not rated	R2 There is scope to improve the quality of the corporate risks register (CRR). The Health Board should review the CRR by the end of March 2020 to ensure it clearly articulates cause and effect, reduces overlap between controls and mitigating actions, specifies controls such as policies and procedures, aligns assurances to controls, indicates whether mitigating action is effective and includes timescales to monitor progress.	The Health Board is in the process of reviewing our Risk Management Strategy, in readiness for approval by the Board in March 2020. 'Risk on a Page' has been introduced and is being further refined to ensure clear links with the IMTP priorities and	31/03/2020	N/A	N/A	Complete	**31**	#VALUE!		CRR process updated with revised reporting templates				31/10/2022	Identified as outstanding in Structured Assessment 2021	
	External	Structured Assessment 2019	Not Rated	Director of Planning, Performance, Digital & IT		Not rated	R3 Board updates on Clinical Futures do not include information on whether planned actions/mitigation are effective, and it is unclear whether risks no longer reported have been eliminated. The Health Board should include information on the effectiveness of risk mitigation in its board updates.	This will be added to future reports.	31/03/2020	N/A	N/A	Complete	**31**	#VALUE!						31/10/2022	Identified as outstanding in Structured Assessment 2021 - As the Health Board moves into the recovery phase of the pandemic, it should consider how progress on the Clinical	
	External	Structured Assessment 2019	Not Rated	Director of Planning, Performance, Digital & IT		Not rated	R4 The recent report to the Finance and Performance (F&P) Committee on progress against the IMTP SCPs did not include progress against the relevant high-impact priorities aligned to them. The Health Board should ensure that committee reports on SCP progress clearly link relevant high-impact priorities with the achievements set out.	Reports have been made on SCPs to Finance and Performance Committee and the Board. This will be regularised in 2020 through the committee and Board forward work programme.	31/03/2020	N/A	N/A	Complete	**31**	#VALUE!						31/10/2022	Identified as outstanding in Structured Assessment 2021 - The Health Board is developing a monitoring and outcomes framework that will enable the Board to monitor, scrutinise and challenge	
	External	Structured Assessment 2017	Not Rated	Director of Finance, Procuement and Value		High	R1 The Health Board should provide more detail to Executives and Independent Members in respect of progress against savings schemes. This should help them to provide sufficient scrutiny and challenge to schemes which are off target.	Current reporting to Board and Finance and Performance Committee (F&PC) provides a summary of savings plans, risk and deliverability. We will look at how to enhance the reporting to ensure that the level of delivery/financial risks is clearly understood both at Board level and where further scrutiny is required at F&PC. This is in addition to the detailed information which is already produced monthly to support Divisional financial assurance meetings	30/04/2018	N/A	N/A	Complete	**54**	#VALUE!		Detailed information on savings shared with Executive Team, Finance & performance Committee and the Board.				31/10/2022	Identified as outstanding in Structured Assessment 2021 - Finance reports provide an overview of Health Board savings progress to date and performance of its high level 'green' savings schemes.	
	External	Structured Assessment 2017	Not Rated	Board Secretary	Head of Risk	High	R3 The Health Board should review risk management arrangements to ensure that corporate risks are appropriately escalated and managed by: a. developing upon its current risk reports to ensure that the context of the risk and progress in managing it are clearly set out; and b. revising the risk rating based on the mitigating actions.	The Health Board undertook a range of revision work to its approach to corporate risk management in 2017 prior to the conclusion of the Structured Assessment with additional training provided for the Board and Executive Team. New reporting formats adopted. The Board is in the process of further developing its approach and will introduce a documented risk and assurance framework following development work planned in line with the risk of non delivery of the IMTP.	30/05/2018	N/A	N/A	Complete	**53**	#VALUE!		Risk reporting established to Board and Board Committees				31/10/2022	Identified as outstanding in Structured Assessment 2022 - The Health Board has reviewed its risk management arrangements and is currently introducing a new approach for	
	External	Structured Assessment 2017	Not Rated	Chief Executive	Assistant Director of Comms and Engagement	High	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	Feb-23		Overdue	**64**			Nov 2022 The Comms and Enagement strategy has now been drafted, and is progressing through internal and external consultation processes. CHC have had sight and commented, citizens panel and some key lms and Executive colleagues.		Low risks determined as work is ongoing with the public, however staff enagement sits within Workforce and OD.		24/11/2023	Identified as outstanding in Structured Assessment 2022 - With the merger of the communications and engagement functions, the Health Board, will review and refresh both	Proposing revised deadline

	External	Structured Assessment 2017	Not Rated	Director of Planning, Performance, Digital & IT		High	R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Boards plans	A Strategic Outline Plan was developed for the Welsh Government in October 2016, which asked for a cost analysis to implement the Welsh Government E-Health and Care Strategy to assess the potential resource implications for Wales. The Health Board is currently revisiting the Strategic Outline Plan and Strategy in the light of the financial context and has also developed a new IMTP for Digital with ten priority areas linked to this Plan. The Health Board has undertaken a review and benchmarking exercise in order to	31/03/2019			Overdue	**43**			Jan 2023 - No update this period.				31/10/2022	Identified as outstanding in Structured Assessment 2022 - There has continued to be increased investment in informatics both in terms of capital and revenue to help
	Internal	IT Service Management, May 2018	Limited	Director of Planning, Digital & IT	Associate Director of Informatics	High	R3 Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	AcceptedWe recognise that this is a priority and that Service Point does not meet the needs of the service to develop the KCS (also identified by this audit) and therefore, Informatics will undertake a scoping and options appraisal exercise to define the requirements, including the resource needed.A business case has been developed for ICT only that seeks to address the concernswithin ICT; this work will inform the requirements of a similar review for Informatics.	31/10/2018	Feb-22	Jan-19	Closed	**48**	9	24/11/22 The remainder of the activity now is sat with DHCW and therefore for AB Audit we propose this is monitored via DDOB and closed.	**Jan-23** Progress on the National Initiative to replace Service Point under the AWIP programme have stalled following submission of Strategic Outline Case to DOF's. Locally there is a preferred solution and a business case is being developed to seek potential funding with this. Satisfactory position in terms of KCS which cannot be improved upon whislt using ServicePoint as the tool - will escalate a risk to the Corporate Risk Register			Implement revised information architecture Define and Implement governance around permissions, review timescales and formats for new artefacts Establish links to service catalogue Ensure criteria for SDI Audit are met	31/10/2022	
	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R4 The Health Board should address areas for improvement in relation to informatics, specifically updating ICT disaster recovery plans and test these to ensure they worked as intended.	key appointments have now been made against a number of positions relating to cyber security. Work is being completed on key personnel polices plans and underlying services. Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team.	31/03/2020	N/A	N/A	Closed	**31**	#VALUE!		**Mar-23:** National Programme still appears stalled. Funding has been secured for local solution to replace service point for Informatics. Conrtact signed with implementation to start Mar 23, go live anticipated in May 23 **Jan-23** Progress on the National Initiative to replace Service Point under the AWIP programme have stalled following submission of Strategic Outline Case to DOF's. Locally there is a preferred solution and a business case is being developed to seek potential funding with this. Satisfactory position in terms of KCS which cannot be			07/03/23 Propose to close	31/10/2022	Identified as outstanding in Structured Assessment 2022 - progress made but not complete
	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R3 The Health Board should improve its information governance arrangements by: • improving compliance with the information governance training programme to reach the national rate of 95%;	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020			Overdue	**32**	1471			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-complance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		31/10/2022	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress against achieving the national rate of 85% with compliance for the organisation currently reported at 74%

	External	Structured Assessment 2018	Not Rated	Board Secretary		High	R1 The Health Board should: • ensure board member induction and training meets the needs of Independent Members;	The Health Board has already introduced a new Induction and training programme for 2018/2019. Several elements of this have been completed. The programme will be completed during 2019. The Health Board is also participating in the redesign of the national NHS Wales Induction Programme.	31/12/2019	Mar-23	Aug-22	Not yet due	**34**	-5		**May-22:** A comprehensive SKMS has now been implemented comprising a knowledge base with c. 1000 articles, a fully indexed and searchable shared document repository and a service catalogue of all Informatics services, fully described for our key services. All areas are cross linked based on Service. Propose that this item can be closed November 2021 Update: Existing knowledge artefacts have been migrated to share point online and are fully searchable and available across Informatics teams.	against achieving the national rate of			31/10/2022	Identified as outstanding in Structured Assessment 2022 - The Health Board does not have local induction arrangements for Independent Members.
	Internal	Job Planning, March 2020	Limited	Medical Director	Interim Director of Operations	High	R1 The Health Board should: · review the escalation process to ensure that it includes appropriate action following escalation to the Medical Director and holds medical staff to account for failure to have an in date job plan; · produce action plans to address poor compliance and review these as part of the monthly divisional meetings with the COO; · complete job plans on an annual basis, as opposed to a 15-month cycle. · consider the process for reviewing job plans and look at ways of increasing compliance, such as aligning job planning dates with other activities (i.e. IMTP /Corporate Planning cycle); and; · agree the job plan and implement an escalation / disciplinary process if there is not a legitimate reason for failure to agree a job plan.	Medical Director to formally write to all DDs with the outcome of this Internal Audit.Escalation Process will be refined giving timelines for response by DDs to Medical Director escalation.Tracker of escalations to be maintained by Medical Directors office.	01/03/2020	N/A	N/A	Complete	**32**	#VALUE!		A review of information architecture is underway which will further consolidate knowledge and categorise by service facilitating a KCS approach. For Service Desk Knowledge, this will be complete by end of Feb 2022 in readiness for our Service Desk Institute Accreditation Audit.	85% with compliance for the			31/10/2022	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager/ Service Lead / General Manager	Medium	R1 The Health Board should periodically review feedback from WAST / staff and patients, incidents, ongoing and expected future costs, overall performance and volume of patients etc. to ensure the expected benefits versus costs are still being achieved.	Agreed.The cost benefit analysis was reviewedagainst the original model and flagged as part of the Clinical Futures Readiness Assessment on 23rdJune. There will be ongoing monitoring of key KPIs.	31/12/2021			Complete	**10**	1471		Monthly meetings with WAST as part of the Tier 2 programme. Implementation of the recommendations of the 6-month review.	organisation currently reported at		This is ongoing as part of the SLA & service specification monitoring arrangements. Proposed	31/10/2022	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Medium	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performancee.g. logging in times and periodically listening to callsand to feedback onperformance;•addressing any training needs that ariseand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. WAST incident numbers, GP surgery etc.;•providingregular refresher training;and•hosting team meetings to share case studies / best practiceand address any issues / concerns that arise.	30/09/2021			Overdue	**13**	1471		work has commenced on QPS and call audit	74%			31/10/2022	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021			Overdue	**13**	1471		Remodelling of service and introduction of APP to FC so KPI to develop in line with new modelling				31/10/2022	

	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R4 We recommend the Flow Centre Team undertake periodic test runs of the business continuity plan against different continuity events. Any learnings or improvements should be detailed specifically in the plan.	Agreed. We will finalise the business continuity plan(BCP)and undertake a test run, including a relocation planto the Grange University Hospital, if required. Any learning or improvements will be incorporated into the BCP.	31/12/2021			Complete	**10**	1471		BCP has now been updated, there have been tests of trial on 2 occasions due to planned power outage and then staffing, to be retested when re sited	moving site from VPH		Mar 23 Updated BCP in place and tested.	31/10/2022	
	Internal	Mass Vaccination Programme, April 2021	Substantial	Director of Public Health and Strategic Partnerships	Deputy Director of Public Health	Medium	R1 The Health Board should review:•how it engages with members of the public who do not have access to the internet; and•advertising the telephone number for the appropriate appointment booking team.	The need to review how the Health Board engages with members of the public who do not have access to the internet is accepted. As part of that review, the Health Board will consider advertising the telephone number and whether the significant operational implications of doing so can be overcome. If advertising the number continues to be too big a risk to the pace of delivery of the programme, alternative options will be provided.	30/06/2021	N/A	N/A	Complete	**16**	#VALUE!		The audit was in April 2021 in the early stages of the programme. Since then a lot of effort has gone into reaching those who have not yet taken up the offer through a range of communication routes including call outs to those who think they are overdue, walk in clinics, local				31/10/2022	
	Internal	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Director of Primary, Community Care and Mental Health	SISU - Strategic Capital and Estates Programme Director and WPWS Programme Manager	Low	R3 We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:•the collection of baseline data;•targets or success measures with which to compare what is actually achieved;•the measurement and recording of the benefit metrics;•responsible managers; and•the oversight body of the benefits, to ensure these are achieved.	Agreed. We acknowledge that a robust benefits realisation plan needs to be developed and we are looking to commission external support to assist with this process for the SISU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.WPWS –to review benefits realisation plans for supporting projects	30/09/2021	May-23	N/A	Not yet due	**#VALUE!**	#VALUE!		Nov 2022 Update: There has been a delay to gaining external support for the benefits realisation plan due to Omicron variant service impact. However Internal benefits work has been undertaken and measurable benefits developed for each service area within SISU. The OBC including benefits realisation is planned to be completed and submitted to the September Board. Benefits realisation plans and measures are being built in to all workstreams of WPWS work. Sanctuary project is being formally evaluated externally. Other alternative to admission				15.11.22	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R1 The Health Board should ensure it clearly documents roles and responsibilities in its governance structures and plans.	Not included within advisory report	31/12/2021	Mar-23	Aug-22	Not yet due	**10**	-5		Accountability & Deployment Framework Included as a governance priority within the IMTP 2022-25				31/10/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R2 Where possible, the Health Board should endeavour to incorporate accountability,reportingand assurance into existing structures, rather than as additional processes which are not sustainable in the longer term.Using the example of the CIP, going forward this could include:i.accountability,reportingand assurancethrough the existing quality and patient safety governance mechanisms;ii.reporting integrated into existing divisional/site-based reports; andiii.CIP compliance assurance integrated into the divisional/site-based clinical audit plans.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Noted for future governance models.				31/10/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R3 The Health Board should clearly document reporting requirements within its governance structures and plans, at each level of the organisation. This should include:i.expected frequency of reporting;ii.level of detail / assurances expected;iii.type of reporting expected, for example, tracking progress, reporting by exception, monitoring key metrics or performance indicators (KPIs), etc;iv.nature of the reports expected, for example, verbal, formal, set template, etc;	Not included within advisory report	31/12/2021	Mar-23	Aug-22	Not yet due	**10**	-5		Accountability & Deployment Framework Included as a governance priority within the IMTP 2022-25				31/10/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R4 Where KPIs or data-driven reporting is used, the Health Board should ensure:i.the data is accurateand can be efficiently accessed; andii.KPIs are presented consistently between the divisions, for example, by clearly defining how KPIs are calculated.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Noted for future reporting requirements.				31/10/2022	

	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R5 The Health Boardshould consider developinga protocol pack for any future surges of the pandemic.This could be implicit within the Health Board's pandemic framework and include, for example:i.Formally identifying governance structures for different surge levels;ii.For each governance structure, identifyinggroups that are required to meet, with clearly documented terms of reference identifying:a.roles and responsibilities;b.anticipated membership, including leadership of the group;c.frequency of meetings;d.reporting requirements (see recommendation6below);ande.records required to demonstrate monitoring, scrutiny and decision-making, for example, minutes, action log, decision log, etc(see recommendation4below).This should take into accountrecommendation 2 above.	Not included within advisory report	31/12/2021	N/A	N/A	Closed	**10**	#VALUE!		Response would vary dependent on type of variant and impact. Learning from the pandemic is embedded in new ways of working.				31/10/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R6 The Health Board should ensure meetingminutes appropriately demonstrate monitoring, scrutiny,decision-makingand assurance, particularlyif reporting isinformal /verbal.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Noted as a principle of good governance.				31/10/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R7 When developing action plans, the Health Board should ensure:iii.the plans contain clear timescales and milestones;iv.clarity is provided on demonstrating progress, for example, RAG rating definitions and requirements for validating progress; andv.benefits and key metrics are defined within the plan.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Noted as a principle of good governance.				31/10/2022	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R1 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	A review of categories of well-being support will be undertaken to ensure staff can readily locate the support that best fits their need.	31/03/2022	N/A	N/A	Complete	**7**	#VALUE!		April 2022 A review of categories of well-being support will be undertaken to ensure staff can readily locate the support that best fits their need. Our understanding of the wellbeing needs of the workforce is evolving as it is based in part on our 4 monthly wellbeing survey. As such we regualry review what support we offer in line with demdn and changing needs.				31/10/2022	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R2 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same).However, the team will review a system of describing what others found helpful. This will enhance the current offer of feedback and satisfaction questionnaires completed by staff following an intervention. The development of an evaluation framework that has commenced with Cardiff Metropolitan University to evaluate the implementation of the Well-being Centre of Excellence will also support this recommendation.	31/03/2022	N/A	N/A	Complete	**7**	#VALUE!		April 2022 This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same).However, the team will review a system of describing what others found helpful. This will enhance the current offer of feedback and satisfaction questionnaires completed by staff following an intervention. The development of an evaluation framework that has commenced				31/10/2022	

	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R3 RecommendationThe Health Board should:•Review each initiative versus the time and financial cost to provide the service against the staff uptake and value / benefit of the initiative. •Consider additional analysis to help assess and target wellbeing initiatives to staff requirements.•Consider establishing wellbeing KPIs or other performance metrics to measure the success of the strategy and specific initiatives.	Calculating the relationship between financial investment and value is a complex process due to the range of clinical and individual variables. Outcome data is regularly collected and evidence based practice followed, the evidence base is evolving and ABUHB is at the forefront of developing this evidence and outcome data.The additional analysis recommended will be provided via the quarterly well-being surveys and deep dive work within divisions. The next well-being survey has enhanced questions that link back to the 6 pillars of the Employee Experience Framework.•The Employee Well-being team will take the recommendation around KPI'sunder consideration and further explore the additional functionality of the new version of the clinical recording system(CORE)now in use.	31/03/2022	N/A	N/A	Complete	**7**	#VALUE!		**Sept 2022** The wellbeing needs of the workforce are complex and evolving, our methods of monitoring offer valuable high level insight but limited granularity. To date we have run and evaluated six healthboard wide wellbeing surveys so have a data base of over 16,000 respnses across over two years. This tool helps us monitor the changing complex wellbeing needs across the organisation via local divisional leadership teams (DLTs) and professional leads. In addition we	We have not been successful in securing the Welsh Government bid (£1.6 mIllion) this represents a challenge to our plans to develop the Wellbeing Centre of Excellence. Alternitve funding methods are being explored.	Alternative methods of funding including income generation are being explored.		31/10/2022	
2021.11	Internal	GUH – Equipment Procurement Assurance - Follow up	Reasonable	Director of Planning, Digital & IT	Project Director	Medium	Management should ensure the ability to utilise "as fitted" water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Lessons learnt from equipment has been picked up as part of the broader lessons learnt report but a review by procurement alongside other projects would be beneficial.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Noted for future procurement				31/10/2022	25/03/2022
2021.11	Internal	GUH – Equipment Procurement Assurance follow - up	Reasonable	Director of Planning, Digital & IT	Project Director	Low	R7 Single Tender / Single Quotation Actions should be reported to the Audit Committee in a timely manner, in line with SFIs, to enable effective scrutiny (O).	Agreed, all outstanding STAs will be taken to the next Audit Committee.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		All outstanding STA's present to Audit Committee Dec 2021. Central process in place to ensure reporting of STAs to Audit, Risk & Assurance				31/10/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	MCA Lead/Head of DOLS	Low	R1 We recommend that procedural documents that have passed their stated review date are updated where required to reflect current legislation.	Agreed This procedure will be reviewed and updated with pace.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		Awaiting Excutive review and sign off of the amended policy and assessment documentation	MCA Forum established. MCA educational training policy agreed at Educational Group			31/10/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R2 We recommend that the 'best interests' discussion for patients assessed as lacking capacity is documented in the designated pages of the capacity assessment document in all cases.	Agreed A reminder will be issued across the organisation regarding robust completion of documentation.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		Awaiting Executive sign off of staff memo re Best Interest Decisions	MCA Forum established			31/10/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	HIgh	R3 We recommend that, excepting where there is no reason to doubt that the patient has capacity, DNACPR decisions forms are accompanied by completed Health Board patient capacity assessment forms in all cases.	Agreed A reminder will be issued across the organisation regarding completion of DNACPR and Capacity Assessment forms.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		Awaiting Executive review and sign off of the staff memo re DNACPR	MCA Forum established. Staff educational film developed and cascaded.			31/10/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Clinical Executives	Low	R4 The All Wales DNACPR policy must be complied with in full without exception. We recommend that succinct but sufficient details of patient or relatives' discussions are recorded on the All Wales DNACPR forms in all casesin order to ensure that the policy is complied with.	Agreed Correspondence will be sent to clinicians outlining the importance of detailing discussions with relatives.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Awaiting Executive review and sign off of the staff memo re DNACPR	Memo. MCA forum established. DNACPR educational published. MCA educational video also published			31/10/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R5 We recommend thatmanagement remind ward staff conducting capacity assessments of the need for competency in this area and that theyseek competency status from each relevant member of staff and if necessary ensure that relevant training is accessed and completed.	Agreed Correspondence will be issued to Divisions, for cascade, highlighting the training available.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		Information sent to Divisional Leads around training December 2021. Full training programme in place now that MCA Specialist Practitioners have been appointed. Training policy developed and approved.				31/10/2022	25/03/2022
2021.02	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent	31/10/2021	Mar-23	Aug-22	Not yet due	**12**	-5		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25				31/10/2022	25/03/2022
2021.01	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	Mar-23	Aug-22	Not yet due	**12**	-5		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25				31/10/2022	25/03/2022

2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Head of Legal Services	Low	R1 Management should update the policies and procedures available to staff on the intranet and ensure only those that are in date and reflect current practice are maintained.	Agreed.Outdated Policies will be removed & existing policies will be updated to reflect changes to WRP and portfolios.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		The policies were updated following internal audit recommendation. They have been approved, and updated to intranet.				31/10/2022	25/03/2022
2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Director of Nursing	Medium	R2 Before payment is processed,clinical negligence cases which have damages in excess of £100k,mustprovide evidenceas having been approved by the LitigationGroup. Where payment needs to be made before the next Group meeting and the Group is unable to reconvene before this date, the Legal Services Team should issue an email to the members of the Group informing them payment will be made before the next meeting and any objections to this payment should be identified immediately. Additionally, the BACs payment sheet should be updated to include the date the case will be brought to the Litigation Group for retrospective approval. This should serve as one of the final checks prior to payment.	Agreed for immediate action	15/12/2021	N/A	N/A	Complete	**10**	#VALUE!		These changes were introduced following the internal audit recommendation. Operational Policy has been updated to reflect the change.				31/10/2022	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R1 Divisions should provide assurance that actions arising from a complaint investigation areaddressed,with ongoing monitoring, depending on the significance of the action. Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The Assistant Director of Nursing will confirm this requirement with all Divisions and a process of audit will be introduced, led by the Corporate PTR Team, for assurance.	31/10/2021	N/A	N/A	Complete	**12**	#VALUE!		The Health Board implemented a new system (RLDatix) for recording and managing complaints on 1 October 2021.This required training and education for users. Go live is June 2022.				31/10/2022	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R2 Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The functionality of the new Datix system will be confirmed for all Divisions prior to implementation, together with the expectation that reports generated from Datix will be formally discussed in Divisional QPS meetings to monitor performance and learning.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Positive meeting with NCCU - action addressed.				31/10/2022	25/03/2022
2021.04	Internal	Charitable Funds	Substantial	Director of Finance	Charitable Funds Manager	Medium	R1 The Health Board should:a)Engage with ward staff via alternative mediums, e.g.,Teams presentations, presentations to Divisional Management Team meetings.b)Establish a timeframe for restarting ward visits and training sessions.c)Continue to promote the Charitable Funds Financial Control Procedure.	a.Agreed. Presentations to be prepared by December 2021 with roll out to commence in the new year with a view to completing by March 2022, confirming suitable dates with the divisions. b.Agreed. Face to face meetings will be dependent on advice from Infection Prevention and Controlbut meetings will be arranged by Teams liaising with relevant ward staff to arrange meetings prior to March 2022.c.Agreed. There will be follow up e-mails by the Charitable Funds Team to a and b above providingthis information.	31/03/2022	Oct-22	06/10/2022	Complete	**7**	0		The slide presentation has been completed covering the areas identified. Infection cntrol have confirmed that face to face meetings can now take place. The Charitable Funds teamswill provide training commencing in October by both face to face meetings and Teams training sessions.	The delay in implementation was partly due to the year end Audit of the 2020/21 Charitable Fund Accountst which wasnt completed until January 2022 and the completion of the 2021/22 Draft Annual Accounts and rAnnual Report which were presented to the June Charitable Funds Committee.			31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R1 Clarity should be sought over the rolesandresponsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner.ABUHB Radiologyinternallyrequest on service point if the department knows the server team need to undertake work. We will continue to do this.				Complete								31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMBfor an integrated electronic process cannot be delivered.The Health Boardshouldcarryout an analysis to fully identifyits needsfor a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	Jun-23		Deadline Revised	**7**	-8		The UAT has been passed and is with clincial apps and Mr Rice to look at.	Needs to be agreed locally and product developed to suit ABUHB			31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	High	R3 Whilst we understand the Health Board isin the process of planning to upgrade to the 2016 version we highly recommend that the Health Board expeditesthe upgrade.	This upgrade took place on 14thNovember however only application server was upgraded. DHCW and ABUHB are working closely to plan the rest of the upgrade. However DHCW will not touch the RadIS local database which stores all of our crystal reports and letters. This is a risk and we havegone to our server team internally to plan anbackupsolutionfor the RadIS local database.	30/04/2022	Jun-23		Deadline Revised	**6**	-7						31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R4 The Health Board should seek clarity over what maintenance tasksare expected and establish a process to ensure that these are completed.	There is a backupregimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022			Complete	**7**	1471		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		31/10/2022	25/03/2022

2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R5 a.The Board should investigate an electronic solution to uploading requestsinto WRIS.b.The Board should introduce a completeness check to ensure that all requestsreceived have been entered into WRIS.	a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	31/03/2022	Jun-23		Deadline Revised	**7**	-7		The UAT has been passed and is with clincial apps and Mr Rice to look at.	Needs to be agreed locally and product developed to suit ABUHB			31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R6 a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have5attempts.				Complete								31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	Jun-23		Deadline Revised	**6**	-7						31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R8 The Health Boardshould request that this logging function be developed.The Health Board shouldconsider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	Jun-23		Deadline Revised	**7**	-7		Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.			31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	Jun-23		Deadline Revised	**6**	-7						31/10/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022	Jun-23		Deadline Revised	**6**	-7						31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations		Low	R1 The Pathology Team should consider updating the External inspection Policy to include one centralised repository for all external reportsthat incorporatetimescales for a responseand provides a clear overviewof progressacross all areas.	Will ensure reportsare maintained in a centralised repositoryand ensure the policyis updated accordingly	24/02/2022			Overdue	**8**	1471		Policy updated and inspection reports collated in one repository				31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 a.All instances of non-conformance identified in the reports should be recorded centrally to support periodic trend analysisand in particular theCAPA module within QPulse.	a.Log UKAS inspection as one single CAPA within QPulse and update progress as per any other non-conformity	24/02/2022	N/A	N/A	Complete	**8**	#VALUE!		UKAS inspections recorded and progress updated in Q-Pulse				31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 b Periodic trend analysis / pattern identification should be completed across all instances of non-conformanceand used to identify common areas of concern for corrective/preventiveaction.	.Try to identify themes and trends across Pathology, though inspections are held at different times of the year for each discipline so not as straightforward.	TBC	N/A	N/A	Not yet due	**#VALUE!**	#VALUE!						31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R3 Liaise with the ABUHB emergency planning team to go through their process for completion of all business continuity planningdocumentation.	Discipline Managers have been liaising with emergency planning team and will continue to do so.	24/02/2022	N/A	N/A	Complete	**8**	#VALUE!		UKAS inspections recorded and progress updated in Q-Pulse				31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R4 Establish aschedule for testing BCPsat all locationsand across a range of likely continuity events.	Will establish a schedule for testing across Pathology	24/12/2021	N/A	N/A	Complete	**10**	#VALUE!		UKAS inspections recorded and progress updated in Q-Pulse				31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R5 The Pathology Team should seek to automate as much of the performance reporting as possibleand includeall test results within the KPIs.	Will horizon scan for new technologies to deliver automated TATs	24/02/2022	N/A	N/A	Complete	**8**	#VALUE!		UKAS inspections recorded and progress updated in Q-Pulse				31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R6 If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis appropriate.	If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis appropriate.	24/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Policy includes sampling procedure.				31/10/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R7 A scorecard/ dashboard reportshould be developedto provide an overview of performance against the key measures/ risks withinPathology.	Scorecard currently in progress and being populated	24/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Pathology scorecard was being populated during audit, now in use across Pathology				31/10/2022	25/03/2022

2021.05	Internal	Pathology	Reasonable	Director of Operations	Assistant Directorate Manager	Low	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2021			Overdue	**20**	1471		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.	31/10/2022	25/03/2022
2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R1 The Health Board should:a)Remind clinical staff of the need to promptly update the administration section of a patient's file.b)Consider the value and benefit derived from using the administration section versus the effort required to maintain the latest position.	a.Issue included on the agenda(item 11a) of the Occupational Health Senior Clinical and Administration team meeting held on the 20thOctober 2021.b.All membersof the occupational health team involved in the process have been communicated with on the 8thNovember 2021to improve management of this data set.c.A monthly report query will be introduced from the 1stDecember 2021 to capture any outstanding issues as an additional assurance layer.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		**April 2022** a.Issue included on the agenda(item 11a) of the Occupational Health Senior Clinical and Administration team meeting held on the 20thOctober 2021.b.All membersof the occupational health team involved in the process have been communicated with on the 8thNovember 2021to improve management of this data set.c.A monthly report query will be introduced from the 1stDecember 2021 to capture any outstanding issues as an additional assurance layer.				31/10/2022	25/03/2022
2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R2 The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately.b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1stNovember and is planned to conclude on March 31st2022. Health function. A detailed service review is	31/03/2022	Oct-23	06/10/2022	Not yet due	**7**	-12		**April 2022** a. The planned introduction of an online referral process has been halted as a new database is being procured on an all Wales basis. b/c. Welsh Government review of Occupational Health in the NHS is currently being undertaken (April 2022). OT pilot completed and the recommendations are being considered.	01/09/2022 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	Ongoing review of skill mix and resources to meet the deamands of the service .	Autumn 2023 for full implementation following procurement and implementation of the new data base.	31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with external Project Manager	Medium	R1 The Project Execution Plan should be updated to reflect the current stage of the project / programme.	Agreed. Will liaise with the external Project Manager to issue an updated version.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		The PEP was updated at the commencement of construction				31/10/2022	25/03/2022

2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R2 To enhance current arrangements, the terms of reference for the Project Team and Project Board should be reviewed and updated accordingly to include: • Coverage of frequency of meetings; • Quoracy for decision making; • Requirement for delegated deputies to be in attendance when there are periods of absence; and • The correct membership (named as generic roles / departments) reflective of both the project named management and current stage of the project.	Agreed. The terms of reference are currently being reviewed and updated for the recommended points including reference to the current stage of the project and the expectations of ownership by the members of the Project Team / Project Board.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		The Terms of Reference of both have been updated				31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with the Cost Adviser.	Medium	R3 The Cost Adviser reports should be updated to incorporate a summary cumulative position to better visualise the current financial position of the project	Agreed. Whilst there is additional information available to the project team to understand the current financial position, it would be helpful to have the 'snapshot' in the Cost Adviser report. Will liaise with the Cost Adviser to include within the reports.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		This is being provided				31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R4 Welsh Government dashboard returns should be shared with an appropriate forum.	Agreed. The latest dashboard was shared with Project Board on 19 October 2021.				Complete								31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R5 Confirmation notice 1 should be finalised as soon as possible for both the Cost Adviser and Project Manager..	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		Nov 2022: Recommendations have now been addressed. Make a recommendation to the Audit Committee that this now be closed.			Further audit being undertaken on Tredegar Health and Well being Centre	20/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R6 Recognising that main construction works have commenced on site, Confirmation Notice 2 should be executed as soon as possible.	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!						31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R7 Agreed. Both recommendations are being addressed as a matter of urgency.	Agreed. Discussions will be held with all relevant parties to confirm the delay damages calculation, and agreed amount, to be included in Confirmation Notice 2.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!						31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R8 Noting that no action can be taken at this project, management should ensure that the requirements of the NHS Wales Investment Infrastructure Guidance are applied at all future projects with regard to Enabling Works and Advanced Works.	Agreed. NHS Wales Investment Infrastructure Guidance will be followed on all future projects.	Noted for future projects	N/A	N/A	Complete	**#VALUE!**	#VALUE!		No Action required , noted for future projects				31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R9 The Project Director should advise the UHB Board of the actions taken to award the Enabling Works element of the contract and the non-compliance with the NHS Wales Investment Infrastructure Guidance.	Agreed. The issue was raised at Project Board and will be raised / discussed further in the first instance at the Strategic Capital and Estates Workstream. It should be noted that the demolition process was conducted via a separate contract and the provision of compensation event for the subsequent grouting was, and is considered, to be the correct approach. It is accepted that the Advance Works should have had a separate contract.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		No Action required , noted for future projects				31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R10 Post submission of KPIs, the Project Board should discuss the collective output [and trend of previous submissions] to ensure issues with performance are reviewed and addressed in an appropriate and timely manner.	Agreed. Collective discussions are now being held for the returns on all current projects. It would be preferred if these discussions were held prior to submission of returns to NWSSP:SES, but it is acknowledged this is not the expectation for collation of DfL data	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Overtaken by events, Shared Services do not want collective discussion on KPIs				31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R11 The risk register should be reviewed to incorporate applicable costs; with the costs regularly reviewed to facilitate monitoring of the project.	Agreed. The initial project risk register informed the FBC contingency pot [September 2020]. Work is underway to complete a reconciliation for the current financial position to review how much of the contingency sum will be consumed with the correct projected overspend for the project. This will then be further analysed to cost the risks, as applicable, on a line-by-line basis.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		Risk Registers are reviewed on a quarterly basis				31/10/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R12 The risk register should be updated to reflect the current risk regarding the financial position of the project, and the proposed mitigating actions / countermeasures.	Agreed. This risk, and any other new ones identified, will be included in the next risk register review scheduled with the external Project Manager.	30/11/2021	N/A	N/A	Complete	**11**	#VALUE!		Risk Registers are reviewed on a quarterly basis				31/10/2022	25/03/2022
2021.09	Internal	GUH: Technical Assurance	Substantial	Director of Planning, Digital & IT	Estates Manager	Low	Management should ensure the ability to utilise "as fitted" water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Agreed. A capital bid has been submitted by the division to (a) employ full time CAD staff to keep records up to date and (b) to have access to the third-party software.	31/03/2022	N/A	N/A	Complete	**7**	#VALUE!		Noted for future procurement				31/10/2022	25/03/2022

202102.00	External	Radiology services: follow-up of 2017 recommendations	Not Rated	Director of Operations	Arvind Kumar	Radiology Directorate Manager	Not rated	R4 The Health Board should look to further develop its collection of patient experience information across its sites and seek to identify any common trends that can be actioned to improve the service. Follow up 2021 - Whilst the Health Board has made positive progress against this recommendation, we feel unable to close this recommendation until the Health Board has implemented the site-specific PREM and reintroduced the comments box. In terms of learning, it would be helpful for the Health Board to identify how learning from patient feedback has made a difference and led to improvements.	A site-specific PREM was introduced, including a comments section, in 2019. This PREM was adapted in 2020 to include COVID-specific questions. Improvements made to service as a result of service user comments have included updating and refreshing the waiting areas, signage and staff education. In 2021 the PREM was updated once again to capture all elements of the service, including the booking	31/03/2018	N/A	Complete		**55**	#VALUE!		The electronic PREM is an ongoing project which we aim to run on a quaterly basis. The data from previous paper PREM to be collated and displayed at each site.		N/A	31/10/2022	
202101.00	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD		High	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	Jun-23	06/10/2022	Not yet due	**6**	-8		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.	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.		Rollout of E-systems commences Feb 2023	31/10/2022	25/03/2022
202101.00	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		High	The HealthBoard should hold workshops with Audit Wales to discuss what information is required to provide assurance for the audit, and what are the best ways of obtaining this.	A workshop will be arranged with Audit Wales in January 2022 to ascertain the information required in order to substantively test payroll transactions. Relevant Health Board employees will be invited to attend this workshop to ensure that going forward information is provided in the format required and on a timely basis.	31/01/2022	N/A	N/A	Complete	**9**	#VALUE!						31/10/2022	25/03/2022
202101.00	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Planning, Performance, Digital & IT		Medium	The HealthBoard should consider strengtheningtheirIT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Wellsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the	31/12/2021			Overdue	**10**	1471		"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."				31/10/2022	25/03/2022
202101.00	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Board Secretary	Head of Corporate Governance	Medium	The draft Annual Reportand Annual Governance Statement should be subject to a Quality Assurance review to ensure compliance with the Manual for Accounts, with evidence of this review submittedfor auditas part of the supporting working papers.	A checklist will be prepared to identify each area within the Manual for Accounts and link to the relevant part of the Annual Report and Annual Governance Statement. This checklist will be submitted to Audit Wales with the draft documents to facilitate review.	31/05/2022	N/A	N/A	Complete	**5**	#VALUE!		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				31/10/2022	25/03/2022

202101.00	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		Low	The new asset tagging system should be implemented as soon as possible, and in readiness for the audit of the 2021-22 financial statements.	The interface between the Fixed Asset Register (Asset 4000) and the new RFID system is complete. The team are working through final issues identified on the user testing of the interface between the EBME equipment register and the RFID system during November 2021, with a view to going live with the system by the end of the month. The user training sessions have taken place. The tagging of new and existing equipment assets has commenced with around 1400 assets tagged to date. The programme of tagging of existing assets will run into the 2022/23 financial year due to the volume of assets and current capacity of staff. However, the finance team are progressing a fixed term appointment to support the delivery of this work over the next year.	31/03/2023	N/A	N/A	Complete	**-5**	#VALUE!		ii. Currently we have 3 devices remaining. The team will continue to liaise with the services to remove the last remaining.				31/10/2022	25/03/2022
202103.00	External	Audit of Accounts Report – ABUHB Charitable Fund and Other Related Charities (Dec 2021)	Not Rated	Director of Finance, Procurement & Value		Medium	FCPs not being updated to reflect the changing profile of the investment portfolio. In addition, the Charitable Fund should consider having clearer procedures regarding the classification of income.	The Charitable Funds financial control procedure is reviewed on a 3-year rolling basis and is due for review in July 2022. Going forward, additional reviews will be carried out on an annual basis to ensure that the procedure remains relevant and that no significant changes have occurred since the last review.For clarity, the income section (section 9 of the current financial control procedure) will be enhanced to include a more detailed section on the types of income received by the Charity and how the classification is determined, eg grant, donation, legacy etc. and the documentation required to be obtained/retained to verify this classification.	31/07/2022	N/A	N/A	Complete	**3**	#VALUE!		iii. Confirmed this was completed.				31/10/2022	25/03/2022
202104.00	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		Not rated	R1 NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	Occupational Health are piloting an Occupational Therapy Service until the end of March 2022 to support staff with post covid syndrome. The work has been supported and funded by the Post COVID Recovery Service and work is ongoing to formalise the service pathway to ensure equitable provision for the whole workforce. A review of this pilot will be conducted in March to identify whether there is scope to expand this service to support our workforce with other underlying ill health conditions.	31/03/2022	N/A	N/A	Complete	**7**	#VALUE!		iv. Confirmed this was completed.				31/10/2022	25/03/2022
202104.00	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		Not rated	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called "#PeopleFirst, #CynnalCynefin, reconnecting our workforce". The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-executive support.	31/12/2022	N/A	N/A	Not yet due	**-2**	#VALUE!		**April 2022** The project team have concluded phase 1 and 2 of the project. Phase 1 was establishing key comms methods. Phase 2 was hosting executives and General managers of site to connect with staff to understand their issues and needs to improve their experience of work. 26 session were completed, speaking with over 250 staff, raising 143 issues of which 75% have an answer. September 2022 Phases 1 and 2 have been presented widely across the organisation including the Board, Execs, TUs and professional leads. Phase 3 will include a continued informal extention of phase 2 (until september 2022) and also working with	The barriers to implementation of the next phases of this project are fourfold. Firstly the workload demand of the staff and having the time to be part of this project, second is the ownership of this project within the local teams and who 'owns' the issues log and third, several divisions are merging crating a disruptive effect and finally we are entering a winter period of predcted extreme, unprecedented pressure.	The project team are engaging with the DMT and also professional leads and describing the methodology and apporoach for the project. We are engaging the teams to understand where and when is best to work with thir teams.	Implementation of the 3rd phase has started. Meetings are ongoing with DMTs and we are awaiting their communications on next steps to work deeper in the organisation.	31/10/2022	25/03/2022

202105.00	External	Structured Assessment 2021	Not Rated	Director of Planning, Performance, Digital & IT	Associate Director of Communications and Engagement	Not rated	R1 The Health Board's website contains some outdated information relating to its governance arrangements and incomplete performance data which is not supported by appropriate explanatory information. The Health Board, therefore, should take immediate action to ensure: • Content is well organised, easy to navigate, clear and concise, and • Key information / data is up-to-date and in a format that the public and stakeholders can interpret and understand.	The Health Board accepts this recommendation. The website is in the process of being reviewed and updated to reflect suggestions made including, ensuring all fundamental Health Board information (related to Board, Committees, and governance arrangements) is accurate and up to date for the public and stakeholders. Further developmental work will be required to ensure Divisional engagement around local pages on the website are kept up to date with useful and meaningful information. However, it should be acknowledged that the resource required in order to conduct such a substantial review is not inconsequential.	31/03/2023	N/A	N/A	Not yet due	**-5**	#VALUE!						31/10/2022	25/03/2022
202105.00	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R2 Some Board members have expressed concerns about the volume of work now undertaken by some of the committees and the robustness of the arrangements for ensuring flows of assurance. The Health Board, therefore, should complete its review of the new governance structure by its intended deadline of April 2022 to be assured that it is operating as intended.	The Health Board accepts this recommendation. A complete and robust Committee and Board effectiveness exercise will be undertaken by April 2022. The Health Board accepts this recommendation. A complete and robust Committee and Board effectiveness exercise will be undertaken by April 2022.	30/04/2022	N/A	N/A	Complete	**6**	#VALUE!		Committee Structure reviewed and revised in March 2022				31/10/2022	25/03/2022
202105.00	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R3 Recent staff turnover within the Corporate Governance Support Team has impacted on the quality of service it is able to provide to the Board and its Committees. The Health Board, therefore, should review the effectiveness of its Corporate Governance Support Team as soon as possible to ensure that it has sufficient resilience and capacity to support all governance functions. Arrangements should also be put in place to ensure staff are able to access suitable training / learning opportunities to develop their knowledge and skills within their respective roles.	The Health Board accepts this recommendation. The Health Board will undertake a review and endeavour to ensure adequate and appropriate corporate governance capacity to fulfil the statutory functions of the Board and the Committees, enabling it to discharge its functions. It should be noted that external training in specific corporate governance, information governance and accredited risk management has been undertaken over the last two years, despite the pressures of the pandemic. This demonstrates the Health Board's commitment to develop and enhance skills within its governance team. However, it is also recognised that further mentorship and training programmes could be developed in order to 'future proof' the department and provide a robust corporate governance function.	30/09/2022	May-23	Aug-22	Deadline Revised	**1**	-7		Mar 23 - Consultation process currently underway for a re-strcuture of the corproate governance team. This will enable the recommendation to be implemented. ARAC to be updated with final outcomes as soon as they become available. Request revised deadline date of 31st May 2023				31/10/2022	25/03/2022
202105.00	External	Structured Assessment 2021	Not Rated	Board Secretary		High	R4 The Health Board has experienced significant changes in its Executive Team and cadre of Independent Members resulting in several interim Executive Director appointments and is currently recruiting to two independent member vacancies. However, maintaining these temporary arrangements indefinitely alongside the turnover of Independent Members present risks at a time of significant operational pressures. The Health Board, therefore, should seek to make permanent appointments to these key Executive Director roles at the earliest possible opportunity. In addition, there remains a need for the Health Board to strengthen its induction and training for new Independent Members in line with our recommendation in 2019	The Health Board accepts this recommendation. Independent Members Interviews have now been undertaken for Independent Members for Finance and Digital and the recruitment process for this continues to progress. Continued liaison with the Public Appointments Team to progress the substantive recruitment of the Vice Chair and an Independent Member for Community is anticipated to progress from February 2022. Executive Team: Chief Executive Officer (CEO) – interim arrangement to be continued during 2022. Director of Primary Care, Community & Mental Health – recruitment in process. Director of Finance & Procurement – interim appointment to be extended in line with Interim CEO arrangement. Deputy CEO – interim appointment to be continued in line with Interim CEO arrangement. Interim Director of Operations – current interim appointment until April 2022. Recruitment	30/04/2022	Mar-23	Aug-22	Not yet due	**6**	-5		Board Member Induction Included as a governance priority within the IMTP 2022-25. Board Member vacancies progressing with most now appointed to.				31/10/2022	25/03/2022

202105.00	External	Structured Assessment 2021	Not Rated	Director of Planning & Performance		High	R5 The Health Board has not finalised its monitoring framework due to the pandemic, subsequently there continues to be limited oversight and scrutiny at Board-level on overall delivery against priorities outlined in the 2021/22 Annual Plan. The Health Board, therefore, should complete the development of its monitoring framework as soon as possible to allow the Board to review and if necessary, challenge delivery of its strategic priorities and progress against the Annual Plan and future Integrated Medium-Term Plans.	The Health Board accepts this recommendation. The delivery framework of the 3 year IMTP process did include a quarterly monitoring report structure which has not been completed this year against the annual plan due to the challenges of the Health Board's response to the pandemic and other priorities. The shared objective of developing a comprehensive outcomes based framework for the organisation is a developmental one and progress has been limited in this area due to the challenges associated with the pandemic, a change in leadership of the performance function (due to the Exec team changes referenced in the report) and due to Welsh Government developing an All Wales outcomes framework that would enable the Health Board to align a local framework to. The Health Board will therefore develop the first iteration of an outcomes framework for 2022/23 to support the 3 year IMTP and align to the Welsh Government framework. The	30/06/2022	N/A	N/A	Complete	**4**	#VALUE!		Outcomes Framework in place				31/10/2022	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021			Overdue	**16**	1471		"Jan-23 - Training for office of the SIRO completed and update to be provided to Exec Team Dec 22. GAB will report and make escalations through this new office. GAB Board established with ToR drafted.providing GAGS with reporting mechanism and KPIs which will be escalated to the OSIRO where required. SIRO				31/10/2022	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R2 A register of compliance requirements for all IM&T related legislation and standards across the whole organisation should be developed for the IGC along with a process for assessing status and reporting upwards to Committee.	Agreed. Currently the establishment, processes and mandate of informatics in ABUHB does not extend (with the exception of IG) beyond the directorate. In terms of accountability where devolved responsibility exists for information assets the same level of scrutiny and compliance should be applied. A corporate risk will be submitted with the recommendation of a strategic options appraisal for Board consideration and within this the role of Informatics as a Directorate will be considered along with other corporate and clinical divisions.	31/12/2021			Overdue	**10**	1471		"Jan-23 - Revised and new policies completed and ready for sign off by the new SIRO which can then be disseminated through the GAGS and on the intranet. Identification of Senior Information Asset Owners and Information Asset Owners is the next stage and accountability to be assigned. Aug 22: New suite of 18 policies currently being internally reviewed and will be ready for policy group in mid September for sign off. Jun-22: Presentation to Board and establishing HBOTS over next 6 months with ToR and training delivery scheduled. New suite of policies to be completed in next 30 days and GAGS to help with rollout and				31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R3 Management should consider enhancing the risk management process in place within the Health Board by providing an annual report that identifies risks that have a low likelihood, have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.	Accepted. Part of the new governance will focus on the objectives of the CDO as SIRO for the Health Board. Following the review and adoption of the Target Operating Framework and HB exec oversight a programme will commence to adopt new policies, training and performance management of ICT and Information Asset including training for Information Asset Owners.	31/03/2022			Overdue	**7**	1471		"Jan-23: Agreement for Rani Dash to take on the role of SIRO, Training completed. New policies awaiting her review and identification of the SIAO and IAO roles in order to provide training. Update to Board being provided by Rani Sept 22: SIRO training has been				31/10/2022	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	ADI Governance and Assurance	N/A	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021			Overdue	**10**	1471		"Jan-23 - Domains aligning risk registers with the Corporate template and to publish so that there is visibility of the entire Informatics Risk to be held by the PMO. The first domain is completed (Programmes) SPD, Service Delivery, ICT Health Records and IG to follow. Sept 22. Awaiting the Octboer DDOB for formal sign off. Aug 22: ADI's have signed off the Clinical Assurance process however the DDOB meeting to approve was cancelled therefore moved to next meeting 18/10/2022 June 22 Final Sign off requested from ADI's to present via CCIO report to DDOB on 12/7/2022. May 22:•Training has been provided to several members of				31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics	31/03/2021			Overdue	**19**	1471		"Jan-23: Paper has been submitted to CEO and is under consideration. Sep-22. The proposal for TOF structures will be submitted October 22 with note at DDOB				31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan	31/12/2022	N/A	N/A	Not yet due	**-2**	#VALUE!		November 2021 Update: This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of "Once for ABUHB" which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Exec Team Q1 and Board Q2 2021.	30/09/2021			Overdue	**13**	1471		"Jan 23: Currently undertaking a HIMSS assessment as part of a national benchmarking exercise. Sept 22. Next steps have been agreed and a paper is drafted to be submitted in Oct 22. Aug 22 An update on progress aginst the Digital Strategy was presented to the Health Board Chair and Exec Team in July 2022. A Digital Delivery Oversight Board (DDOB) has been established to review progress, support prioritisation and give executive oversight and direction to the				31/10/2022	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021			Overdue	**16**	1471		"Jan 23: Awaiting funding for Head of PMO. Benefits management audit underway in programmes. Sept 22. This is part of the TOF paper submission Oct 22. Aug 22: 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 22: Portfolio dashboard under development and quarterly portfolio review & update meeting scheduled. Head of PMO included in TOF funding requirements. Programmes looking to recruit Portfolio				31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021			Overdue	**13**	1471		"Jan 23: Funded CNIO and Nursing Informatics lead. First Divisional meeting scheduled for December and await the outcome of the financial bid for the TOF Sept 22. 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 immidiate priorities for more effective engagement with Informatics in the HB. Aug 22: WNCR rollout plans include a nurse on each ward being champions for digital systems and GAG's promoting the need for diivisional champions to be identified by the SIAO's. Jun-22: agreement of co-funding				31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R10 The Informatics Directorate budget should be set to reflect the actual need of the organisation. Where funding cannot be fully granted, the impact on the underfunded position of Informatics work and Digital Strategy delivery should be clearly stated and agreed with Executives.	Agreed. The Portfolio approach and executive oversight governance will provide the framework in which difficult prioritisation decisions must be taken to avoid historical best endevours approaches. Part of the recommendations from the review of informatics in ABUHB is to establish a dedicated Digital Investment Panel which will provide performance management and oversight to investments in digital. The Health Board recognises the need to prioritise and invest in order to deliver benefits and supports the principle of a benefits management realisation framework and strategy. Budget setting is taking place for next financial year with the aim to agree a growth commensurate with strategic objectives. The Target Operating model is designed to ensure capacity and capability of Informatics is fit for purpose and is currently being costed to inform a case for consideration.	01/10/2021			Overdue	**13**	1471		"Jan 23: DDOB cancelled for Q3. IMTP Planning underway which will result in a financial appraisal going forward. Sept 22. Budget setting has been completed. DDOB now will consider resources for significant initiatives on a quartlerly basis. Aug 22 Singificant work undertaken during the last quarter on budget setting and realignment of cost centres providing high level of confidence and clearly defined areas that still require investment. Jun-22: yet to be realised - to be discussed at Digital Delivery Oversight Board in Q3 November 2021 Update: A final internal challenge session is scheduled for December within				31/10/2022	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021			Overdue	**13**	1471		"Jan 23: Working through SOP for training and prioritisation of requests to be agreed. Skills profiles being matched with JD's and engage on national task and fiish group to provide benchmarking Sept 22. The DIrectorate now has a small but dedicated budget for training and development to support the PADR and workforce planning agenda. Aug 22 Register of training opportunities, expressions of interest forms to be completed and assessed by senior manager with identification of funding available if applicable. Jun-22: Limited				31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R12 Once the team has been re-established, the key security tasks should be in place:•regular review of firewall rules;•regular vulnerability testing; and•development of a security incident response plan.	Accepted. Active recruitment has been taking place with a Cyber Security Team leader successfully recruited. Emergency Planning colleagues have been collaborating with the cyber teamand the Health Board has contracted with specialist consultancy to accelerate the development of a Information Risk and Cyber Security operating model. Work will commence Q1 including cyber resilience and response plans.	31/12/2021	N/A	N/A	Complete	**10**	#VALUE!		"Jan 23: Monthly reporting of KPIs to SIRO and Deputy SIRO in place- Office of SIRO to be estblished but reporting to DDOB has been established. Sept 22. Reporting continues and will support the induction of the new SIRO. Aug 22: KPI's monthly and will be reported at the October meeting with the new SIRO. Jun-22: now producing KPIs and reporting to Digital Delivery oversight Board (DDOB), established programme of work with Templar, which is led by the SIRO May 2022: contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO / delegated letters of authority to all information asset			Systems established - propose to close the reccomendation.	31/10/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021			Overdue	**10**	1471		"Jan 23: Part of the HBOTS work programme to be established wiith SIAOs Sept 22. Paper is drafted and will be submitted October 22. Aug 22 Pending financial strategy andTOF implementation Jun-22: subject to financial strategy for TOF implementation November 2021 Update: This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system"November 2021 Update: This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset				31/10/2022	

	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021			Overdue	**10**	1471		"Jan 23: Part of Cyber Resilience Programme- SIAOs in the process of being identified by new SIRO supported by Informatics- SIAOs will be trained and each will be accountable to identify assets within each division and directorate. Sept 22. SIRO training completed and new plan to be agreed in first Office of SIRO meeting. Aug 22: SIRO training scheduled in September and letters of delegatioN to be issued thereafter to the identified Senior Information Asset Owners Jun-22: Cyber Resilience programme commenced May 2022: contract awarded to consultancy Mar 2022 to implement				31/10/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R1 The function and membershipsof the Statutory Compliance Group and Electrical Safety Sub-Group should be reviewed to ensure:a)Both groups meet with the required frequencies set out in their Terms of Reference; b)Responsibilities and memberships across the two groups meet the recommendations of WHTM 06-01;c)Anelectrical-specific Terms of Reference, or as a minimum, a standard agenda, is developed for the Electrical Safety Sub-Group and approved by the SCG;d)Awritten report be submittedby the ESSG to each SCG meeting, providing assurance on thekey areas of compliance required byHTM 03; ande)Minutes from all meetings should be retained for future reference, in line with the UHB's agreed document retention policy and WHTM/HTM requirements (O).	Agreed. The next meeting of the ESG has now been scheduled for 24th March 2021.	30/06/2021	N/A	N/A	Complete	**16**	#VALUE!						31/10/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R3 a)An audit / recommendation tracker should be put in place, to monitor the status of compliance-related recommendations received.b)Progress should be monitored at the Electrical Safety Sub-Group (and other sub-groups as appropriate),and reported to the Statutory Compliance Group(O).	Agreed, an action tracker will be implemented. We recognise this may also facilitate funding allocations.	30/06/2021	N/A	N/A	Complete	**16**	#VALUE!						31/10/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R6 Limitation of Access forms should be used where appropriate for work undertaken by the maintenance contractor (e.g. circuit breaker protection trip testing) (O).	Agreed. Appropriate documents will be in place from now onfor relevant works.	30/04/2021	N/A	N/A	Complete	**18**	#VALUE!						31/10/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R2 The NWSSP: SES website should be periodically checked to ensure Works & Estates are in receipt of all relevant hazard notices(O).	Agreed, the website will be periodically checked from now on. The omission was not the fault of the UHB, and further we would normally expect input from NWSSP:SES to provide additional assurance in this area. Under normal circumstances, we would also monitor alerts for reporting to the Statutory Compliance Group / ESG (as discussed above).	30/04/2021	N/A	N/A	Complete	**18**	#VALUE!						31/10/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R4 a)Operational Procedure and Operations & Maintenance files should be reviewed, with out of date documents archived and current documents filed, as required by HTM 06-03.b)Site/substation log books should be maintained in the format required by HTM 06-01 (section 8).c)Records of inspections / replacement of equipment for which the UHB is responsible for should be maintained in the HV files(O).	Agreed, we recognise the benefits of improved record keeping, to make current documents more accessible.	30/06/2021	31/102022	06/10/2022	Not yet due	**16**	#VALUE!		70%	None	Currently working from previous policy and existing litrature until documents have been reviewed	01/10/2022	31/10/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R5 The UHB's HV policy requirement for inclusion of specific wording on the Limitation of Access forms should be reviewed, and removed if no longer considered feasible / necessary (D).	Agreed. We have reviewed the policy and agree the reference will be removed.	30/06/2021	31/102022	TBC	Complete	**16**	#VALUE!		90%	None	Currently working from previous policy until revised	01/10/2022	31/10/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R1 The UHB should have appropriate procedures in place to ensure that when determining the preferred supplier to inform the design, confirmation is received of willingness to participate in the subsequent procurement/market testingexercise (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Complete	**17**	#VALUE!		No action required noted for future projects				31/10/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R2 Lessons learnt from the development of the design and equipment procurement exercise should be captured, either separately or as part of the formal post project evaluation (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Complete	**17**	#VALUE!		Lessons Learnt report has been issued for comment				31/10/2022	

	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R3 For accuracy of reporting, the Cost Adviser cash-flows should be reconciled to UHB payments made. (O)	Agreed; and has already been addressed.	N/A	N/A	N/A	Complete	**#VALUE!**	#VALUE!						31/10/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R5 The monthly Welsh Government dashboard reports should be submitted in accordance with expectation (O).	Agreed. The Welsh Government reports will continue to be submitted.	31/03/2021	N/A	N/A	Complete	**19**	#VALUE!		The project has now been completed				31/10/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R6 An HDSU Project Board should be established to take through to completion / handover (as a minimum) (O)	Agreed. The GUH Project Board currently fulfils this function and alternative arrangements will be made after the April 2021 meeting.	30/04/2021	N/A	N/A	Complete	**18**	#VALUE!		The LGH Reconfiguration Board has fulfiiled the role of Project Board and prior to that it was undertaken by the GUH Project Board				31/10/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R7 At future projects:Contract documentation should be signed in a timely manner, prior to the commencement of works.	Agreed. The importance of a quick turnaround of contract documents has been relayed to the various project SCPs, PMs and ABUHB corporate services.	31/03/2023	N/A	N/A	Complete	**-5**	#VALUE!		Noted for future projects				31/10/2022	
	Internal	Clinical Futures - Workforce (2020/21)	Substantial	Director of Workforce & OD		Medium	R1 The Health Board should reinstate the completion of the Action and Delivery Frameworks to assist in the delivery of the IMTP objectives.	It is acknowledged that the monitoring of the WOD IMTP Objectives and milestones changed during the pandemic. The WOD function is planning on introducing a revised internal monitoring process in line with the 2021 People Plan which will be aligned to the Health Board's approved Annual Plan.	31/01/2022	N/A	N/A	Complete	**9**	#VALUE!		**September 2022 -** People Plan has been agreed by the Board. A Delivery and Monitoring Framework has been developed to support the implementation of the People Plan 2022-2025. Revised workforce dashboards have been developed to support benefits measurement/KPI's of the People Plan. The Framework includes governance and assurance which will be overseen by the People and Culture Committee The TOR for the Workforce and OD Group to support the alignment of the IMTP key service priorities will be be submitted to the Clinical Futures Board October 2022 (November pending scheduling)	The People Plan was approved on 25 May and the Clinical Futures Programme Board has recently been reconfigured to support the delivery of the IMTP 10 priorities. It is anticipated that the Clinical Futures Workforce Group will be sub group of the Programme Board	Workforce representatives are on each of the priority programmes. The workforce ouputs of these priority programmes will be fed back into the IMTP and associated reporting frameworks.		31/10/2022	
	Internal	Management of Balance Sheet Assets (2018/19)	Reasonable	Director of Finance, Procurement & Value	Head of Capital Finance	High	R1 The Health Board should introduce tagging / identity marking of all relevant assets.	Agree the Recommendation.For clarification, whilst capital assets are not tagged with the individual Fixed Asset Register number, a significant proportion of assets are tagged by other departments such as Medical Electronics and IT. Current processes involve the asset register being updated with serial numbers and the appropriate Medical Electronics reference, however, this information is not available for all historic assets.To improve the security of assets, and identification as part of the annual verification process, the Capital Team will, in consultation:□Develop a policy for asset tagging which defines where tagging is appropriate;□Investigate options for the purchase of an asset tagging system, considering existing systems in use in ABUHB and potential for linking to the Medical Electronics database and research the systems employed at other health boardsand trusts;□Develop a business case and plan for the implementation of a preferred option in 2019/20 including outline specification, cost/benefits analysis, procurement options, funding requirements and resource implications.	31/03/2020	N/A	N/A	Complete	**31**	#VALUE!		November 2022 Update: The implementation took an extended period due to Software integration issues, which are now resolved. Tagging is on-going and full live roll out is underway for Capital and EBME. A plan for completion has been prepared as an update to the Audit committee. Due to time pressures it is not possible to tag all assets in 2022/23 so there will be a need for manual verification for an element of assets at year end, but this will be materially reduced compared to previous years. The timetable is optimistic and could be impacted by availability of appropriateness of attendance on sites (ie busy or covid).The Capital team have				31/10/2022	

	Internal	Well-being of Future Generations (Wales) Act 2015 (2018/19)	Reasonable	Director of Public Health and Strategic Partnerships		High	R1 The Wellbeing of Future Generations Act Programme Boardshould include a review of the objectives and the progress against them as part of itsagenda, to ensure objectives are fit for purpose and the activities required to meet them are identified and monitored. 2) EachProgramme Board should be chaired by the Executive Lead in order to provide leadership, monitor effectivenessand highlight the importance of attendance. 3) Poor attendance at the Programme Board should be taken forward by the Executive Lead in order to ensure that it is rectified.	Agreed1.Thereview of the Wellbeing Objectiveswill be undertaken in conjunction with a broader review of where these objectives sit in the context of other Organisational priorities and ambitions. A landscape review/mapping of these various aspects will need to be undertaken in conjunction with the ABUHB Planning Teamtoinform the review of Well-being Objectivesas part of the IMTP process.The Programme board will include a review of progress against objectives as part of its agenda. 2.Programme Board meetings will be moved from a monthly to a quarterly basis and will be chaired by the Executive Director of Public Health and Strategic Partnerships. This will be supported bysub-Board meetings.3.The Executive Director of Public Health and Strategic	31/12/2019	Mar-23	06/10/2022	Overdue	**#VALUE!**	#VALUE!		April 2022 Update: the review of the Wellbeing objectives continues to be put on hold due to the prioritisation of the response to the Covid-19 pandemic. ABUHB is actively engaged in the process to agree a new collective set of Gwent PSB Wellbeing Objectives which will subsequently inform the review of the ABUHB Wellbeing Objectives' August 2022 Update: No change from April position. The pandemic response	Integration of the WBFGA within ABUHB has been led by the Public Health Team. Re-deployment of significant staffing capacity into the COVID-19 pandemic response has created a barrier to leading this work and responding to the audit recommendations since 2020. There is also an interdependency with the Gwent PSB and work taking place to develop a new well-	The risk is being mitigated by aligning completion of the recommendations with the Gwent PSB planning cycle. To close down this risk the product of work to develop a Gwent well-being plan needs to be published which will not happen before the end of 2022/23.		14.11.22	
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out:how service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting;the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next;methodology for undertaking the inspection, i.e. the process for completing one from start to finish;how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; andfindings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	Mar-24	06/10/2022	Deadline Revised	**-1417**	-1488		Mar 23 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	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.			
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	Mar-24	06/10/2022	Deadline Revised	**-1417**	-1488		Mar 23 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	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.			

	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	Aug-23	Aug-22	Not yet due	**#VALUE!**	#VALUE!		Nov 2022: This recomendation is monitored reguarly 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 assests however, further work is required to phyiscally tag the equipment and ensure compliance and tracibility.	Barriers to the delay to this stage has been down to software developers of the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) involved in this process to ensure the smooth transition of data between all systems. Once the system is fully operational there is still an extenstive amount of work to visit every site and tag locations and equipment, more so given the current service pressures. The past two years has also seen the opening of the GUH and a major transfer of assets across various sites as restructuring of services/departments has been undertaken on an ongoing basis throughout our LGH's.	Medical Electronics (EBME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (EBME) 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.	By the end of 2022 we would anticipate that that basic fundamentals of the 'Asset Tracking' system would be fully operational. It may be some time during 2023 before we could say that all assets across all sites have been tagged. The primary focus will be at the GUH before rolling out across the HB.	18.11.22	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	Apr-23	Aug-22	Not yet due	**#VALUE!**	#VALUE!		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	Complex absence management factors in relation to the QPS Infusion Device Service Training Manager post have affected progress in designing and implementing the new infusion device training strategy. Input from the Clinical Practice Educators teams has maintained	The risk associated with running with an absence of the Health Board's Infusion Device Service Training Manager has been mitigated by providing the high level training to specific Practice Educators to skill them to provide a limited round of effective training to particular groups of	The starting date set for the new QPS Infusion Device Service Training Manager is currently 01/11/2022. Consolidation of the infusion device training records could be achieved within a month of this, i.e.by 01/12/2022. Development of a	18.11.22	
	Internal	Pay Incentives (2019/20)	Limited	Director of Operations		High	R1 The Health Board should restrict additional session payments to standard levels, but where this is not possible; maintain an approved schedule of enhanced rates ratified by the Executive Team with appropriate justification / reasoning included. The schedule of enhanced rates should be reviewed frequently e.g. every three months.	Approval to continue paying WLI rates from Executive Team – taken forward to RATS Committee. Review as part of IMTP demand and capacity discussions each year.	30/09/2019	N/A	N/A	Complete	**#VALUE!**	#VALUE!		November 2022 Update: Rate card has been revised and drafted across all divisions and will be shared and signed off by the Divisonal Director's with a view to sign of at Execs for the end of November, with the agreement of the MD				11.11.22	
	Internal	Pay Incentives (2019/20)	Limited	Director of Operations		High	R2 In relation to the non-automated process only, consultants should submit signed claim forms for all additional sessions they are claiming payment for, listing appropriate details in respect of session dates, start/ finish times etc. and including a declaration that all sessions claimed are in addition to contracted work. The submitted claim form should be reviewed, validated and checked for accuracy before any payment is made.	Agreed. Executive Team will agree the approved system for claiming for all additional sessions and communicate with the Health Board. This must simplify the process for claiming to maximise compliance.	30/09/2019	Apr-23	N/A	Not yet due	**#VALUE!**	#VALUE!		Nov 2022 Temporary additional sessions for Consultants and SAs staff are agreed as part of the job planning process and paid at the doctors usual rate and annotated on the job plan proforma. Recently been agreement from Execs about consistent payment for all consultant staff, which is positive to note.			System in place all divisions adheres to the system/process	11.11.22	

2021.16	Internal	Flu Immunisation	Reasonable	Director of Public Health and Strategic Partnerships	Consultatnt in Public Health	Medium	R1 a.The Health Board should review and investigate all promotional activity and flu vaccination delivery methods to determine the degree of success each brings. Alongsidethis, a reflection exercise should be completed to identify any lessons to be learnt or improvements to incorporate in future campaigns R1 b.Theflu champion database should be reviewed, updated and regularly maintained.	a.The Health Board will be holding annual Staff Flu Vaccine planningevent for 2022-23 in April/May 2022. This report will be shared with the Staff Flu Working Group in advance to ensure that members have the opportunity to reflect on this report. This event will both reflect and act on the lessons learnt during the provision of staff vaccines during2021/22,from an operational, communication and organisational view;as well as providing analysis of all available division/flu champion/vaccination data. Lessons learnt will be highlighted during this event and 2022/23 will be planned strategically to take advantage of positiveaspects, such as the mass vaccination centre approach (if an option), improving the flu champion model through improved digital innovation/organisational planning as well as mitigating barriers to vaccine uptake born of the staff survey/reflections.It is intended to be supported by a staff survey of "how they felt the vaccine programme did." It will form the basis of a user centred approach by listening to employee concerns as well as an opportunity to capture staff ideas.In addition,itis anticipated that greater use of technology will be implemented which will offer a greater array of options and	31/07/2022	N/A	N/A	Complete	**#VALUE!**	#VALUE!		Nov 2022 Two planning sessions have taken place – 19th May and 22nd June. On 19th May event, we had our planning workshops structured around the audit feedback and lessons learned. These were taken into account in the 2022-23 plan. The Report has been shared with the Staff Flu working group ToRs have been agreed and shared with Exec Team. Our plan is to give access to WIS to all Flu Champions so that all data is captured electronically, this is work in progress and still remains challenge relating to digital accessibility A central Database is maintained by lead of flu vaccine training . In addition each DFL is provided with list of			Both recommednations were implemnated In 2022-23 Staff Flu Vaccine Plan. A coomuncation plan was developed. It had five phases strating from July Pre-campaign to end of season messages. We utilised all media channels to promte flu vaccine. An emphasis was placed on personal communication. We also created a central database of Flu Champions. Each Divisional Flu Lead was given the list of flu champions from their directorate. We created Teams Channels for swift communication between the Project lead, Project Manager DFLs and flu champions	14.11.22	07/04/2022
2021.16	Internal	Flu Immunisation	Reasonable	Director of Public Health and Strategic Partnerships	Consultatnt in Public Health	Low	R2 a. The terms of reference for both Working Groups should be reviewed and updated where required. R2 b. The terms of reference for each group should be finalised.	a.Staff Flu Immunisation Working Group will review and update the Terms of Reference at the planning event b.Staff Flu Immunisation Working Group Terms of Reference will be finalised once reviewed.c.Community Flu Immunisation Working Group Terms of Reference will be reviewed and finalised.	31/07/2022	N/A	N/A	Complete	**#VALUE!**	#VALUE!		They have been reviewed for 2022/23 flu and COVID campagins but superceded by National imms framework - therefore propose to close this recommendation down.				14.11.22	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science		High	R1 a.Identify any underlying reason for the non-completion of MFRAsand the impact of the pandemic.	a.It is recognised that the non-completion of the falls risk assessment is multifactorial and the challenges have been heightened during the Covid pandemic. This is both in association with the changing levels of comorbidities for our patient cohort and the availability of staff resources due to competing demands in support of the Health Boards response to the pandemic.Some wards were also subject to changes in their functions with the redistribution of patients in support of the management of the pandemic. The Health Board through its falls management structure will continue to utilise both qualitative and quantitative information to identify themes and trends to instigate the necessary quality improvement initiatives. This will look to include a broader remit of evaluating compliancewith the completion of the MFRAthrough the development of an audit suite aligned to and extending the existing methods being adopted by the wards. The outcomes will look to define any change requirements and will be communicated at all levels within the organisationstructures.	31/07/2022	31/10/2022	06/10/2022	Complete	**4**	1		Nov 2022 Work has continues to establish an audit tools to evaluate compliance aligned to the completion of the MFRA . Due consideration is being given to the opportunities presented by the implementation of the electronic document alongside the adoption of the Focus Review held within the Incident reporting system. Both would look to provide a means to use the IT systems to generate information on compliance.This will form an element of the audit inspection programme for risk assessments	Nov 2022 The full adoption of the WNCR MFRA in totality across ABUHB is not anticipated to be until the Spring of 2023. This provides limitation on the ability to effectively establish a unified audit approach due to the use of both electronic and paper based systems.		Mar 23 The impact of the pandemic saw an unprecedented surge in both the numbers and complexity of admissions with a focus on effective management of C-19 in which the key challenge became controlling the factors very much characterised by the respiratory symptoms and minimising transmission. Non completion of the MFRA to a degree was causation related to patients being to a greater extent bed bound due to the effects of C-19 and the perception that a person was less susceptible to a fall. It remains important that we place this in the context of the overall challenges experienced at this time and the multiple factors which influenced patient care needs. Audit remains ongoing to ensure any areas of concern are identified.	16/11/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences	High	R1 b.Review the MFRA documentation to determine if it can be rationalised / updated to be more concise. For example, a permanent section and an ongoing care plan that is periodically revised.	b.The MFRA represents one assessment within the suite of the Welsh National Care Records (WNCR). This is due to be adopted in its intended electronic format in ABUHB in the Summer of 2022and will provide a more streamlined systematic MFRA. Although currently being used in a paper format ABUHB as part of the process have submitted a number of change requests,which have been accepted. The detail held within the MFRA is reflective of the many factors which influence the risks of falls and likewise contribute to the wider understanding of the patient's condition. ABUHB is represented at National level and will continue to contribute to the discussions.	30/09/2022	N/A	N/A	Complete	**2**	#VALUE!		Nov 2022 Work remains ongoing to support infrastructure and implementation aligned to the use of CWS . The WNCR MFRA has been presented to the Inpatinet Falls and Bone Health Hopsital Group and Comiittee. Review sessions have been understaken to deterrmine the clinical training required alongside the implementation of the electronic system.	Nov 2022 Intergration challenges associated with CWS		Mar 23 ABUHB has commenced its phased implementation of the Welsh Nursing Care Record, MFRA which supports a more streamlined approach to the documentation through its electronic format but looks to encompass the key parameters which influence falls. This commenced at GUH in November 2022 and will be further rolled out during 2023. An integrated electronic care plan is being developed at a National level to support further informing the continuity of falls management. Any changes will be subject to National agreement.	16/11/2022	07/04/2022

2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 c.Continue with the falls management training, but target the programme towards areas of poorer compliance rates.	c.It is recognised that training is a key component in supporting the ABUHB's approach in minimising inpatientfalls. The aim is to build on what has already been established. The evaluation of data willlook to underpin a focussed approach where areas of concern are identified and will look to inform the training strategy going forward. Aligned to the work of ABUHB we are also representedat an 'All Wales's levelin discussions to develop a generic learning platform linked to ESR to support all staff who have a role infalls management. It is intended that this will translate into a national product and provided consistency of approach across Wales.This platform will support enhancing knowledge and skills from both an inpatient and community perspective. The learning package will provide a level 1-2 education upon which additional modules will be developed.	31/12/2022	N/A	N/A	Complete	-2	#VALUE!		Nov 2022 All Wales platform presented at the National Falls taskforce for updated discussions on content.ABUHB meetting scheduled to progress to planned implementation.			Mar 23 Falls management training continues to be delivered and has been adapted to support those areas in which paper documentation remains in use and where we have moved to the digital format. Monitoring of falls incidents continues to determine potential areas of concern in which we have seen increases in incident numbers. It is however important that we ensure that we look at the context surrounding such increases and if required provide targeted training. This is supplemented by individual wards identifying concerns through DECI and One Patient One Day audits.	31/10/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 d. Remind staff of the falls management requirements.	d.Through the newly established structure in support of falls management an ongoing awareness campaign is to be established. The further development of theintranet pages through SharePoint willthe provideenhancedcommunication approaches. This will be looked at in the context of falls from a Hospital and Community perspective.This will be used to develop a falls network, provide a platform to share good practice, research and act as a resource depository.The concept of falls champions will be promoted. All will look to support quality improvement initiatives across the falls pathways. The agendas set for the fall'sforums will look to ensure suchgood practice, learning and necessary change initiatives continue to promote the requirements to manage falls.	30/09/2022	31/10/2022	06/10/2022	Complete	2	1		Nov 2022 Both the Hopsital and Community Falls and Bone Health Groups have been established. An agenda item at the inaugural meetings included discussions on the content of the pages with the sharing of ideas to promote future content. The nelwy established pages have been populated with data , resources,and links to key services in support of falls management and the prevention agenda.			Mar 23 Awareness around falls management is much more heightened in the Health Board with wards proactively undertaking work around minimising falls. A standing agenda item for the Hospital Falls and Bone Health group is Divisional feedback on the work that is happening providing one of the many opportunities to share learning, experiences and outcomes. The Falls and Bone Health page has been established to which we have and continue to add resources and content. We are using social media platforms to promote falls and what this means and have developed videos which are anticipated to be released in the coming weeks. A wider piece of work is continuing aligned to the prevention agenda within the community settings and the opportunities this may present to avoid	16/11/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 e.Where 1P1D/DECi inspections identify failures an immediate correction of the patient record and a rerun of the check (and potentially training) should be completed.	e.Should non-compliance concerns be identified the findings are shared with the Nurse in Charge, Ward Manager along with the Senior Nurse and QPS Lead. The outcomes are relayed to the member of staff responsible for the care of the patient and the wider team as a means of learning.The responsible member of staff looks to action any requirements to rectify non-compliance. The QPS Lead subsequently undertakes a more extensive focussed audit to identify any systemic concerns within the given ward and to inform the Divisional 'deep dive' discussions. Work is underway to look at how the data can be cross referenced with the overarching falls management data and on the reinstatement of the Health and Care Standards Audits. This approach will look to be supported by the training strategy.	31/12/2022	N/A	N/A	Complete	-2	#VALUE!					Where potential failing have been identified numerous approaches are being adopted at operational level depending upon cause with records being updated to reflect any required changes. This includes discussions as teams or at individual level. Again, the learning experiences are being shared. Audits are being rerun to ensure actions are effective post implementation.	31/10/2022	07/04/2022

2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences	Medium	R2. The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	30/09/2022	30/05/2023		Deadline Revised	**1**	-7		Nov 2022 Work has been undertaken to look at the opportunities to use the falls focus review held within the DATIX system . This would further support the incident reporting process.	Mar 23 suggest that this remains open as we are in the process of implementing the falls focus review held within the system as a phased approach and looking to establish the data parameters that provide the requirements of the recommendation through a digital process. outstanding – revised accountability framework still in draft status (March Board 23) – however existing Budgetary control FCP still relevant as a financial accountability mechanism as part of core governance.			31/10/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R1.1 Management should confirm available data and conclusions relating to functionality of the GUH, by comparison to business case objectives pre and post opening.	Agreed	TBC	N/A	N/A	Not yet due	**#VALUE!**	#VALUE!						31/10/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R1.2 Management should re-baseline relevant, objectives for the facility based on current information in order to inform revised functional models.	Agreed	TBC	N/A	N/A	Not yet due	**#VALUE!**	#VALUE!						31/10/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R2.1 Management should confirm an appropriate forum to which to report on-going monitoring of the investment benefits derived from the GUH facility .	Agreed. The reporting of the energy efficiency benefits of GUH will be picked up as part of the broader energy review and discussed at the Strategic Capital & Estates Group.	TBC	N/A	N/A	Not yet due	**#VALUE!**	#VALUE!						31/10/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R1.1 The Health Board should: • Develop a plan setting out how key objectives within the Risk Strategy will be achieved, with milestones set out. The progress of the plan should be reported into the Audit, Finance and Risk Committee. • Review the Risk Strategy to determine if it still reflects current practice and update it accordingly e.g. the corporate overview or risks.	A plan has been developed and is being presented to the Audit Committee on 7th April 2022 following discussion with Executive Team. A review of the Strategy will be undertaken as part of the plan, in September 2022, specifically to review effectiveness one year post implementation.	30/09/2022	N/A	N/A	Complete	**1**	#VALUE!		Risk Strategy Realisation Plan agreed. Routine updates scheduled within ARA Committee workplan for 2022/23				31/10/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R2.1 The Health Board should: • Consider undertaking risk management training for key areas, whilst awaiting the implementation of the risk management module within DatixCloudIQ. • Develop a plan to deploy risk management training, to commence once the full implementation of DatixCloudIQ has been completed.	As part of the strategy realisation plan, the Health Board will develop an in-house training package aimed at the three levels outlined within the Strategy (operational, management and Board level). This will be made available to relevant staff during May/June 2022. Further National development work will resume once the RLDatix risk management module has been finalised and bespoke training programmes can then be developed.	30/06/2022	30/06/2023	06/10/2022	Not yet due	**4**	-8		OFWCMS risk management model delayed nationally. Expected April 2023 for implementation and training/awareness to commence.		Targetted training is provided to teams in the meantime.		31/10/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R3.1 The Health Board should: • Provide guidance detailing how risks should be recorded and monitored at different levels within the organisation. • Ensure each risk entry is fully recorded in a standard format.	3.1 This recommendation forms part of the Risk Management Strategy realisation plan. The Health Board training programme will provide material and literature to help support staff to populate Datix and risk registers appropriately and consistently ensuring alignment with best practice. The provision of in-house training will be made available to staff by May/June 2022.	30/06/2022	30/06/2023	06/10/2022	Not yet due	**4**	-8		OFWCMS risk management model delayed nationally. Expected April 2023 for implementation and training/awareness to commence.		Targetted training is provided to teams in the meantime.		31/10/2022	07/04/2022

2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Divisional Director	High	R 1.1 The Division should further strengthen performance reporting, with a heightened focus on QPS metrics (akin to the processes embedded with the Complex Care Division: general adults). 1.2 The Division should explore interim options to automate and streamline the existing databases until the introduction of WCCIS, and ensure the databases are up to date. 1.3 The Division should improve the reporting arrangements of commissioned services ensuring Executive sightedness together with Patient Quality, Safety & Outcomes Committee. 1.4 The Divisional Risk Register should be updated to include the risk associated with the backlog of auditing.	1.1 The Performance report will be strengthened to include PQS metrics. 1.2 The utilisation of the databases will be reviewed with an interim plan developed to reduce duplication and ensure completeness. 1.3 A quarterly performance report will be produced and discussed at Divisional level and the Executive Assurance meeting, together with inclusion in the PQSOC Performance Report as per the business cycle.1.4 The Divisional Risk register will be updated to include the risks associated with the auditing backlog.	30/06/2022	30/06/2023	N/A	Not yet due	**#VALUE!**	#VALUE!		Nov 2022 - first performance report to be presented on 25th November 2022 to CHC Divsional assurance meeting. Remains in progress at this stage. Process supported by SIM who is now in post. WCCIS is now operational however, there have been challenges in implementation. A plan to develop organisational assurance mapping linked to internal control systems has been agreed between the Head of Risk and Assurance and the Directorate. A deadline of April 2023 is being actively worked towards.				15.11.22	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Nursing/Director of PCCMH		High	3.1 a. The Health Board should explore options for strengthening its oversight of services commissioned, on its behalf, through the NCCU, with reporting to the PQSOC. b. The Health Board should request the NCCU informs commissioners when providers do not re-join the AWF.	a. This Audit recommendation will be discussed with the NCCU to explore opportunities for strengthening monitoring and ABUHB oversight. b. The NCCU will be asked to inform ABUHB when a provider does not re-join the AWP list.	30/04/2022	N/A	N/A	Complete	**6**	#VALUE!		A) Quarterly meetings with NCCU & all Health Boards have been re-established where intelligence is shared about providers and placements. There is an All Wales escalation process in place to share any concerns about providers and placements. The MH & LD Commissioning Team manager meets with Assistant Director of Nursing & Quality of NCCU on a regular basis to share information. B) NCCU have been asked to inform MH & LD Commisioning Team of any provider who has come off AWP list. Any provider who comes off AWP list are removed from CCAPS system. MH & LD				31/10/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Divisional Director	High	4.1 Divisional management should ensure: a. the Division introduces a sustainable programme of training for CHC; and b. CHC compliance and quality audits are incorporated into the Divisional clinical audit plan.	a. A business plan inclusive of the training requirements for Commissioning is being considered by the Divisional Management Team in conjunction with other IMTP priorities. The CHC framework forms part of the training needs identified. A bid for temporary funding for training personnel will be prepared to address this issue quickly. b. Clinical auditing of the CHC process will be added to the annual Divisional audit plan.	30/06/2022	N/A	N/A	Complete	**4**	#VALUE!						31/10/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse	High	R5.1 A revised framework, following the launch of the new national CHC policy (anticipated April 2022), should include client-specific requirements for MH & LD and ensure consistent use across all Health Board services.	5.1 The Deputy Divisional Nurse for MH/LD will work closely with the Divisional Nurse for Complex Care to ensure inclusion of MH/LD client specific requirements within the revised framework for CHC, following the launch of the new national policy.	30/06/2022	N/A	N/A	Complete	**4**	#VALUE!						31/10/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse	Medium	R2.1 Clarity should be provided in terms of the roles and responsibilities of the Commissioning Team and the Care Coordinators, particularly associated with annual reviews.	2.1 The respective roles and responsibilities of the Commissioning Team members and Care Coordinators will be reinforced, ensuring clarity.	31/03/2022			Overdue	**7**	1471		Nov 2022 - 2.1 'Role of Care Coordinator and Case Managers' document produced for review. To be finalised by end of September 2022.				31/10/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Finance Business Partner	Medium	R6.1 The Division should: a. undertake a review of its overarching CHC / S117 provider contracts, ensuring they include all aspects of performance monitoring; b. identify appropriate signatories for the contracts in line with the Standing Orders and Scheme of Delegation.	6.1 a. A Task and Finish Group will be convened to review and strengthen the contracts. b. The authorised signatories list will be reviewed to ensure full compliance with the Scheme of Delegation and Standing Orders.	31/07/2022	N/A	N/A	Complete	**3**	#VALUE!						31/10/2022	07/04/2022

2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Medium	We recommend that the Health Board assesses the effectiveness of those assurances on which reliance is being placed, and report their findingsor gaps identifiedas part of the BAF reporting structure.Where gaps are identified action plans should be developed and monitoredfor progress.	R1. The Health Board accepts this recommendation as part of the iterative development of the Board Assurance Framework. Work to address this recommendation is planned during May/June 2022 and a revised BAF incorporating a robust assessment of assurances will be included. Assurances will be RAG rated and identified gaps will have associated plans to improve the position, monitored by the Audit,Risk and Assurance Committee.	31/07/2022	30/04/2023	06/10/2022	Complete	**3**	-6		Mar23: The Board has now received the Risk Assurance Report at March 2023 meeting therefore, propose to close this recomomendation. Nov 2022: Revised BAF approach discussed with ARA Committee August 2021. Revised BAF to be developed alongside IMTP for approval and implementation in April 2023.		Risk management informing board and committee assurance needs.		31/10/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Medium	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	30/04/2023	N/A	N/A	Not yet due	**-6**	#VALUE!						31/10/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Low	R2. We recommend that the Health Board completes an assurance mapping exercise to record all assurances being sought in relation to those principalrisks reported under the BAF process. The exercise should be regularly reviewed to identify any missingand / or the accuracy of theassurance.	The Health Board accepts this recommendation and actions to undertake this are outlined in recommendation 1. The Health Board has established processes in place to review the BAF at least twice yearly with all principal risks reported to executive team, relevant committees and to the Board at each meeting.	31/07/2022	30/04/2023	06/10/2022	Complete	**3**	-6		Mar23: Prpose to close as RAF presented to March 2023 Board. Revised BAF approach discussed with ARA Committee August 2021. Revised BAF to be developed alongside IMTP for approval and implementation in April 2023.		Risk management informing board and committee assurance needs.		31/10/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Low	R3. We recommend that the Health Board continues to monitor the embedding of the BAF related risk management oversight responsibilities of the Committees to ensure that:1 the Committee Risk papers form the basis of the six monthly BAF reporting to the Audit, Risk and Assurance Committee and the Board; and,2 appropriate oversight is provided by each Committee on reported BAF activity.	The Health Board accepts this recommendation and plans to include strengthened assurance mapping arrangements and assessments for the next iteration of the Board Assurance Framework (BAF). In addition to this, the template reporting for Board and Committees is due to be reviewed, it is proposed that incorporated into this review will be the ability to cross reference each Board and Committee report to the BAF to make explicitly clear where papers address and provide assurance against a principal risk.	31/07/2022	30/04/2023	06/10/2022	Complete	**3**	-6		Mar23: Prpose to close as RAF presented to March 2023 Board. Revised BAF approach discussed with ARA Committee August 2021. Revised BAF to be developed alongside IMTP for approval and implementation in April 2023.		Risk management informing board and committee assurance needs.		31/10/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R1 The upcoming review of theBudgetary Control Policy and Financial Control Procedure, issue 3, should considerestablishing effective control procedures that allow for practical compliance across the Health Board and that any accepted deviation from defined procedures isdocumented, such that authorisation of such changes is defined and communicated. Areas for consideration include:1.1.1whetherthe formal budget delegation and acceptance letter process applied to the initial annual budget needsto be applied to any significantbudget changes madeduringthe financial year;1.1.2shouldthe monthly budget review and reporting processes reflect the specific needs of each division / directorate, given an assessment of the variation in budget risk between the divisions; and1.1.3whethereach virement requiresformal approval by the Board or could delegation of authority be given to the ExecutiveTeamwith the subsequent notification to the Board, subject toappropriatefinancial limits.The full findings of this review should be consideredwhen the documents are reviewed.	1.1.1Delegation of such large £'s during the year is relatively recent and became apparent during Covid due to late notice of confirmation and receipt of funding.We would normally expect to issue delegation letters only at the start of the financial year, whenthe vast majority of budgets are delegated, recognising that these are at a point in time, there will always be subsequent changes as new funding is agreed.The delegation is approved by the CEO and the expectations of managing that budget are clear in the initial letter and FCP's. The FCP will be reviewed and revised to reflect the clarity of this process. 1.1.2The Board financial report includes an overview of each budget head.'FBI' provides the standard ABUHB Budget holder reports in detail.No action proposed. 1.1.3The budget is delegated through the Board and CEO to the Executive, to deliver the agreed priorities. There should be no need to refer changes to the Board as they have already delegated the authority of its management. However, where there are significant changes to the proposed usage which are outside of agreed priorities and delegation arrangements, there is an expectation that the Board is notified and potentially approval	31/08/2022	N/A	N/A	Complete	**2**	#VALUE!						31/10/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R2 The Directorof Finance, Procurement& Valueshouldensurethatthe budgetarycontroltraining provided is appropriate and that each staff member receives an adequate level oftraining toaddress their needs andfulfil their role.This should includetheinclusion of budgetary control training in staff PADRs (where appropriate),monitoring attendance at budgetary control training sessions,and clear, documented justification where a budget holder does not need to attend the training(for example, if they had significant budgetary control experience in a previous role).	Financial and budget training is part of induction training sessions and FBI training is provided in addition to encouraging budget holders to attend.Non attendance reports are provided to line managers and Business Partner Accountants teams to follow up.Reminders will be sent to all budget holders and line managers to ensure attendance	31/08/2022	N/A	N/A	Complete	**2**	#VALUE!						31/10/2022	30/06/2022

2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R3.1 Going forward, the Director of Finance,Procurement& Valueshouldconsider enhancing/ expandingthe Board reporting around the delivery ofsavings plans, as pressure to deliver a sustainable balanced budget becomesever increasing.	Savings information is provided in summary in the Board Financial Report, in addition the appendix provides a line by line analysis.The Finance & Performance Committee will receive a more detailed savings analysis as part of regular agenda updates, including analysis of recurrent, non-recurrent and delivery performance.	31/07/2022	N/A	N/A	Complete	3	#VALUE!						31/10/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R3.2 Whilst savings are not separately budgeted for, the Director of Finance, Procurement & Values should consider the reporting of savings achieved analysed by key generic savings activities across the Health Board. For example,an analysis of savings planned and achieved fromthe more effective management of variable paycosts across the Health Board, orthe avoidance of additional costsas a result of efficiencies achieved.	Savings information is provided in summary in the Board Financial Report, in addition the appendix provides a line by line analysis.The Finance & Performance Committee will receive a more detailed savings analysis as part of regular agenda updates, including analysis of recurrent, non-recurrent and delivery performance.	31/07/2022	N/A	N/A	Complete	3	#VALUE!						31/10/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Medium	R4.1 The Health Board should ensure clear alignment between itsTransformation Projects, IMTP Core Priorities and Priority Programmes.	Agreed.Implemented as part of IMTP 22/23 –24/25	30/04/2022	N/A	N/A	Complete	6	#VALUE!						31/10/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Clinical Futures Programme Director	Medium	R4.2 Before Transformation Projects are put forward for review and approval, the Health Board should ensurethat SMART criteria for measuring a project's development and "what success looks like" aredefined, and theaccounting structures to be applied to record each project are documented and subject to review.	Agreed. Each Programme should have benefits criteria agreed by its own Programme Governance and signed off by the Clinical Futures Programme Board (HSLG). The SRO should lead the development of the benefits measures with support from business partners and programme leads Finance Leads to be allocated to IMTP priorities programmes. Accounting of efficiency and savings progress to be captured in financial management information packs.	31/07/2022	N/A	N/A	Complete	3	#VALUE!		Nov 2022 Programme Benefits & achievements reporting & tracking process in place via scorecards. The benefits in year will be detailed via the Q2 report to the Board and the programme benefits for next year confirmed via the IMTP (NM)				31/10/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R4.3 The Health Board should ensure that Transformation Projects areexpressed as financially sustainable with identified funding from redeployment of existing budgets and/or non-recurrent funding sources.	Agreed in principle. Recommendations from programme workstreams will be considered through organisation planning, reporting andgovernance arrangements ultimately to Executive Team and the Board.	30/06/2022	N/A	N/A	Complete	4	#VALUE!						31/10/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R4.4 There is an inherent risk that elements of non-recurrent funding of Transformation Projects are not forthcoming in future years. Any decision to continue projects without an identified recurring source of income risks financial sustainability in future years.Therefore, the Health Board should consider developing a clear mechanism to compare projects to allow for clear decision making where funding resources are limitedandthere may be a need to prioritise Transformation Projects.	Agreed. Aprioritisation process to support resource allocation as part of IMTP development is being developed by the Executive team for consideration by the Board.	30/06/2022	N/A	N/A	Complete	4	#VALUE!		Nov 2022 Executive team agred process - not yet presented to Board				31/10/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Senior Primary Care Pharmacist	Low	R1 Management should review the terms of reference (ToR) for theGwent Controlled Drugs Local Intelligence Network,including its quoracyrequirements. Meetingsthatare not quorate should either be deferred or recognised at the start of the meeting ensuring those in the meeting understand the implications of this.The requirement to complete minutes and action logs after each meeting should also be added to the ToR.	The terms of reference of the Gwent CDLIN will be reviewed and updated as requested at the next CDLIN on 1stAugust 2022.1.The TOR will be updated to remove need for Police representation at each member.2.To recognise any non-compliance with quoracy requirements at the start of any meeting. The implications of this to be noted in the minutes. 3.To add the requirement to complete minutes and action logs after each meeting will be added to the TOR.	31/08/2022	N/A	N/A	Complete	2	#VALUE!						31/10/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	N/A	N/A	Not yet due	-5	#VALUE!						31/10/2022	30/06/2022

2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policyand confirm the areas of non-compliance identified as part of this review have been rectified.	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance.The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	31/03/2023	N/A	N/A	Not yet due	-5	#VALUE!						31/10/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R3. Management should continue as planned to add the Omnicell user guides to Sharepoint and direct staff to this learning material. The guides should be useful to the front end user and also to Ward Managers regarding the reporting capabilities within anOmnicellmachine.	There are user guides for both end and superusers provided by Omnicell. The Principal Pharmacy technician at RGH has developed basic user guides for the wards which detail the common functions with picture guides. These are available on the wards, but staff cannot always find them. The plan is to add them to SharePoint and signpost staff to them. Short training videos are also to be developed which will be uploaded toYouTube. QR codes will be placed on the side or front of the cabinet and linked to the videos which will show staff how to maximise the Omnicells functionalities.	31/08/2022	31/12/2022	06/10/2022	Complete	2	-2		Nov 2022 All the user guides are now available on SharePoint and training plans have been implemented for GUH staff. Still waiting for videos from Omnicell		Nov 2022 Awaiting training videos from Omnicell to determine if they are suitable for end users and implement QR code Youtube plan. If not local videos will be developed.		31/10/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services	Medium	R4 The PharmacyTeamshould comply with the relevant Health Board policies and SOPs for controlled drugs, in particular the removal of expired controlled drugs and the completion of six-monthlystock reconciliations(which should all be completed in a consistent manner). Where compliance with the policycannot be achieved, for example due to resourcing, an agreed temporary deviation from the Policy should be agreed and approved at anappropriateGroup.	A full review will be conducted into the Pharmacy processes relating to 6-monthly CD stock reconciliations to determine the extent of the issue and to provide assurance of compliance. The Pharmacy Team will input into the Management of Controlled Drugs Policy, with the potential to visit the mechanism of how expired drugs are reported to Pharmacy, to ensure a more robust system with auditable records is available in the future.	30/09/2022	N/A	N/A	Complete	1	#VALUE!		Nov 2022 A review has been completed to ensure consitency in the Pharmacy checking process across all sites. A QR code has been developed which is available for wards to notify Pharmacy of expired stock.				31/10/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Low	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	N/A	N/A	Not yet due	-2	#VALUE!						31/10/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	N/A	N/A	Not yet due	-2	#VALUE!						31/10/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R3 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.	NIS Improvement Plan is already being developed by the Cyber Team. Thecompleted plan willbe presented for management review and sign off. Currently ABUHB are still awaiting the publication ofCAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being developed.	31/07/2022			Overdue	3	1471		"Jan 23: Cyber continues to maintain the NIS Risk Register and Action plan. CRU are currently reviewing all risk registers submitted with a view to finding and reporting common risks to Welsh Government . This may result in a common approach for remediation being adpoted for all Boards.Cyber will await results and support any required actions to be taken as directed by CRU Sept 22: The completed and updated register is submitted. Aug 22: The ABUHB NIS remedial Action Plan has been used to support a CRU led workshop and support the remediation of risk identified on the CRU created ABUHB NIS Risk Register. Work				31/10/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022			Overdue	1	1471		"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."				31/10/2022	30/06/2022

2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security.5.2The risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022			Overdue	1	1471		"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				31/10/2022	30/06/2022
2021.23	Internal	Operational Resumption of Services	Reasonable	Director of Operations		Medium	R2 The Health Board shouldreview the current performance reportingfor the resumption of servicesand incorporate metrics to monitor the effectiveness of actions undertaken and the profile of the overall reduction of the waiting lists.	Performance is measured weekly actual v planned and set against the agreed trajectories as per IMTP Weekly performance meetings reinstated with Divisions and chaired by the Director of Operations	30/06/2022	N/A	N/A	Closed	5	#VALUE!		National guidance and metrics is constantly evolving with regards to the new performance targets. When finalised, all national guidance and metrics are incorporated into internal reports and documents.	Nov 2022 The recommendation is implemented however further external guiadnce is awaited regarding performance targets.			20/11/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service Manager (USC)	Medium	R1.1 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	The Flow Centre Team have performed regular audits throughout the year and learning outcomes identified. This recommendation features on our regular 1:1s with individuals, staff weekly updates and will be a focus over the next fewmonths in line with this audits recommendation.Assurance is given via the Operations Structure and Urgent Care Divisional meetings with a monthly frequency and contain a feedback loop to ensure learning is disseminated to the teams.Flow Navigator audit tool to be created. Key area of focus for our Flow Navigator Auditor over the next 2 months	31/07/2022	N/A	N/A	Complete	4	#VALUE!		Mar 23 •We have seen a marked improvement with regards to documentation – noted through auding. •We have a full time Senior Flow Navigator who is responsible for auditing to help with this aim •A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement.				20/11/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Flow Centre Nurse	Medium	R1.2 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	This audit has highlighted a key learning outcome regarding the process followed when closing calls on the system and the loophole associated with the system used for recording the referral (Nugensis).Learning identified and training provided to staff Key area of focus for our Flow Navigator Auditor over the next 3 months	31/07/2022	N/A	N/A	Complete	4	#VALUE!		Mar 23•A reduction has been noted •This remains a key area of audit				20/11/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Flow Centre Nurse	Low	R2 The Flow Centre Team should establish the required level of information to be documented on the Transfer Form for each patient screenedand all forms should be uploaded onto CWS.	In the past 3 months an internal audit performed by the department highlighted further evidence of this practice and an action plan has been implemented to improve this area of practice.Clinical audit tool to be created. Initial audit to be completed –5% of Flow Nurse workload. Learning identified and training provided to staff	30/09/2022	N/A	N/A	Complete	2	#VALUE!		Mar 23 A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement.				20/11/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Flow Centre Nurse	Low	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre	30/09/2022	31/07/2023	N/A	Deadline Revised	2	-8		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			20/11/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service Manager (USC)	Medium	R4.1 We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	31/07/2023	N/A	Deadline Revised	5	-8		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 Divsional changes have meant that the BCP now requires further refinement however, orginal recommendation was implemented.			20/11/2022	30/06/2022

2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service Manager (USC)	Low	R4.2 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	31/07/2023	N/A	Deadline Revised	**1**	-8		Mar 23 •This is on hold until we return to our call centre.				20/11/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service Manager (USC)	Medium	R5 The Flow Centre Team should provide assurance to an appropriate committee or group of the delivery of the expected benefits.	The Flow Centre has been operational for a period of time that will enable an effective review of the service projected benefits and assurance to the objectives given. With recent changes in clinical and operational leadership of the Flow Centre a focus will be to review the service by the target date.	30/08/2022	31/07/2023	N/A	Deadline Revised	**3**	-8		Mar 23 •The flow centre feeds into Urgent Care SMT and DMT governance structures as well as weekly SLR operational oversight.				20/11/2022	30/06/2022
2021.26	Internal	Facilities - Care After Death	Reasonable	Director of Operations	Care After Death Manager	Low	R1 The Care after Death (CaD) Teamshould ensure that standard operating procedures:•are documented on an agreed template, with version number, issue date, review date and document owner;•incorporates links to other SOPs, documents, standardsor relevant websites;and•detail the full procedure, including all required paperwork/data entry into supporting records.	The CaD Team accept this recommendation in full.	30/09/2022	N/A	N/A	Complete	**1**	#VALUE!		This has been undertaken by the CAD Manager following the audit report.				31/10/2022	30/06/2022
2021.26	Internal	Facilities - Care After Death	Reasonable	Director of Operations	Care After Death Manager	Low	R2 The Care after Death(CaD)Teamshould ensure a staff training register is maintained, which details the training completedby team members and the date for refresher training to be undertaken.	The CaD Team accept this recommendation in full.	30/09/2022	N/A	N/A	Complete	**1**	#VALUE!		CAD Manager now has a dedicated training register for all CAD Team membes as per audit recommendatins.				31/10/2022	30/06/2022
2021.26	Internal	Facilities - Care After Death	Reasonable	Director of Operations	Care After Death Manager	Medium	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:•remotelyaccessible acrossall sites, at all times;•update immediatelyfollowing any change inputted;•link to keysoftwarewithin the Health Board,to minimise manual data entry;•produce management information / a dashboardand 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 levelsto facilitateaccess control; and•be fully compliant with the Health Board and DHCWshared 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	30/04/2023		Deadline Revised	**-1470**	-1477		Nov 2022 Alternative software solution has been procured via Synbiotix. Ongoing liaison between Synbiotix, 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.	Mar 23 Ongoiong liaision with Associate Director of Informatics Strategy & Planning	Q4 of 2022/23		30/06/2022
2021.26	Internal	Facilities - Care After Death	Reasonable	Director of Operations	Care After Death Manager	Low	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	30/06/2023	N/A	Deadline Revised	**1**	-8		Mar 23Being 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.	None		Q3 2022/23	31/10/2022	30/06/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	1.1 Ensure that the Waste Management Policy has been reviewed/updated and reflective of the above findings. That the updated Policy is underpinned by formal Board Level approval with all key elements of WHTM 07-01 guidance incorporated.	1.1 The Waste Management Policy will be reviewed/updated and formally approved by the Board.	31/10/2022			Overdue	**0**	1471						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	1.2 Waste management operational control procedures review dates should be updated following each review.	1.2 OCPs will be formally reviewed with associated record of actions.	31/10/2022			Overdue	**0**	1471						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	1.3 Out-of-date policy / procedural documents published online should be updated.	1.3 All online policies and procedures will be reviewed and updated where necessary.	31/10/2022			Overdue	**0**	1471						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Low	2.1 Enhancement of the Waste Management Policy to include staffing groups as identified by the WHTM 07-01 guidance.	2.1 Staffing groups not recorded on OCP training evidence but recorded on induction training for Facilities and Clinical staff. To be recorded on all training sessions going forward.	TBC	N/A	N/A		**#VALUE!**	#VALUE!						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	2.2a The training needs assessment should be reviewed and enhanced, encompassing all relevant UHB staff groups to determine the level and frequency of waste management training required by each staff group (which could range from general guidance on waste segregation and recycling, to technical guidance on clinical waste handling and include additional training provided due to COVID).	2.2a Training needs assessments will be reviewed and updated where necessary.	31/10/2022			Overdue	**0**	1471						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	2.2b Management should investigate options to provide waste management/recycling/green agenda training to all UHB staff.	2.2b Provision of online training has been discussed and could be implemented within ABUHB, however we believe it would benefit from an all-Wales approach. This could potentially be coordinated via Welsh Health Environmental Forum	TBC	N/A	N/A		**#VALUE!**	#VALUE!						31/10/2022	31/07/2022

2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	3. A consistent approach should be taken to the waste stream used for disposal of offensive (but non-infectious) PPE, in public areas within the hospital sites - based on official guidance and management decision.	3. This is a recurrent issue across the country and every effort is made to ensure correct segregation through waste audits, spot checks and walkarounds by Environmental Team, Compliance Team, Senior Management and Divisional Director. These measures will continue to be employed along with enhanced communication.	TBC	N/A	N/A		**#VALUE!**	#VALUE!						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	4. Staff will be reminded of the importance of complying with waste management operational procedures including (but not exhaustive): • the maintenance of secure waste storage areas; • the correct classification and disposal of waste; • the correct labelling of all waste items (including sharps)	4. As with Management Action 3 these are common, ongoing issues at all sites. Internal audits, ISO14001 audits (external), spot checks and walkarounds by Environmental Team, Compliance Team, Senior Management, Divisional Director and external auditors along with enhanced communications will reduce instances going forward	TBC	N/A	N/A		**#VALUE!**	#VALUE!						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	5.1a Waste recycling provisions and targets will be reintroduced across the UHB.	5.1a Due to the issues highlighted above, ABUHB was unable to review waste service and associated targets in recent years. Review to be undertaken.	30/09/2022	01/10/2023	N/A	Deadline Revised	**1**	-11		**24/03/2023** Recycling targets will be determined as a result of this contract extension, including the new regulations covering non-patient healthcare premises from Oct 23	**24/03/2023** Environment Act (Wales) in consultation period leading to enforcement of increased recycling regulations from Oct 23 (non-inpatient premises) and Oct 25 (inpatient premises). Therefore requirements may change in the lead up to implementation of the Act			31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	5.1b A review of waste volumes and types across the UHB should be completed, to identify potential for waste minimisation in line with WHTM 07-01 (5.3).	5.1a Due to the issues highlighted above, ABUHB was unable to review waste service and associated targets in recent years. Review to be undertaken.	30/09/2022	01/10/2023	N/A	Deadline Revised	**1**	-11		**24/03/2023** Ongoing review of clinical waste incl site visits to both over and under 5 tonne clinical waste sites being arranged in conjunction with Stericycle (all Wales clinical waste contractor). Food waste review being undertaken as part of contract process (inc all sites with in-patient dining). General waste/recycling review as part of contract extension negotiations. Ad hoc waste collection services e.g. elec equipment, chemicals etc to be undertaken as part of contract process	**24/03/2023** As above plus staffing levels in Environment Team			31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	6.1a Recommendations / non-conformities arising from internal (pre acceptance audits) and external audits should be monitored via the central tracker.	6.1a All non-conformities (NCs) and recommendations are recorded by a central tracker spreadsheet. At the time of the audit, the tracker had not been updated with the latest NCs. All NCs/recommendations will be recorded as soon as raised/published. This would be reviewed every 6 months as part of external ISO14001 audit.	TBC	N/A	N/A		**#VALUE!**	#VALUE!						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	6.1b Audit non-conformities, and progress towards actioning the same, should be reported to an appropriate forum.	6.1b Audit outcomes will be raised on an exception reporting basis to the Health & Safety Committee which has direct escalation to Corporate H&S and Exec Board.	TBC	N/A	N/A		**#VALUE!**	#VALUE!						31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	7.1a Waste Management monitoring and reporting arrangements should be enhanced (particularly through to Committee/Board levels), with appropriate scrutiny and challenge demonstrated.	7.1a Environment to be a regular agenda item on Health & Safety Committee	31/08/2022	N/A	N/A	Complete	**2**	#VALUE!		Regular agenda item on H&S Committee				31/10/2022	31/07/2022
2021.27	Internal	Waste Management	Reasonable	Director of Operations	Environmental Manager	Medium	7.1b Waste risk management processes and procedures should be enhanced to widen the scope of reporting of waste management issues, inclusive of the development of a localised waste risk register and top waste risks reports, with joined up mechanisms to incorporate contract performance issues, recommendation tracker updates etc.	7.1b Local waste risk register with associated report to be created which will feed into Divisional Risk Register	31/08/2022	N/A	N/A	Complete	**2**	#VALUE!		Identified risks are being entered on Local Risk Register (on DATIX). This will be managed by Env Mgr with oversight by Compliance Manager. Escalation to Divisional and Corporate Risk Registers if necessary	N/A		23/09/2022	31/10/2022	31/07/2022

2022.01	Internal	CYP Continuing Care	Reasonable	Director of Operations	General Manager	High	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	N/A	N/A	Not yet due	-5	#VALUE!						31/10/2022	07/10/2022
2022.01	Internal	CYP Continuing Care	Reasonable	Director of Operations	Assistant Service Manager	Medium	Incorporate the use ofthe recently developed All Wales CCN Senior Nurse forum KPIs for CCNS within the performance monitoring process.Regular monitoring of the performance report within the CCNS with annual (minimum) reporting to the Division.	Medium1)RL Datix to be utilised further to capture compliments as an initial step to provide more balance. 2)Key Performance Indicators for the Children's Community Nursing Service is being looked at within the All Wales Forum. Once finalised, these will be implemented locally and reported to Division two-monthlyin line with QPS frameworkwith appropriately agreed action plans supported3)CIVICA has recently been commissioned by the UHB and will support the development of a dashboard to analyse service user feedback, key performance indicators and Quality outcome measures.	31/12/2022			Overdue	-2	1471						31/10/2022	07/10/2022
2022.01	Internal	CYP Continuing Care	Reasonable	Director of Operations	Assistant Divisional Nurse / Division Lead for QPS	Medium	Develop quality assurance mechanisms to assess the quality of:•CYP CC assessments;•care delivered by the CCNS team; and•care delivered by external providers (respite and commissioned CYP CC).Incorporate the QA mechanisms into the CYP CC Policy.	1)Quality Assurance mechanisms have been under review and considered through the multiagency CC development group. This to be finalised and rolled out across services2)CC policy will reflect clearly the mechanisms used for assurance	30/11/2022			Overdue	-1	1471						31/10/2022	07/10/2022
2022.01	Internal	CYP Continuing Care	Reasonable	Director of Operations	Assistant Divisional Nurse / Division Lead QPS	Low	Acceptance of target risk scores outside the tolerance levels should be made at an appropriate level and clearly documented in the risk register.	1) Risk Register to be reviewed in light of service development and transformation opportunities. 2) Tolerance levels of risk for the service will be mitigated as far as possible within this workstream, clearly identified and understood with required transformation changes supported by both Division and Executive team.3) Ongoing monitoring and scrutiny at Division/Executive on 2 monthly basis	30/09/2022			Overdue	1	1471						31/10/2022	07/10/2022
2022.01	Internal	CYP Continuing Care	Reasonable	Director of Operations	Assistant Divisional Nurse/ Division Lead for QPS	Low	Implement robust communicationmechanismsbetween 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			Overdue	-1	1471						31/10/2022	07/10/2022
2022.01	Internal	CYP Continuing Care	Reasonable	Director of Operations	Senior Nurse & Practice Educator	Low	Develop a CCNS Training Strategy to bring together and provide oversight for existing training activities.Implement a sustainable rolling programmeof practical CYP CC training.Monitor the impact of the resource issues on training and competencies to ensure they are not adversely affected.	1)Ongoing comprehensive training programme has re-commenced and is monitored for compliance. Compliance of training programme is currently affected by safe staffing needs –Division will continue to monitor expected improved compliance withmitigated workforce challenges2)Compliance to be reviewed two monthly as per QPS framework and to allow for implementation of follow up actions. Reported to DivisionalManagement Team	30/11/2022			Overdue	-1	1471						31/10/2022	07/10/2022

2022.01	Internal	CYP Continuing Care	Reasonable	Director of Operations	Division Director / Chair for CCC Panel	Low	Include links to the following within the CYP CC Policy to provide full clarity on requirements:•relevant laws and regulations;•relevant Health Board policies and procedures, e.g., those relating to escalation and concerns; and•relevant local processes not already reference, e.g., local procedures to support implementation of Health Board escalation and concerns.Include all roles and responsibilities and reporting lines for completeness, even though they follow the Divisional structure.Inform CCNS staff of recent updates to the CYP CC Policy and where the Policy is stored.	1)Suite of policies and procedures have been undergoing review to ensure they are updated and make reference to concurrent local and UHB Policyas well as the wider National Policy and Legislation2)Policies and procedures, guidelines, standardsto be registeredon the Intranet A-Z Policies and Procedures, and the Children's community nursingstaff pages of Healthier Together Website for ease of access for the wider team3)Terms of Reference updated and awaiting final Division approval/sign off.4)Updated Continuing Care Policy	30/11/2022			Overdue	**-1**	1471						31/10/2022	07/10/2022
2022.02	Internal	Job Evaluation Process	Reasonable	Director of Workforce & OD		Medium	The Health Boardshouldensure that all necessary job evaluation documentation is completed correctly and centrally stored,to ensure that all posts have a comprehensive audit trail of how decisions are made.	Recommendation accepted.The service will ensurethe consistency process adhered to and administration processes are followed in line with agreed processes with all documentation filed in JE database/job library and using unique CAJE identifiers. Adherence to Job evaluation handbook guidance in terms ofconsistency checkingand maintaining good job evaluation practices.To commence immediately.Development of Job evaluation intranet with all relevant document relating to job description to support good practice and links to existing policies with flow charts to support correct policy.	31/12/2022	N/A	N/A	Complete	**-1473**	#VALUE!					Mar 23 Job evaluation and re-evaluation policies have been updated and ratified by the Executive Committee. Intranet has been set up to include links to polices and job description templates - all actions completed		07/10/2022
2022.02	Internal	Job Evaluation Process	Reasonable	Director of Workforce & OD		Low	The Health Board should review, update if applicable,and ratify the Banding of New Posts policy. Once this has been completed,theHealth Board should ensure all related policies / procedures have been updated and linked correctly on the intranet page.	Recommendation accepted. Work has commenced to update the Banding of New Posts Policy inpartnership with staff side lead,ensuring alignment with any recent JEG recommendations. First draft to be submitted to the Workforce & OD Policy Group in December2022.	31/03/2023	N/A	N/A	Not yet due	**-5**	#VALUE!						31/10/2022	07/10/2022
2022.03	Internal	GUH Financial Assurance	Substantial	Director of Planning & Performance		Low	Management should confirm appropriate action in respect of £10,190 of delivered fencing not utilised at the GUH project	Agreed.	30/11/2022	N/A	N/A	Not yet due	**-1**	#VALUE!						31/10/2022	07/10/2022
2022.04	Internal	Agile Delivery	Advisory	Director of Workforce & OD		High	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	30/03/2023	N/A	Not yet due	**#VALUE!**	#VALUE!		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	Estates review, accomdation group, ICT infrastructure, service change, impact of cost of living crisis on staff, capital availibility, financial review	regular review through agile delivery programme board also the cost of living risk and estates risk is highlighted on the CRR		25.10.22	07/10/2022
2022.04	Internal	Agile Delivery	Advisory	Director of Workforce & OD		Low	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	30/04/2023	N/A	Deadline Revised	**-1472**	-1477		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.	Redesigning vision following presentation and feedback from the Executive Committee and will progress this to Board		**Request extension until end of April 2023** to enable approval and implementation		07/10/2022
2022.04	Internal	Agile Delivery	Advisory	Director of Workforce & OD		Low	Update the Agile Working Group termsof reference (ToR). The ToR should be updated to include,but not limited to:•The frequency of meetings; and•The quoracy required at meetings.	Agreed.	31/10/2022	N/A	N/A	Complete	**-1471**	#VALUE!					Mar 23 TOR updated - recommend close down		07/10/2022
2022.04	Internal	Agile Delivery	Advisory	Director of Workforce & OD		Low	The Health Board should engage with staff separately from surveys, for example a more targeted collection of information. Currently, the surveys received a low response rate in certain areas. A different approach to engagement within these areas should be explored and implemented (e.g. site visits).	TU / LNC engagement will continue along with Newsletters and specific Departmental meetings to discuss agileworking principles and ways of working.This includes sharing of good practice and initiatives in specific areas. Agile discussions and engagement will take place in part under the umbrella of the People First initiative. Other forums will be useddependant on the local context.A delivery plan to support the roll out of the Agile Framework, including communications and engagement,has been developed.	31/10/2022	N/A	N/A	Complete	**-1471**	#VALUE!					Mar 23 Drop in engagement sessions being undertaken as part of the Retention Cafes - staff are encourage to discuss their experience of agile working, information is shared. These events have been undertaken across all sites and will continue. Additional staff survey and divisional survey undertaken to assess agile toolkit		07/10/2022

202106	External	Quality Governance Review	Not Rated	Director of Therapies & Health Science		N/A	R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should:•ensure there is appropriatescrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. •ensure that risk registers arecompleted and maintainedacross all directorates thatidentify quality and safety risksand mitigating actions andthere are appropriate riskescalation arrangements.	The form and functionof Quality Patient Safety Operational Group is currently being reviewed, with the aim of strengthening oversight of Risk. ABUHB are in the process of introducing the OFWCMS with the Risk module part of a future phase of roll-out. This will be a driver for improving Divisional ownership of risk management and mitigation. A programme of Divisional awareness raising will be introduced across ABUHB to strengthen risk management processes.The responsibility of Divisional Directors will be reinforced in terms of maintaining registers and ensuring appropriate mitigation.	31/10/2022	Sep-23		Deadline Revised	**0**	-10		This action is currently marked as overdue on the tracker, and I propose a revised deadline of end of September 2023. The justification for this revised deadline is related to the implementation of the HB's new Quality Strategy that was only agreed by the Board in March 2023, and because this Internal Audit recommendation has now been superseded by the development of the Quality Strategy.				31/10/2022	07/10/2022
202106	External	Quality Governance Review	Not Rated	Medical Director		N/A	R2 During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should:•complete the work on its clinicalaudit strategy, policy, and plan.The plan should covermandated national audits,corporate-wide and local auditsinformed by areas of risk. This plan should be approved by the Patient Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely. •update and finalise the terms ofreference for the ClinicalEffectiveness and StandardsCommittee.•ensure there is sufficientresource and capacity forclinical audit at an operationallevel•ensure systems for learningand good practice from clinicalaudit are embedded across theorganisation.	ABUHB will undertake a review of resources and capacity available to support the completion of the National Clinical Audit programme.The Clinical Standards and Effectiveness Group is the forum where Clinical audit is discussed and presented to ensure scrutiny and assurance. Bi-annual reporting to the PQSOC takes place to provide assurance of clinical performance and the development of action plans to address requisite improvements. A review of the membership of the group will be undertaken to support improved Divisional representation.	31/08/2022			Closed	**2**	1471	The Health Board updated the clinical audit strategy and policy in October 2022. As part of the implement ation plan the strategy has been presented at Divisional meetings with a request for Divisions to develop a clinical audit plan. The Health Board's Clinical Effectivene ss and Standards group (CSEG) terms of reference were updated in					31/10/2022	07/10/2022
202106	External	Quality Governance Review	Not Rated	Director of Workforce & OD		N/A	R3The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel:•they are not treated fairly orgiven feedback when reportingerrors, near misses orincidents. that the Health Board does notact on concerns they raise ortake action to minimise futureoccurrence of errors, nearmisses or incidents	The ABUHB Value Framework has been refreshed recently. There is clearly a need to remind managers and leaders to ensure feedback to staff who have raised concerns and this will be reinforced through Divisional Triumvirates for cascade. A review of concerns raised by staff and the actions taken will be conducted to provide assurance.	31/10/2022	31/05/2023	N/A	Deadline Revised	**-1471**	-1478		Mar 23 Collaboration with departments has explored the Datix reporting mechanisms to understand the feeling around this process and how we can better support managers to feedback learning and outcomes. Finally, we are beginning to design the core skills training programs across the Health Board in a host of areas such as difficult conversations, giving and receiving feedback and others related to this issue which will support staff to take action.	The size of the Health Board will provide a barrier. Targeting at specific reporting hotspots and triangulating with other metrics will be key.	Support is being provided through the PADR process and specific training in this area is being delivered on current leadership programs.	**Request an extension to the end of May 2023.**		07/10/2022
202106	External	Quality Governance Review	Not Rated	Director of Nursing		N/A	R4Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should:•undertake work to understandwhy patient feedback updatesare not regularly provided towork areas or departments.•ensure there are systematicarrangements for collating andactinguppp patient experience information	A business case is in-development for the procurement of 'Civica' as part of the OFWCMS. If supported this will strengthen the ability to capture live patient experience which Divisions and Directorates will own, strengthening feedback.	30/09/2022	N/A	N/A	Complete	**#VALUE!**	#VALUE!		CIVICA was purchased and is launching this month therefore a system to collate patient feedback. Therefore propose to close this reccomendation.				21.02.23	07/10/2022
202106	External	Quality Governance Review	Not Rated	Director of Nursing		N/A	R5 The Health Boards Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.	The PTR policy will be updated with an extension to the date in light Welsh Government are reviewing the PTR policy aligned to the Quality & Engagement Act implementation.	30/06/2022	N/A	N/A	Complete	**#VALUE!**	#VALUE!		The policy has been extended awaiting further guidance and legislation from WG, therefore propose to close.				21.02.23	07/10/2022

202106	External	Quality Governance Review	Not Rated	Clinical Executives		N/A	R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:•complete its review of thequality and safety framework toensure that flows of assuranceare appropriate, and that the •framework functions asintended.•articulate the operationalstructures and processes forquality and safety within thequality assurance frameworkand how they align with thecorporate structure to provide a'floor to board' assurance.	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF. The revised Quality Assurance Framework will include the operational structures and processes.	31/10/2022	N/A	N/A	Not yet due	0	#VALUE!						31/10/2022	07/10/2022
202106	External	Quality Governance Review	Not Rated	Clinical Executives		N/A	R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.	A review of roles for QPS across Divisions will be undertaken with the aim of implementing a consistent approach (this will include time for leads to undertake their role effectively).	31/10/2022	N/A	N/A	Not yet due	0	#VALUE!						31/10/2022	07/10/2022
202205	Internal	Digital Benefits Realisation	Reasonable	Chief Executive	Chief Digital Officer	Medium	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			Not yet due									
202206	Internal	Digital Benefits Realisation	Reasonable	Chief Executive	Chief Digital Officer	Low	R2 The Health Board should continue with an annual reporting cycle that summarises the benefits position for the Audit, Risk and Assurance Committee. Work on the benefits dashboard should be completed and incorporated into future reporting.	Benefits updates are provided at monthly programme boards and quarterly to Programme Delivery Board (PDB). Work is ongoing with the PMO using the informatics portfolio register to develop oversight of portfolio level benefits. A local dashboard is under development for summary reporting to DDOB on a six monthly basis. This dashboard can be updated to provide an annual update to the Audit, Risk and Assurance Committee.	01/09/2023			Not yet due									
202106	External	Quality Governance Review	Not Rated	Clinical Executives		N/A	R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:•review the operational patientsafety and quality groups toensure they are effectivelysupporting the Health Boardsquality governancearrangements.•ensure that other operationalmeetings / forums providesufficient focus on quality andsafety alongside finance,performance, and operationalmatters.	The patient, quality and safety structures for each Division will be reviewed and outlined in the revised Quality Assurance Framework (see R6).Divisions will be reminded to ensure a robust focus on patient quality and Safety through Divisional and Directorate meetings.	31/10/2022	N/A	N/A	Not yet due	0	#VALUE!						31/10/2022	07/10/2022

202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	Workforce & Organisational Development Business Partner Accountant Interim Facilities General Manager	N/A	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 development programme we shall be utilising a student placement to assist with decarbonisation metrics, reporting and engagement starting in 23/24.	01/11/2023			Not yet due										
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	AFD	N/A	DAPs should be fully costed to fully determine the total funding required.	Sub groups of the main DPB have been tasked with developing action plans relating to their delegated national initiatives. This work will include costing projects and is currently in progress. Programme/project costs to meet the interim CO2 reduction targets are currently being analysed.	Q4 2022.23			Not yet due									
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	Decarbonisation Programme Board (DPB) Workstream Leads	N/A	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			Not yet due									
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	Energy & Carbon Manager DPB Workstream Leads	N/A	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	Agree. Net Zero Report data sources, analysis and report generation will be subject to an internal review. The HB have now set up a Decarbonisation Programme Board which incorporates the existing metrics along with additional scrutiny of new projects coming on line within the working groups.	01/05/2023			Not yet due									
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	Asst. Director Finance & Finance & Resources Workstream Lead	N/A	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 four task 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 Bi monthly board meetings within the health board.	01/11/2023			Not yet due										
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	DPB & Workstream Leads	N/A	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Agree. Appropriate governance structures for the DPB and subsequent workstreams have been established with ToRs for both DPB and workstreams complete	TBC			Not yet due									
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	Decarbonisation Programme Board Workstream Leads	N/A	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 sub groups each with national initiatives delegated to them. The DPB and sub groups each have ToR's and scheduled meeting frequencies	01/11/2023			Not yet due									

202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	Energy & Carbon Manager	N/A	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	Agree. ABUHB & PTHB are currently collaborating on Biodiversity Assessments funded through HSC Climate Emergency Fund	31/03/2023			Not yet due									
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	DPB & Head of Communications & Comms/Training/Digital Workstream Lead	N/A	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Agree. SusQI training has been rolled out to relevant officers. ABUHB would support the development of an All-Wales training package	TBC			Not yet due									
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	DPB & Workstream Leads	N/A	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			Not yet due									
202206	Internal	Decarbonisation - Advisory	Advisory	Director of Finance, Procurement & Value	Workstream Project Leads	N/A	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			Not yet due									
202207	Internal	Clinical Audit	Limited	Medical Director	Assistant Director QPS	High	R 1.1 Review and renew the Clinical Audit Strategy, which should include: • how the Health Board plans to track and monitor actions raised in national clinical audits; • 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; • resourcing requirements to ensure both national and local clinical audits are effectively monitored; • role and responsibilities for clinical audit, including the monitoring groups; • how assurance is provided from each applicable divisions / directorates; and • the escalation process for actions raised within audits.	The internal audit focused on two main parts of the clinical audit, firstly at how the health board participate in national clinical audits and then secondly its participation in local clinical audits. It has been highlighted that sample testing around the local clinical audits would have been undertaken but not possible at this time as the control framework around this area was not robust. However, it has been noted in the report that this is improving. The Clinical Audit Strategy was updated and published in Oct 2022. It provides the Strategic Direction for Clinical audit for the Health Board and sets out the commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness. The strategy includes the requirement for Divisions and Corporate leads to develop Clinical Audits plans aligned to quality and safety risk with a key set of benchmarks to support this. The Divisional	01/06/2023			Not yet due				Mar23 Divisional meetings held throughout March regarding establishing Clinical Audit Plans. Presentation shared on Clinical Audit Strategy and Aims for Audit. Reviewing standardisation of reports presented to CSEG. AMaT is being used for action plans from audit. AMaT training underway and Divisions aware of its use. Tracking of audit actions has started. Reviewing capability of AMaT to look allow the facilitation of recording for validation and peer review. Outlier SOP has been developed and used for outlier status. Terms of reference shared with CSEG. Progress with the Quality Strategy and using clinical audit as	Time taken to attend at Divisional meetings due to busy agendas, or cancelled meetings due to site pressures. Currently the resource is a 0.8WTE Clinical Audit Lead who delivers both the National Clinical Audit and Local Audit Plans. All work is falling to one key person in the team who works part time.	Ensuring compliance with National Clinical Audit Programme is being followed according to the nine month plan set up by Healthcare Quality Improvement Partnership.			
202207	Internal	Clinical Audit	Limited	Medical Director	Assistant Director QPS	High	R2.1 The Health Board should create a local clinical audit plan using a risk-based approach.	As part of the Clinical Audit Strategy an implementation plan will be developed to ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual Plan. The strategy includes the requirement for Divisions and Corporate leads to develop Clinical Audits plans aligned to quality and safety risk with a key set of benchmarks to support this.The plan will ensure ABUHB has clear lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.	01/03/2023			Complete				Mar 23A Clinical Audit Plan has been written and signed off by PQSOC. This aimed to engage with Divisions to ensure Clinical Audit Plans were being developed within each area. These papers have been written for ARA April meeting after ratification by PQSOC. As part of the launch of the Strategy the clinical audit team has attended Divisional meetings to present the strategy and discuss clinical audit plans for the ongoing year.			Papers ratified by PQSOC and presented to ARA in April 2023. F&T 6/2/23, Medicine 8/2/23, Scheduled Care 9/3/23, Urgent Care 21/3/23, PCC 21/3/23, MHLD 13/4/23, Clinical Specialities TBC		

202207	Internal	Clinical Audit	Limited	Medical Director	Assistant Director QPS	High	R 2.2 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.	The Divisional Triumvirates will be sighted on all relevant documents relating to Clinical Audit, as well as the Clinical Lead. Audit should be mandatory and non-performance will be challenged. AMaT will facilitate clinical audit and provide an oversight of the data. This will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to the Committee and Executive Board. Going forward there will be standardised approach to reporting audit findings. These will be reported under: • Areas where good practice has been identified • Areas of where practice requires improvement • Actions to be taken - using SMART objectives We will ensure learning from audit and review is shared across the organisation and communicated to staff and patients.	01/01/2023			Complete				Divisional meetings attended to discuss Clinical Audit Strategy. AMaT demonstrations being given to clinical areas to record actions and track. AMaT allows an action plan to identify successes, challenges and actions with SMART objectives. Learning will at CSEG and look to embed as part of the Quality Strategy and clinical effectiveness.			Papers ratified by PQSOC and presented to ARA in April 2023. F&T 6/2/23, Medicine 8/2/23, Scheduled Care 9/3/23, Urgent Care 21/3/23, PCC 21/3/23, MHLD 13/4/23, Clinical Specialities TBC		
202207	Internal	Clinical Audit	Limited	Medical Director	Assistant Director QPS	Medium	R 2.3 The local clinical audits should be recorded onto AMaT, as is currently being done with national clinical audits.	It is acknowledged that the current process in ABUHB for local audit has lacked structure and formal documentation. AMaT will be utilised for local audit and will enable the development of a formally recognised process for reviewing the organisations performance when reports are published. The AMaT report will include 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. The Clinical audit lead, CSEG and the Assistant Medical Directors will scope how to mandate the use of AMAT. We will agree on a formal process for registering a local audit (which sets out audit lead, reason for audit (e.g. complaint response etc etc), methodology (e.g. how will data be collected and analysed), standard being audited against, timeline, when report due and action to be taken from audit (including	01/06/2023			Not yet due				Mar 23 As part of Clinical audit strategy when meeting with Divisions it has been requested to put ALL clinical audits onto AMaT. Divisions have been asked to train how to use AMaT so this can be captured. Training is underway and we are making huge progress in areas like Infection Prevention and Control. Now other Directorates have seen the functionality of AMaT they are keen to use it.	Currently the resource is a 0.8WTE Clinical Audit Lead who delivers both the National Clinical Audit and Local Audit Plans. All work is falling to one key person in the team who works part time.				
202207	Internal	Clinical Audit	Limited	Medical Director	Assistant Director QPS	Medium	R 3.1 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.	As each National Clinical Audit (NCA) is published it will be added to the web-based audit tracking system AMaT and assigned to a Clinical Lead. The Clinical Lead will act as a champion and point of contact for every National Clinical Audit and Outcome Review which the Health Board is participating in. Full participation is expected in ALL NCAs. The NCA programme for 2022/23 will be shared with Clinical audit leads to allow planning for attendance at CSEG. AMaT is seen as the solution to effectively recording audit results, tracking progress and challenges and developing an action plan within a specific timeframe. With the introduction of AMaT, there will be positive engagement for participation in audit. Audit should be mandatory and non-performance must be challenged. ABUHB is in the process of training staff to use AMaT, currently 90 users are registered. All National Clinical Audits are to be registered. The Clinical Audit Strategy states that all	01/03/2023			Complete				Mar 23 When each National Clinical Audit (NCA) is published the results have been added to the web-based audit tracking system AMaT and assigned to a Clinical Lead. The Clinical Lead is asked to present the results at CSEG. Following the Divisional meetings the NCA programme for 2022/23 has been shared with Clinical audit leads to allow planning for attendance at CSEG. AMaT allows the development of an action plan within a specific timeframe. The action plan is forming the minutes of CSEG. Since the introduction of AMaT and training underway there has been positive engagement for participation in audit.			Introduction of AMaT and presentation at each of the Divisonal meetings. Following the Divisional meetings the NCA programme for 2022/23 has been shared with Clinical audit leads to allow planning for attendance at CSEG. AMaT allows the development of an action plan within a specific timeframe. The action plan is forming the minutes of CSEG.		

202207	Internal	Clinical Audit	Limited	Medical Director		Medium	R 3.2 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.	The use of AMaT will allow reports to be easily produced for Clinical Directors and Clinical Audit Leads. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. AMaT will facilitate clinical audit and provide an oversight of the data. This will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to the Committee and Executive Board. Going forward there will be standardised approach to reporting audit findings. These will be reported under: • Areas where good practice has been identified • Areas of where practice requires improvement • Actions to be taken - using SMART objectives The Clinical Standards and Effectiveness Group (CSEG) oversees the governance relating to clinical audit and reports biannually to POSOC the outcomes	01.03.23			Complete				Mar 23 The implementation of AMaT has allowed the reporting of audits to be uploaded to AMaT and this can be used to document successes, challenges and a detailed action plan with SMART objectives. As the number of audits are being added to AMaT it allows data points to track improvements and produces visual results in the form of dashboards, Through training, staff are finding it easy to use and intuitive, so are seeing the benefits to include simple management of audits, easy management of reaudits and noncompliance. Providing an oversight of the data. This will improve			Implementation of AMaT, minutes from CSEG. Dates of attendance at Divisional meetings. Documented training for staff.		
202207	Internal	Clinical Audit	Limited	Medical Director		Low	R4.1 Add the AMaT guidebook to the Intranet	This will be actioned, the AMaT guidebook will be added to the Clinical Audit intranet page for ABUHB.	01/12/2022			Complete				Mar 23 Completed.			Clinical Audit plan has been updated on the Corporate QPS intranet page.		
202201	External	The National fraud Initiative in Wales 2020-21	Not Rated	Director of Finance and Procurement		N/A	•R1) All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.														
202201	External	The National fraud Initiative in Wales 2020-21	Not Rated	Director of Finance and Procurement		N/A	R2) Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.														
202201	External	The National fraud Initiative in Wales 2020-21	Not Rated	Director of Finance and Procurement		N/A	R3) Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.														
202202	External	Equality Impact Assessments: more than a tick box exercise?	Not Rated	Director of Workforce & OD		N/A	•Public bodies should review their overall approach to Equality Impact Assessment considering the findings of this report and the detailed guidance available from the Equalities and Human Rights Commission and the Practice Hub														
202308	Internal	NCN Final Report	Reasonable	Director of Primary, Community Care and Mental Health		Low	R1 The Health Board uses the term NCN to describe each of their cluster groups. The word NCN should be used instead of clusters in documents to prevent any misunderstandings.	The Executive Team have agreed to the use the term NCN rather than cluster groups and NCN Development Programme rather than Accelerated Cluster Development Programme.	Complete			Complete									
202308	Internal	NCN Final Report	Reasonable	Director of Primary, Community Care and Mental Health		Low	R2 The NCN intranet pages should be updated to ensure all information, specifically the 'Plans on a Page' are in date.	The newly appointed Communication & Engagement Officer in the NCN Office will be responsible for updating the AB Pulse intranet web pages which will include the NCN plans.	01/02/2023			Overdue									
202308	Internal	NCN Final Report	Reasonable	Director of Primary, Community Care and Mental Health		Medium	R3 Workforce planning should be more detailed within the NCN plans. If the NCNs want to implement certain projects or initiatives, there should be a clear understanding of how that will affect the workforce in that area. Given GP workforce requirements are so challenging, producing a workforce report that details where GPs are based, and who may be available to cover certain locations when required etc may be useful.	The newly appointed Workforce & Organisational Development Transformation Project Manager in the NCN Office will support the NCN Leads and Borough locality team to develop workforce plans to implement specific projects, initiatives or models of care. The National Workforce Reporting System (NWRS), hosted by Shared Service Partnership, has been analysed to identify areas where there are shortages in the GMS workforce. This information formed the basis of a recent round of NCN sustainability meetings and a Board Briefing session. The Executive Director for Primary Care, Community Services and Mental Health has re-established the Primary Care Sustainability Board which will respond to the workforce issues through a costed action plan	01/04/2023			Not yet due									

202308	Internal	NCN Final Report	Reasonable	Director of Primary, Community Care and Mental Health		High	R 4 The Health Board should identify keys goals for the ACD/NCN programme going forward. Management should also identify the key metrics that can be tested, to understand whether the goals have been reached or where the programme requires improvement.	The Health Board is currently recruiting a Data Analyst who will work with Information Services and the Business and Performance Team to identify a basket of indicators that can be used to understand the impact of the NCN Development Programme.	01/03/2023			Overdue									
202308	Internal	NCN Final Report	Reasonable	Director of Primary, Community Care and Mental Health		Low	R5 Management should review the structure of the ACD/NCN programme and understand whether a more streamlined approach could be undertaken, to best utilise the resources available.	The Primary Care and Community Service Division has sponsored a report to the RPB and ABUHB Public Board about a suitable governance structure for NCN planning and delivery which meets the Ministerial milestones.	01/12/2022			Overdue									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Medium	R1 Treatment of charitable funding and application should be explicit in project cost reporting.	Agreed. The FBC cost form did show this as a separate funding item on FBC 7 (note: it was in the sum of £150k incl. VAT) but the Welsh Government approval stated the funding total of the entire sum. Welsh Government have been notified and are awaiting their clarification.	31/01/2023			Overdue									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Low	R2 The PEP should be updated to reflect the current stage of the project	Agreed. The PEP will be updated to show current position	31/01/2023			Complete									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Medium	R3 The role and responsibilities of the UHB roles of Senior Responsible Officer, Project Director, Project Manager etc., should be fully defined and approved by the Project Board.	Agreed. PEP will be updated to reflect this.	31/01/2023			Complete									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Medium	R4 Operation and membership of the commercial meetings should be defined at the Project Execution Plan to include (a) the requirement to minute meetings; (b) UHB officer membership; and (c) interaction with other key project groups e.g., the Project Team.	Agreed. PEP will be updated to reflect this.	31/01/2023			Complete									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Medium	R5 The UHB should finalise Project Manager contract as soon as possible.	Agreed. We are still awaiting a final contract to be sent through. Meeting has taken place on the 6 December 2022 between Health Board and Project Manager to discuss. Confirmed that a draft contract will be sent through as soon as possible.	31/01/2023			Overdue									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Low	R6 The PEP should define the integration of the contractual change control procedures and the UHB's Scheme of Delegation.	Agreed – the PEP will be updated to reflect this.	31/01/2023			Complete									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Low	R7 The Change Control Form should be updated to enhance clarity of the decision process designating changes as 'for information or 'for action' prior to submission to Project Board.	Actioned since fieldwork.	31/01/2023			Complete									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Medium	R8 Risk registers should be formulated/updated for the current stage of the project, with project management, and contractual versions of the register corresponding for any common risks.	Agreed. The management risk register will be updated to show the contractual risks.	31/01/2023			Overdue									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Medium	R9 Risk registers should include risk costs, risk owners (named individuals), and time parameters for risk mitigations.	Agreed. A risk register meeting will be held to address the recommended inclusions.	31/01/2023	30.04.23		Deadline Revised									
202309	Internal	Unified Breast Unit at YYF	Reasonable	Director of Operations	Associate Director of Capital	Low	R9 To enhance reporting, an exception report should be published of targeted risk mitigations not achieved.	Agreed. This will be shown on the Project Highlight Report for discussion at Project Board, should anything need to be highlighted, rather than a separate report.	31/01/2023			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		Low	R1 The Project Execution Plan should be updated to reflect current governance arrangements	Agreed. The PEP will be updated.	31/01/2023			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		Medium	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			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		Medium	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			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		Medium	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			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health	Programme Manager	Low	R5 A standard and consistent range of project reports should be submitted to the Primary Care & Community Estates Programme Board, to support the 'project board' role and responsibilities of the forum (to be defined as per recommendation 2.1).	Agreed. Improved reporting has been implemented at other projects and will be introduced at Newport going forward.	01/01/2023			Overdue									

202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health	Programme Manager	Low	R6 Project Team meetings should be supported by a standard agenda, including submission of a Low standard and consistent range of project reports. This should include the Cost Report and external PM's progress report for information (albeit recognising the full detail of these technical reports may not be reviewed during the meetings).	Agreed. Improved reporting has been implemented at other projects and will be introduced at Newport going forward.	01/01/2023			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health	Programme Director and Torfaen Service Lead	Medium	R7 The UHB Service risk register should be developed as soon as possible, with key risks reported to the Project Team and Programme Board on a routine basis (see also MA2).	Agreed. The need for the development of the risk register was raised at the last Project Team meeting.	01/02/2023			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health	Programme Director	medium	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			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		medium	R9 At Future Projects Target cost / tender reports should be presented to the Project Board for scrutiny and approval.	Actioned since fieldwork.				Complete									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		medium	R10 Project Control Forms should be authorised in accordance with the Standing Orders (Scheme of Delegation).	Ongoing throughout project.	N/A												
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		Low	R11 At future projects Contracts should be executed before works / duties commence.	Agreed. We will endeavour to have contracts in place prior to duties commencing going forward at future projects.	N/A												
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		Low	R12 At future projects Contracts should be dated.	Agreed. Signing process to be reviewed and strengthened.	N/A												
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health		Medium	R13 At future projects Contracts over £100k in value should be signed by both the Chief Executive & Chair in line with the Standing Orders (Scheme of Delegation).	Agreed. Approval and signing process to be reviewed, along with communication to teams in respect of delegated limits and associated requirements for authorisation	N/A												
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health	Project Director, with support from Capital Finance and the external Cost Adviser	High	R14 The UHB should ensure cost information is adequately scrutinised and understood in a timely manner to feed into routine WG updates (via the PPR process), and to allow for timely exception reporting if required.	Agreed.	Ongoing												
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health	Project Director	Low	R15 The Project Bank Account should be implemented as soon as possible.	Agreed. The UHB is awaiting a list of sub-contractors from the SCP who wish to join the PBA.	01/02/2023			Overdue									
202310	Internal	Newport HWB Centre	Reasonable	Director of Primary, Community Care and Mental Health	Project Director	Low	R16 KPIs should be submitted as required by the D4L Framework.	Agreed. Note that during this period the project was awaiting FBC approval and had not commencement on site. There would have been limited performance matters to measure.	Ongoing												
202311	Internal	Policies	Limited	Director of Corproate Governance		Medium	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.	30/09/2023 and 31/03/24			Not yet due									
202311	Internal	Policies	Limited	Director of Corproate Governance		Low	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.	30/09/2023			Not yet due									
202311	Internal	Policies	Limited	Director of Corproate Governance		Low	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	30/09/2023			Not yet due									
202311	Internal	Policies	Limited	Director of Corproate Governance		Medium	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.	30/09/2023			Not yet due									

202311	Internal	Policies	Limited	Director of Corproate Governance		High	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.	30/09/2023			Not yet due										
202311	Internal	Policies	Limited	Director of Corproate Governance		High	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.	30/09/2023			Not yet due										
202311	Internal	Policies	Limited	Director of Corproate Governance		Medium	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.	30/09/2023			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	DPO and Head of IG	Medium	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.	31/03/2023 31/03/2023			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Interim ADI – Governance & Assurance	High	R2 The importance of maintaining record management quality should be re-iterated to clinical staff, using communications from senior clinical staff and clinical information leads	As per 1.1 above, we will seek to enforce attendance at Health Records awareness sessions and further re-iterate the professional standards required.	31/03/2023			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Chief Nursing Information Officer (CNIO)	Medium	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			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Head of Workforce and OD	Medium	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 Nursing and 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			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	DPO & Head of IG	Medium	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			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Interim ADI - Governance & Assurance	Medium	R6 It should be ensured that storage conditions for records meet basic standards.	Information on unsuitable storage areas will be presented to the Medical Director every three months by the Data Protection Officer with appropriate risk assessments. Action plan with the Medical Director will be agreed.	31/03/2023			Not yet due										

202312	Internal	Records Management	Limited	Chief Executive	DPO & Head of IG	High	R7 Patient records security should be ensured at all times.	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			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Interim ADI - Governance & Assurance	Low	R8 Conditions of boxes used for records management should be regularly checked, and boxes which are collapsing should be replaced.	This will be reviewed six monthly and will be an item on the agenda at Governance and Assurance Meetings.	30/06/2023			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Chief Nursing Information Officer	Low	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			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Interim ADI - Governance & Assurance	Medium	R10 Each ward should adhere to the records management process, and this should be formally monitored (e.g., through exception reports). Specific KPIs should be developed to measure problematic areas	A bespoke report will be requested from Information services and/or DHCW. Where delays in returning documentation are identified via the report, these will be flagged and escalated to ward and clinical management.	30/06/2023			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	Interim ADI - Governance & Assurance	Medium	R11 Issues of records management process slowdowns should be investigated and escalated when required.	As per 4.1 above, a bespoke report will be developed. However, staffing resource will be required to check if discharges have been actioned and records have been returned. The need for additional resources will be escalated.	31/03/2023			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	DPO & Head of IG	Medium	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			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	DPO & Head of IG Interim ADI – Governance & Assurance	Medium	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			Not yet due										
202312	Internal	Records Management	Limited	Chief Executive	DPO & Head of IG Deputy Head of Health Records Chief Nursing Information Officer	Medium	R14 A formal process should be developed and adopted across the Health Board to share, escalate and resolve record management issues.	a.) The Governance and Assurance group will provide the forum for divisions to report records management issues. b.) A Health records representative will attend these sessions and work with the divisions going forward to improve records management. Progress will be monitored and reported quarterly and recorded on the centrally held portfolio register for each division. c.) Clinical coding teams report issues via the Health Records management monthly meeting and sit on the Governance and Assurance group. As part of this process Clinical Coding will highlight areas where loose records have been identified.	31/03/2023			Not yet due										
202313	Internal	Use of Off-Contract Agency (Nursing)	Limited	Director of Nursing	Deputy Director of Nursing Head of Strategic Resourcing Workforce and Development	Medium	R1 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.	January 2023 March 2023			Overdue										

202313	Internal	Use of Off-Contract Agency (Nursing)	Limited	Director of Nursing		Medium	R2 We recommend that divisional management teams include within their approval emails for off-contract agency confirmation that all pre-requisite checks have been completed. This could take the form of a small template checklist. In addition, there should be a limit to the number of shifts that can be approved for each email request / approver.	Staff requesting off-contract agency reminded of the need to ensure it is confirmed via email that all stages of the escalation process have been considered prior to escalation to off-contract agency.	01/02/2023			Overdue									
202313	Internal	Use of Off-Contract Agency (Nursing)	Limited	Director of Nursing	Assistant Director of Workforce	Medium	R3 We recommend that the Health Board issue best practice guidance prescribing the unfilled shift escalation timeline. This should encompass the end-to-end process requirements, to assist divisional staff in managing the process of filling roster gaps. There may be exceptions to 14 day rule, but these should be defined, with an appropriate approval process in place	The Off contract Agency Request Escalation process outlines the various steps for filling shifts with agency. There are not timelines recommended and this was fit for purpose during the covid period. However, whilst mentioned in the matters arising the recommendation does not acknowledge that these recommendations have been amended in October 22 as part of the VPR programme of work. The Resource Bank Rules came into effect in October 2022. The application of the 14 day rule for sending shifts to contract agencies has now been extended to 28 days, this is from the point the roster is released. This is to ensure the majority of shifts go out to substantive and bank workers in the first instance. However, it is acknowledged that rosters are live and will continually change as staff become absent due to a variety of reasons such as sickness, compassionate leave or demand increases. During these circumstance decisions will need to be made in regards the most appropriate means to fill shifts at	Completed October 2022 – reviewed and redistributed January 2023.			Complete									
202313	Internal	Use of Off-Contract Agency (Nursing)	Limited	Director of Nursing	Divisional Nurses	High	R4 We recommend that the Health Board monitor and address any compliance issues with the current process in use. Where anomalies are identified going forward, these should be investigated and training provided to assist with the embedding of the controls. Furthermore, • rosters should be prepared in a timely manner; • shifts should be released to the bank, contract and off-contract agencies at the appropriate time, with sufficient time to ensure all alternative options are considered.	This recommendation does not acknowledge that this has been actioned. The new Bank Rules (October 22) and Agency Reduction Programme provide mechanisms to ensure that any anomalies are picked up, highlighted and addressed.During the Covid Pandemic patient safety was the Health Boards priority, it is recognised that some practices highlighted within the audit were undertaken as a consequence of these exceptional circumstances. Practises such as: releasing shifts to bank and agency on the same day, releasing to on and off contract agency on the same day, the release to off-contract prior to the shift date is considered appropriate, if the circumstances dictate this as being necessary to maintain patient safety. In addition, the practice of using off contract agency directly was approved during various stages of responding to the COVID pandemic and most recent winter pressures which have extended into the year (evidence provided). It was				Complete									
202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R1 Re-visit efficiency plans to re assess their realistic cash releasing potential as soon as practically possible. Plans should be re-prioritised according to the cash releasing potential.	The Board has established additional Board and executive level financial recovery arrangements including a continuous focus on the identification of areas that can reduce costs. This will be invigorated through the IMTP process to further progress general efficiency, cost avoidance and cost reduction opportunities to support an improvement to the recurrent financial position of the Health Board. The Board will consider how focus is given to higher benefit schemes going forward.	31/03/2023			Complete									
202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R2 By the end of January 2023, the Health Board should ensure earlier preparation of deployment/service level savings to deliver the IMTP's key efficiency programmes. Ideally the savings planning approach should be continuous going forward to prevent any hiatus at the beginning of the financial year.	To provide further detail to the response to R1 above. The Executive team hold a monthly financial recovery board to identify and monitor savings delivery and includes a continuous focus on the identification of areas that can reduce costs. The continuous identification of savings schemes are part of the action plan of the ABUHB financial recovery plan, engaging divisional teams and workforce throughout ABUHB as well as executive led plans.	31/03/2023			Complete									

202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R3 By the end of January 2023, ensure comprehensive and effective operational service engagement with the team preparing the compendium so that the opportunities identified within the compendium can be translated into deliverable saving schemes.	The finance team has engaged with the Board, Sub-committees, Executive team, transformation programmes, divisional teams and corporate teams as part of its usual workplan to spread the opportunities for efficiency improvement throughout the organisation. The expected delivery of savings through the transformation programmes & divisions has not been achieved during 2022/23 due to operational pressures. As a result, it is accepted that more engagement work is required to gain service ownership to progress the opportunities for efficiency improvement and savings delivery.	Ongoing			Complete										
202301	External	Efficiency Review	Not Rated	Director of Planning		N/A	R4 By February 2023, align the efficiencies and savings expected in the IMTP improvement programmes with a more coordinated work programme utilising the key enablers including the Programme Management Office, the Value Based Healthcare Team, the Clinical Futures team and wider research and development.	The plan for 2022/23 aimed to progress service and financial sustainability & deliver efficiency through transformation. This would be enabled by the PMO structure with multi professional teams working with service teams across pathways to deliver improvement, this is more inclusive than the teams quoted. Due to operational pressures the progress has not delivered the expected results during 2022/23 but will be revisited to consider application for 23/24 as part of the IMTP review.	31/03/2023			Complete				New Savings approach refocussed onto divisional plans per IMTP, with PMO and multi-professional support team approach continuing, additionally Transformation priorities now rationalised.					
202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R5 By February 2023, strengthen scrutiny of savings plans which are risk assessed as amber or (in future) red risk rated plans. In addition: Ensure that financial savings targets and timescales are agreed and regularly updated. strengthen the effectiveness of management intervention where efficiency plans are off track.	Savings plans are developed with scrutiny through the Executive team, they are risk assessed, updated regularly, and reported formally on a monthly basis to the Exec team, WG and Board. Chief executive Officer It is recognised there is a need to reconsider & develop a new approach to Savings agreement and ownership and management intervention, this will be developed as part of the revised governance approach for ABUHB, through the financial recovery plan actions.	31/03/2023			Complete										
202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R6 Update the year-end financial forecast position more regularly based on the changing level of risk to the finances, as well as the year to-date financial position.	Financial forecasts and risks are identified, reviewed, updated on an ongoing basis with formal reporting on an established monthly cycle. 2022/23 remains a very volatile and uncertain year and while the forecast did not formally change until mid-year, the risk analysis was updated monthly & reflected the risk appetite of the Board. This process will continue as good practice going forward.	Ongoing			Complete										
202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R7 By March 2023, ensure there is clarity of operational financial risk sharing (for example where operational directorate responsibilities for delivering savings and IMTP programme responsibilities for delivery of efficiencies overlap).	The approach to savings responsibility and accountability will be revisited and established as part of the financial recovery process and IMTP development.	31/03/2023			Not yet due				Complete – Savings responsibility at divisional level established for IMTP financial plan 23/24 R7.2 – outstanding – revised accountability framework still in draft status (March Board 23) – however existing Budgetary control FCP still relevant as a financial accountability mechanism as part of core governance.					
202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R8 By March 2023, strengthen the use of visual management tools including service transformation trackers, saving trackers and linked risk trackers for all programmes. This performance information needs to be communicated to relevant service management for increased responsiveness.	The approach to more visual savings reporting will be aligned with the response to R7 above and established as part of the financial recovery process and IMTP development.	31/03/2023			Not yet due				Savings reporting at divisional level will be given greater focus as part of financial reporting in 23/24 – aligned to IMTP.					

202301	External	Efficiency Review	Not Rated	Director of Finance and Procurement		N/A	R9 By the end of January 2023, implement stronger approaches for monitoring the deployment/delivery of savings to better understand where service improvements are and aren't delivering the necessary efficiency and financial improvement. As part of this ensure there is timely and effective corrective action.	t is recognised there is a need to reconsider & develop a new approach to Savings agreement and ownership and management intervention, this will be developed as part of the revised governance approach for ABUHB, through the financial recovery plan actions.	31/03/2023			Not yet due				outstanding – revised accountability framework still in draft status (March Board 23) – however existing Budgetary control FCP still relevant as a financial accountability mechanism as part of core governance.					
202302	External	Structured Assessment 2022	Not Rated	Director of Corproate Governance		N/A	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.	30 September 2023 30 April 2023			Not yet due									
202302	External	Structured Assessment 2023	Not Rated	Director of Corproate Governance		N/A	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 Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	Revised report templates will be developed and rolled-out for the new financial year, with supporting guidance. The provision of report writing training will also be explored.	30/04/2023			Not yet due									
202302	External	Structured Assessment 2024	Not Rated	Director of Nursing		N/A	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			Not yet due									
202302	External	Structured Assessment 2025	Not Rated	Director of Planning and Performance		N/A	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	A new interactive performance dashboard has been developed. The Quarterly Performance Report has been revised and developed into an IMTP progress report with outcome measures, reportable performance measures and the actions taken as a result. This includes Quality and Patient Safety measures and the quarterly outcomes and progress of the 10 priority programmes. This report has been in place for Q1 and Q2 and the format will and has been provided to the Board and continue to be reviewed.	N/A			Complete									
202302	External	Structured Assessment 2026	Not Rated	Director of Planning and Performance		N/A	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: • review of the Clinical Futures Strategy to ensure it helps to shape financially and clinically sustainable service models; and • develop a detailed long-term clinical plan that underpins the Clinical Futures Strategy.	The Health Board is delivering the Clinical Futures Strategy through its 10 High Priority Programmes as outlined with the IMTP and refreshed annually. These programmes reflect the changing nature of health care delivery and the challenges faced by the Health Board in terms of demand, demographic changes and workforce supply and are therefore reflective to current trends. However, it is accepted that a review of the Clinical Futures long term strategy is also required to take a broader view strategically on the structure and nature of service provision for future generations. It is proposed that the Strategy review will be formed over the following financial year and finalised in 2024/25.	30/04/2023			Not yet due									

202302	External	Structured Assessment 2027	Not Rated	Director of Planning and Performance		N/A	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.	The Health Board has implemented a new infrastructure and dedicated corporate planner and transformation team to work with partners, including the provision of direct support to the Regional Partnership Board (RPB) and Neighbourhood Care Networks to align cluster planning, borough level plans and the RPB's Joint area plan with the Health Board's Integrated Medium-Term Plan, acknowledging that these are ongoing and maturing processes. In addition, the team engages with other partners such as the Health Board's Trade Unions Partnership and the Community Health Council.	30/04/2023			Not yet due										
202302	External	Structured Assessment 2028	Not Rated	Director of Corproate Governance	Director of Finance and Director of Planning	N/A	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 budgetary position and achievement of financial efficiencies at and below executive levels.	The Health Board's existing accountability arrangements have been endorsed by the Audit, Risk & Assurance Committee and is aligned to Standing Orders and Standing Financial Instructions. The Executive Team has commenced work with the organisation's senior leadership team to further embed a culture of empowerment, autonomy, authority and accountability, building on existing arrangements in place. This Framework will cover all aspects of the organisation's business (not just a focus on finance) and will be presented to the Board for consideration in March 2023. Upon approval, further work will be required to support the embedding of the framework in practice.	Approval of Framework 30 April 2023 Embedding of the Framework will be ongoing			Not yet due										

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Danielle O'Leary, Head of Corporate Services, 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 paper presents the Audit, Risk and Assurance Committee with an overview, as of 31st March 2023, against all identified internal and external audit recommendations and current implementation status.

The paper presents the Audit, Risk and Assurance Committee with a position since the last reporting period on recommendations that have progressed, where there has been a revised deadline proposed, recommendations that remain outstanding and an overview of the management action plans that have now been completed in totality.

Cefndir / Background

Procedure for the Management of Internal and External Audit Recommendations

As agreed by the Committee at its meeting in April 2022, a revised and adopted approach has been operational in relation to internal and external audit recommendations management. It is intended for the procedure to support a

structured approach to the management of internal and external audit recommendations, with clearly defined actions that will enable the Health Board to have a comprehensive oversight of its internal and external audit activity.

The procedure does not extend to the management of improvement actions arising from Regulatory Inspections or Independent Reviews (such as those undertaken by Healthcare Inspectorate Wales and/or the Community Health Council). The nature of which are dealt with under a separate process and overseen by the Board's Patient Quality, Safety and Outcomes Committee.

During the last Quarter of 2022/23, an Internal Audit review of '*Follow Up of High Priority Recommendations'* was undertaken. The report is due to be formally received by the Committee at its April 2023 meeting. The report did not make an assessment in relation to an assurance level but did however, make two observations:

- We did note that there are recommendations within the audit that are noted as outstanding, which is accurate, but have subsequently been superseded through more recent internal audit reports. One example is that of Clinical Audit, which was completed during this audit year (2022/23) and previously as a follow-up review (2018/19).

- Where the recommendations sampled required an extension, it was clear when the Health Board should be expecting the action to be completed. We also found that the Tracker is updated regularly and the process regarding the sample is managed well. However, we did identify an exception within our sample, where the high recommendation action raised as part of the Falls Management internal audit was overdue. A status update on the action was provided during November 2022 stating the action was still ongoing, but the due date for the action had not been amended from October 2022. We suspect this requires a simple administrative update to resolve.

The Committee is asked to note that superseded recommendations previously identified have now been removed from the master tracker document. In meetings with Executive leads for audits and respective service leads, it has been explained that if a recommendation for an extension to the deadline is requested, this should be verified and referenced within the update. Copies of the Standard Operating Procedure (SOP) have also been shared to provide absolute clarity on the process regarding audit recommendations.

In addition to actions already outlined, an extensive review of the tracker itself has been undertaken to ensure that administrative errors as highlighted in the recent internal audit report have been rectified. The Committee is asked to take assurance that the observations within the report on '*Follow Up of High Priority Recommendations'* have since been addressed.

<u>Scope of the Audit Recommendations Tracker and Role of the Committee</u>

The Audit, Risk and Assurance Committee will focus its attention at each meeting on those recommendations that are overdue past the original agreed timeframe for completion, those that have been closed during the last reporting period which require

noting and the number of audit recommendations that are not yet due for implementation.

The Director of Corporate Governance will ensure that all completed actions are retained for any potential future reference.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking, 31st March 2023

Since the last reporting period further work has been undertaken to update the master tracker to reflect all Internal and External Audit Reports that have been considered by the Audit, Risk and Assurance Committee (in-line with the agreed procedure). The Master Tracker is attached as a supporting **Appendix A**, which is inclusive of overdue, not yet due and completed/closed actions.

Following the last report to the Audit, Risk and Assurance Committee, the Executive Team was asked to review and update progress in implementing internal and external audit recommendations, specifically the recommendations that were overdue, and focussing on whether the historical recommendations remained relevant or if they had been superseded. The position reported in this paper is therefore reflective of the position as of 31st March 2023. Further updates will be requested from the Executive Team, for those items due and overdue, over the next reporting period in readiness for reporting to the Committee in Summer 2023.

Internal Audit

The position reported to the Audit, Risk and Assurance Committee, as of 31st March 2023, in respect of overdue (passed the original agreed implementation date) internal audit recommendations is:

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017/18 2018/19 2019/20 2020/21	10	1	4	15	30
2021/22	3	24	14	0	41
2022/23	1	0	2	0	3
Grand Total Overdue at 31/03/2023					74

Of the **74** recommendations that are overdue for implementation passed the original agreed implementation date, there are **22** proposed revised timescales for implementation. Therefore, there are **52 internal audit recommendations which remain overdue at 31st March 2023**. The **22** proposed revisions to deadlines relate to the following Internal Audits and have been asterisked within **Annex 1:**

- ***Structured Assessment 2021***
- ***Health and Safety 2017/18***
- ***Flow Centre***
- ***Facilities – Care After Death***
- ***Waste Management***
- ***Agile Delivery***

- ***Unified Breast Unit at YYF***
- ***IT Systems Controls (WRIS)***

A breakdown of the reports for which actions have been completed since the last reporting period, are highlighted below with an update on how many recommendations have been implemented in full, to-date:

- ***Waste Management*** *(2 medium)*
- ***Clinical Audit*** *(2 high, 2 medium, 1 low)*
- ***Facilities – Care After Death*** *(2 low)*
- ***Clinical Futures: Transport 2021*** *(1 medium, 1 low)*
- ***Operational Resumption of Services*** *(1 medium)*
- ***Job Evaluation Process*** *(1 medium)*
- ***Agile Delivery*** *(2 low)*
- ***Falls Management*** *(5 high)*
- ***Flow Centre*** *(2 medium)*
- ***Corporate Governance Review: Board Assurance Framework*** *(1 medium, 2 low)*
- ***Flu Immunisation*** *(1 medium)*
- ***Health and Safety 2017/18*** *(3 medium)*

The Committee is requested to note that of the **27** actions that have been closed since the last reporting period, these will consist of overdue *and* not yet due actions.

The Position reported to the Committee in February 2023 (as at 31st January 2023) is provided below for reference.

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017/18 2018/19 2019/20 2020/21	10	1	5	15	31
2021/22	5	26	16	0	47
2022/23	1	1	4	0	6
Grand Total Overdue at 31/01/2023					84

Therefore, since the last reporting period, the Health Board has closed or proposed revised deadline dates for 32 Internal Audit recommendations.

The Audit, Risk and Assurance Committee is asked to **consider and approve**, if appropriate, the revised timescales for implementation as provided in **Appendix A** (column J [original agreed date for implementation] and column K [proposed revised date for implementation). These changes have been highlighted in *blue*, within the spreadsheet, for ease of reference.

The detail provided at **Annex 1** of this paper provides the Audit, Risk and Assurance Committee with an overview of progress in implementing the totality of audit recommendations arising from internal audit reviews; demonstrating the number of actions implemented, overdue and not yet due at an individual audit review level. It is proposed that this oversight is provided to the Audit, Risk & Assurance Committee

with each audit tracking report to enable the Committee to focus its attention on those actions overdue for implementation as well as being able to take assurance that action plans are being completed.

The Internal Audit Reviews reported to the Audit, Risk & Assurance Committee from April 2023 will be added into the Master Tracker thereafter (in-line with the agreed procedure).

External Audit

The position reported to the Audit, Risk and Assurance Committee, as of 31st March 2023, in respect of overdue (passed the original agreed implementation date) external audit recommendations is:

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017 2018 2019 2020	3	0	0	0	3
2021 & 2022	1	1	0	1	3
Grand Total Overdue at 31/03/2023					6

The Position reported to the Committee in February 2023 (as of 31st January 2023) is provided below for reference.

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017 2018 2019 2020	3	0	0	0	3
2021 & 2022	1	1	0	1	3
Grand Total Overdue at 31/01/2023					6

Of the **6** recommendations that are overdue for implementation passed the original agreed implementation date, there are **2** proposed revised timescales for implementation. Therefore, there are **4 external audit overdue recommendations as of 31st March 2023**. The proposed revision relates to the following External Audits:

- **Quality Governance Review**
- **Structured Assessment 2021**

The Audit, Risk and Assurance Committee is asked to **consider and approve**, if appropriate, the revised timescales for implementation as provided in **Appendix A** (column J [original agreed date for implementation] and column K [proposed revised date for implementation).

The detail provided at **Annex 2**, provides the Audit, Risk and Assurance Committee with an overview of progress in implementing the totality of audit recommendations arising from external audit reviews; demonstrating the number of actions

implemented, overdue and not yet due at an individual audit review level. As with Internal Audit, it is proposed that this oversight is provided to the Audit, Risk and Assurance Committee with each audit tracking report to enable the Committee to focus its attention on those actions overdue for implementation as well as being able to take assurance that action plans are being completed.
Argymhelliad / Recommendation The Audit, Risk & Assurance Committee is asked to: • **DISCUSS** and **NOTE** the position in respect of overdue audit recommendations; and • **CONSIDER** and **APPROVE** proposed revised dates for implementation in respect of several audit recommendations outlined (**Appendix A**).

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
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.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
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:	

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

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

Internal Audits Outstanding from:

- **2017/18**
- **2018/19**
- **2019/20**
- **2020/21**

Audit Title	Lead Director	Assurance Rating: Substantial Reasonable Limited No	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due (at 31/01/23)				All Audit Recs Implemented
				H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
Health & Safety, (2017/18)	DoTHS	Limited	**5**	2	3			0	3			2*	0							✗
IT Service Management (2017/18)	DoPPD&IT	Limited	**11**	4	7			3	7			1	0							✗
Medical Equipment & Devices (2017/18)	DoTHS	Limited	**5**	2	3			0	3			2*	0							✗
Wellbeing of Future Generations Act (Wales) 2015 (2018/19)	DoPHSP	Reasonable	**3**	1	2			0	2			1*	0							✗
Management of Balance Sheet Assets (2018/19)	DoFPV	Reasonable	**12**	1	9	2		0	9	2		1	0	0						✗
Clinical Audit Follow-up of actions from 2016/17 (2018/19)[1]	MD	Limited	**3**	3				1				2*								✓
Job Planning (2019/20)	MD	Limited	**5**	3	2			3	2			0	0							✓
Pay Incentives (2019/20)	DoWOD	Limited	**7**	2	4	1		0	4	1		1*	0	0		1				✗
IM&T Control and Risk Assessment (2020/21)	DoPPD&IT	Advisory	**14**				14								13				1	✗

[1] These recommendations are no longer relevant due to revised Clinical Audit report and associated findings.

High Voltage Electrical Systems Management, (2020/21)	DoOps	Reasonable	**6**		3	3			3	1			0	2*							×
Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	DoOps	Reasonable	**7**		7				7				0								✓
Clinical Futures – Workforce (2020/21)	DoPPD&IT	Substantial	**1**		1				1				0								✓
Clinical Futures – Transport (2020/21)	DoPPD&IT	Reasonable	**4**		2	2			1	1			1	1							×
Mass Vaccination Programme	DoPHSP	Substantial	**1**		1				1				0								✓
Mental Health and Learning Disabilities Divisional Review	DoPCCMH	Reasonable	**4**		2	2			2	1			0	1*							×
(2020/21) Staff Experience	DoWOD	Advisory	**3**				3				3				0						✓
Covid-19: Reducing Nosocomial Transmission (2020/21)	DoCG	Advisory	**7**				7				5				2*						×
TOTAL			**98**	18	46	10	24	7	45	6	8	**10**	**1**	**4**	**15**	1	0	0	1		

**** indicates that a revised deadline has been proposed/agreed***

2021/22 Internal Audits

ABUHB Ref	Audit Title	Lead Director	Assurance Rating: Substantial Reasonable Limited No	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review			Audit Recs Implemented to-date			Audit Recs Overdue (against original agreed timescale)			Audit Recs Not Yet Due			All Audit Recs Implemented
					H	M	L	H	M	L	H	M	L	H	M	L	
2021.06	Mental Capacity Act	DoPCCMH	Reasonable	**5**	1	3	1	1	3	1	0	0	0				✓
2021.01	Gifts, Hospitality and Declarations of Interest	DoCG	Reasonable	**2**		2			0			2*					×
2021.03	Clinical Negligence Costs	DoFPV	Substantial	**2**		1	1		1	1		0	0				✓
2021.02	Putting Things Right	DoN	Reasonable	**2**		2			2			0					✓
2021.04	Charitable Funds	DoFPV	Substantial	**1**		1			0			1*					×
2021.12	IT System Controls (WRIS)	DoPPDIT	Reasonable	**10**	1	9		0	3		1	6*					×
2021.05	Pathology	DoTHS	Reasonable	**9**		3	6		3	3		0	2			1	×
2021.07	Occupational Health	DoWOD	Substantial	**2**			2			1			1*				×
2021.10	Tredegar Health and Well Being Centre	DoPPDIT	Reasonable	**12**	4	6	2	3	6	2	1	0	0	0	0	0	×
2021.08	GUH: Financial Assurance (Follow-up)	DoPPDIT	Substantial	**0**													
2021.09	GUH: Technical Assurance	DoPPDIT	Substantial	**1**			1			1			0			0	✓
2021.11	GUH: Equipment Procurement Assurance Follow-up	DoPPDIT	Reasonable	**2**		2			2			0			0		✓
2021.17	Corporate Governance: BAF	DoCG	Reasonable	**4**	0	2	2		1	2					0	1	×
2021.12	Risk Management	DoCG	Reasonable	**3**		3			1			2*					×
2021.18	Financial Sustainability	DoFPV	Reasonable	**8**		2	6		1	4		1	2				×
2021.13	Continuing Healthcare MH&LD	DoPCCMH	Limited	**6**	4	2		3	1		1*	1					×
2021.16	Flu Immunisation	DoPHSP	Reasonable	**2**		1	1		1				1				×
2021.19	Medical Equipment and Devices[2]	DoTHS	Not Rated														
2021.20	Medicines Management (including Controlled Drugs)	DoOps	Reasonable	**5**		4	1			1		1*			3	0	×
2021.15	Falls Management	DoTHS	Reasonable	**6**	5	1		5				1*					×
2021.21	Datix	DoTHS	Not Rated	**0**													
2021.22	NIS Directive	DoPPDIT	Reasonable	**6**		5	1					1			4	1	×
2021.23	Operational Plan for Resumption of Services	DoOps	Reasonable	**2**		2			1			1					×
2021.24	Flow Centre	DoOps	Reasonable	**7**		4	3		2			2*	3*				×
2021.26	Facilities Care After Death	DoOps	Reasonable	**4**		1	3			2		1	1*				×
TBC	Waste Management	DoOps	Reasonable	**14**		13	1		2			2*			9	1	×
2021.14	GUH: Quality	DoN	Reasonable	**3**		3									3		×
2021.25	Follow-up on Previous Recommendations	DoCG	Not Rated	**0**													

[2] This audi[illegible] ising from the [illegible] are not doub[illegible] unted in th[illegible] 1/22 nu[illegible]

2022.01	Children's Community Nursing Service -Children and Young People Continuing Care	DoN	Reasonable	**7**	1	2	4					2	4	1			×
TOTAL				**125**	16	74	35	12	30	18	**3**	**24***	**14***	4	20	4	
**** indicates that a revised deadline has been proposed/agreed***																	
2022/23 Internal Audits																	
					H	**M**	**L**	**H**	**M**	**L**	**H**	**M**	**L**	**H**	**M**	**L**	
2022.02	Job Evaluation	MD	Reasonable	**2**		1	1		1							1	×
2022.03	GUH Financial Assurance (Final Accounts)	DoF	Substantial	**1**			1						1				×
2022.04	Agile Delivery	DoWOD	Not rated	**4**	1		3			2	1		1*				×
2022.05	Digital Benefits Realisation	CEO	Substantial	**2**		1	1								1	1	×
2022.06	All Wales Decarbonisation	DoF	Not rated	**11**[3]		11									11		×
2022.07	Clinical Audit	MD	Limited	**7**	3	3	1	2	2	1				1	1		×
2023.08	NCN Final Report	DoPCCMH	Reasonable	**5**	1	1	3										
2023.09	ABU YYF Breastcare	DoPPDIT	Reasonable	**10**	0	5	4		1								
2023.10	Newport East Wellbeing Centre	DoPPDIT	Reasonable	**16**	1	8	7										
2023.11	Policies Management	DoCG	Limited	**7**	2	3	2										
2023.12	Records Management	CEO	Limited	**14**	2	10	2										
2023.13	Usage of off-contract agency (Nursing)	DoN	Limited	**4**	1	3											
TOTAL				**27**	11	46	25	2	4	3	**1**	**0**	**2***	1	13	2	
**** indicates that a revised deadline has been proposed/agreed***																	

KEY:	
MD	Medical Director
DoN	Director of Nursing
DoTHS	Director of Therapies & Health Science
DoPPDIT	Director of Planning, Performance, Digital & IT
DoPHSP	Director of Public Health & Strategic Partnerships
DoPCCMH	Director of Primary, Community Care & Mental Health
DoFPV	Director of Finance, Procurement & Value
DoOps	Director of Operations
DoCG	Director of Corporate Governance

[3] These recommendations are not rated as they form an overall action plan for Wales and have therefore been allocated to medium rated recommendations for monitoring purposes

ABUHB External Audits Outstanding from:

- **2017**
- **2018**
- **2019**
- **2020**

ABUHB Ref	Audit Title	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
			H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
TBC	Structured Assessment 2017	**7**	7				6				1*								✗
TBC	Structured Assessment 2018	**5**	5				3				2								✗
TBC	Structured Assessment 2019	**4**				4				4									✓
TBC	Structured Assessment 2020	**0**																	
TOTAL		**16**	12			4	9			4	**3**	**0**	**0**		1				

**** indicates that a revised deadline has been proposed/agreed***

ABUHB External Audits 2021 & 2022

ABUHB External Audits 2022 & 2023

ABUHB Ref	Audit Title	Lead Director	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
ABUHB Ref	Audit Title	Lead Director	Total Number Of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
				H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
202101	Audit of Accounts Report, 2020-21 – Addendum issued	DoFPV	5	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	×
2023.01	Arrangements for Securing Efficiencies	DoFPV	9				9												9	×
202102																				✓
2023.02	Structured Assessment 2022	DoCG	7				7												7	×
TOTAL			16				16					0	0	0	0				16	×
	Other Related Charities (Dec 2021)																			
202104	Taking Care of the Carers (Oct 2021)	DoWOD	6				6				5				1*					×
202105	Structured Assessment 2021	DoCG	5	4			1	2			0	1*			0	1			1	×
202106	Quality Governance Arrangements	DoN	8				8*				3				0				6	×
202201	National Review: The National Fraud Initiative in Wales 2021-22	DFPV	3				3												3	
202202	Equality Impact Assessments: more than a tick box exercise?	DWOD	1				1												1	
TBC	Orthopaedic Follow Up of Recommendations Made in 2015	DoOps	Not yet Reported																	
TBC	Unscheduled Care Arrangements	DoOps	Not yet Reported																	
TOTAL			**30**	6	3	1	16	3	2	1	9	**1***	**1**	**0**	**1**	2			13	

**** indicates that a revised deadline has been proposed/agreed***

KEY:	
MD	Medical Director
DoN	Director of Nursing
DoTHS	Director of Therapies & Health Science
DoPPDIT	Director of Planning, Performance, Digital & IT
DoPHSP	Director of Public Health & Strategic Partnerships
DoPCCMH	Director of Primary, Community Care & Mental Health
DoFPV	Director of Finance, Procurement & Value
DoOps	Director of Operations
DoCG	Director of Corporate Governance

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:	18 April 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Post Payment Verification Progress Report – 1st April 2022 to 31st March 2023
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Amanda Legge

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

Er Sicrwydd/For Assurance

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle, and the two previous. It also demonstrates the overall performance of the health board against the national averages. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

Cefndir / Background

The past year in 2022-2023, PPV have faced challenges associated with the ability to perform 'Business as Usual' due to different factors.

To effectively respond to challenges identified within Primary Care we continued to investigate further avenues to enhance our PPV services which has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

Asesiad / Assessment

General Medical Services (GMS): Following communications that went out on 20th December, regarding the inability to undertake the entirety of the visits on the visit plan for 2022/2023, we are planning to condense all remaining visits from the 3-year visit plan into 2-year period of 2023/24 and 2024/25.
We also experienced some transitional points with the introduction of the new payment system so a separate assurance exercise is being undertaken by our payment colleagues in SSP for the data range January 2022 to September 2022. As a result, we will begin by checking the data submitted from practices from October 2022.

The length and period of data will extend as time moves forward as it has done historically as part of the PPV assurance.

Regarding the revisits that were raised because of routine visits in the last financial year, and any outstanding visits, we will be utilising the same data, however if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

The visit plan runs on a 3-year cycle for GMS and is agreed by Health Boards.

General Ophthalmic Services (GOS): The visit plan for GOS 2022-2023 was agreed by Health Boards after explaining that these visits were subject to change due to beginning a new way of working. PPV began remote access options having full support from Optometry Wales and begun to carry out virtual visits via Microsoft TEAMS which proved successful. Future visits will now be included in the 2023-2024 visit plan, and although we are hoping to increase the number of remote visits, we are also incorporating physical visits to carry us through this transition period of electronic claiming which is being encouraged by Welsh Government. We also continue to undertake the GOS quarterly patient letter programme across Wales to provide additional elements of assurance to our Health Boards.

Pharmacy Services (GPS): Due to COVID-19, the Medicines Use Review (MUR) service was stopped in March 2020. In 2022/23 NWSSP introduced a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and the Collaborative Working Scheme. We will now be going 'Live' in April 23/24 with the Quality and Safety scheme and seeking approval for our GPS visit plan from our Health boards.

Additional Services
As requested by Welsh Government in 2022/2023 we have both verified Bonus Payment checks that were claimed and paid to all Health Service staff in 2021 and verified the PPV declaration for additional community pharmacy payments that were paid in 2022/2023.

We are providing a new service check for dispensing data and after a successful pilot we rolled this out nationally in August 2022 using the quarterly data form April-June 2022. This will continue as a quarterly service for all Health boards across Wales.

The GMS snapshot and statistics tab now separate the routine and the revisit errors and averages. Revisits are generally higher percentages due to 100% of the claims checked over a longer period.
Argymhelliad / Recommendation It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance and details specific risks as outliers in a traffic light system, but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The monitoring and reporting of PPV is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Finance is integral to the delivery of IMTP objectives.
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:	N/A
Rhestr Termau: Glossary of Terms:	N/A

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

We have representatives from every Health Board in Wales and have set up a newly reformed GMS working Group. These meetings are held bimonthly and are very successful. This is to keep communications open and transparent between PPV and Health Boards whilst also collaboratively working to review specifications and ensure standardised approach for PPV remote access samples.
Hold National and local counterfraud (CF) quarterly meetings to discuss the PPV work being carried out and any issues that we feel need to be raised.This establishes excellent working communications with our CF colleagues across Wales and avoids any duplication of work.
We continue the transition into an All Wales service. This will guarantee a more robust PPV team and ensure business continuity.
We have developed a video recorded guide to PPV to aid contractors and equip them with useful information in a simplified format/update FAQ documents.
To use technology to continue one-on-one training requirements from practices that request this as this was previously undertaken in person in the practice premises.
New 360 degree PPV questionnaire released to capture feedback from our contractors after a PPV visit has taken place and the file is closed.
All PPV audit reports are sent to the Directors of Primary Care for information purposes and for feedback.
Began PPV training/Roadshow events to Practice Managers across Wales, utilising technology to host these events as opposed to ‘in-person’ presentations.
Verified contractor Bonus claims and payments to NHS staff in Wales as required by Welsh Government.
We have re-established our quarterly meeting with ourselves, Primary Care, Counter Fraud and finance in our quarterly meetings. The idea behind this being that we can decide on appropriate actions from the appropriate division for all the practices in Amber and Red.
General Opthalmic Services, we can now complete remote access PPV visits after a successful pilot. We continue to utilise trend analysis data to write out to patients to ensure they are receiving the services that have been claimed in their names.
PPV will go Live on New services checks for Pharmacy from April 2023. This is the Quality and Safety Scheme. The Pilot for Collaborative working Scheme and the is still ongoing and are hoping to go Live on this scheme at some point in 2023/24.
We are now producing reports for out HB's and practices with all relevant incorrect Dispensing Patient data. This will be a quarterly piece of work for the PPV team.

GMS

	Health Board		
	2020/2021	2021/2022	2022/2023
Number of practices visited	40	25	11
Average claim error rate	11.44%	9.23%	9.72%
Recovery amount	£43,719.65	£19,219.67	£8,235.23

All Wales		
2020/2021	2021/2022	2022/2023
187	218	36
11.66%	12.82%	17.93%
£232,012.10	£327,058.29	£50,339.13

	Health Board - ROUTINE		
	2020/2021	2021/2022	2022/2023
Number of practices visited	26	19	10
Average claim error rate	5.51%	4.12%	8.97%
Recovery amount	£13,165.93	£7,842.92	£7,575.23

All Wales - ROUTINE		
2020/2021	2021/2022	2022/2023
122	138	29
5.88%	6.05%	7.01%
£68,772.35	£74,982.07	£7,257.32

	Health Board - REVISIT		
	2020/2021	2021/2022	2022/2023
Number of practices visited	14	6	1
Average claim error rate	22.45%	25.41%	36.07%
Recovery amount	£30,553.72	£11,376.75	£660.00

All Wales - REVISIT		
2020/2021	2021/2022	2022/2023
65	80	7
14.46%	16.25%	20.74%
£163,239.75	£252,076.22	£43,081.81

GOS

	Health Board		
	2020/2021	2021/2022	2022/2023
Number of practices visited	N/a	1	6
Average claim error rate	N/a	3.88%	3.07%
Recovery amount	N/a	£108.70	£766.91

All Wales		
2020/2021	2021/2022	2022/2023
N/a	4	30
N/a	11.41%	4.31%
N/a	£1,777.37	£4,753.21

	Health Board - ROUTINE		
	2020/2021	2021/2022	2022/2023
Number of practices visited	N/a	1	6
Average claim error rate	N/a	3.88%	3.07%
Recovery amount	N/a	£108.70	£766.91

All Wales - ROUTINE		
2020/2021	2021/2022	2022/2023
N/a	4	30
N/a	11.41%	4.31%
N/a	£1,777.37	£4,753.21

	Health Board - REVISIT		
	2020/2021	2021/2022	2022/2023
Number of practices visited	N/a	0	0
Average claim error rate	N/a	0.00%	0.00%
Recovery amount	N/a	£0.00	£0.00

All Wales - REVISIT		
2020/2021	2021/2022	2022/2023
N/a	0	0
N/a	0.00%	0.00%
N/a	£0.00	£0.00

Aneurin Bevan University Health Board

GMS and GOS PPV Progress Report: 1st April 2022 to 31st March 2023

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave (GMS Routine)	8.97%
Apr 2022 - Mar 2023 recovery amount	£7,575.23

UHB Claim error % Ave (GMS REVISIT)	36.07%
Apr 2022 - Mar 2023 recovery amount	£660.00

GMS Routine	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 1	May-19	Routine	11.82%	£652.40	Dec-20	REVISIT	10.65%	£3,258.30	Nov-22	Routine	Visit file in progress			
Practice 2	Apr-19	Routine	2.96%	£300.69	Jan-21	REVISIT	6.67%	£30.00	Dec-22	Routine	266	10	3.76%	£584.83
Practice 3	Feb-19	Routine	8.26%	£437.88	Jan-21	REVISIT	16.48%	£645.54	Nov-22	Routine	142	15	10.56%	£456.65
Practice 4	Mar-19	Routine	2.50%	£248.48	Jan-21	REVISIT	3.18%	£571.71	Sep-22	Routine	264	53	20.08%	£1,966.94
Practice 5	Mar-19	Routine	7.87%	£828.57	Dec-20	REVISIT	31.22%	£3,077.28	Nov-22	Routine	298	12	4.03%	£359.80
Practice 6	Oct-14	Routine	2.20%	£283.15	Nov-18	Routine	1.83%	£628.77	Jan-23	Routine	208	16	7.69%	£741.91
Practice 7	Jun-16	REVISIT	1.34%	£23.22	Feb-19	Routine	0.00%	£0.00	Dec-22	Routine	188	10	5.32%	£186.63
Practice 8	Apr-19	Routine	2.59%	£123.59	Feb-21	REVISIT	16.67%	£206.72	Apr-22	Routine	197	13	6.60%	£689.36
Practice 9	Feb-18	Routine	3.81%	£618.36	Apr-19	REVISIT	8.93%	£1,195.98	Dec-22	Routine	222	12	5.41%	£511.17
Practice 10	Jan-17	REVISIT	1.25%	£7.71	Feb-19	Routine	0.41%	£10.03	Sep-22	Routine	209	7	3.35%	£184.40
Practice 11	Mar-19	Routine	9.92%	£299.07	Nov-20	REVISIT	11.19%	£817.02	Nov-22	Routine	146	44	30.14%	£1,893.54

GMS REVISIT	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 12	Nov-19	REVISIT	24.14%	£8,302.34	Mar-21	Routine	14.13%	£201.39	Apr-22	REVISIT	61	22	36.07%	£660.00

UHB Claim error % Ave (GOS Routine)	3.07%
Apr 2022 - Mar 2023 recovery amount	£766.91

GOS Routine	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 13	Sep-15	Routine	2.00%	£22.80	Nov-18	Routine	1.94%	£100.00	Jul-22	Routine	103	2	1.94%	£63.37
Practice 14	Jan-17	Routine	2.00%	£120.60	Aug-19	Routine	4.85%	£175.65	Jul-22	Routine	103	9	8.74%	£446.26
Practice 15	N/a	N/a	N/a	N/a	May-17	Routine	5.00%	£187.50	Sep-22	Routine	103	5	4.85%	£157.58
Practice 16	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	Jul-22	Routine	103	2	1.94%	£78.48
Practice 17	Jun-17	Routine	15.00%	£561.40	Oct-18	REVISIT	18.33%	£1,660.26	Jan-23	Routine	103	1	0.97%	£21.22
Practice 18	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	Oct-22	Routine	103	0	0.00%	£0.00

Internal Audit Progress Report

Audit, Risk and Assurance Committee

April 2023

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

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1. Introduction

The purpose of this report is to:

- highlight progress of the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the April 2023 Audit, Risk and Assurance Committee (the 'Committee');
- request the approval for the replacement audit for the Urgent Care System, with that of Contract Management;
- request the approval of the 2023/24 Internal Audit Plan; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2022/23 Internal Audit Plan

There are 31 individual reviews in the 2022/23 Internal Audit Plan plus two reported from 2021/22. In addition, our Specialist Services Unit (SSU) undertake assurance work over major capital projects (4 during 2022/23). These are reported to the Committee separately, but recorded within Appendix A.

The table below details progress against the 2022/23 Internal Audit Plan.

Number of audits in plan (including 2 from 2021/22):	33
Number of audits reported as final	23
Number of audits reported as draft	2
Number of audits work in progress	8

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 14th February 2023:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Discharge Planning	Limited
Bevan Health and Wellbeing Centre	Limited
Risk Management	Reasonable
Financial Sustainability	Reasonable
Monitoring Action Plans	Reasonable
Management of the Robotic Process Automation	Reasonable
IT Strategy	Reasonable
Cyber Security	Substantial
Follow-up of High Priority Recommendations	N/A

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

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the substantial, reasonable and limited assurance reports issued since the last meeting on 14th February 2023.

Discharge Planning (limited assurance)

This audit examined the processes within the Health Board, for ensuring a timely discharge of patients that are medically fit for discharge.

We found that the Discharge Policy was inconsistent with current practice within the Health Board. However, we acknowledged that there is a process across Wales to introduce an All-Wales Discharge Policy.

Furthermore, we found that there is no training in place to assist staff with the discharge process.

Within our sample tested, we found incomplete evidence on Clinical Workstation (CWS) to support the discharge process. Additionally, we found a lack of controls to support the discharge of complex cases. In particular, the complex discharge list was not always accurately maintained.

Finally, we identified weaknesses in the process for monitoring discharge compliance and analysing re-admission metrics for patients.

Bevan Health and Wellbeing Centre (limited assurance)

The audit sought to review the management arrangements in place to progress the Bevan Health & Wellbeing Centre.

This assessment primarily recognises the significant delays in the delivery of the project (currently circa 30 weeks) and associated current cost pressures. Whilst currently forecast to be delivered £380k (2%) over the approved budget, there remain further significant risks. These are not currently accommodated within the forecast outturn cost projections, and the associated delay in achieving the anticipated business case objectives. Whilst noting the same, it is acknowledged that the delays are not currently being attributed to Health Board actions.

The key findings include:

- The role of the Project Board has not been formally defined, with the number of meetings inconsistent with the terms of reference.
- Roles and responsibilities are not fully defined.
- Operational risks are not always fully costed, with risk owners and implementation dates not identified.
- Whilst lease agreements have been drafted, they have yet to be agreed and signed by the parties.
- Variances identified with the Welsh Government Project Progress Returns.
- Discrepancies with the approval of compensation events / inflationary additions and compliance with the Scheme of Delegation.

- A single tender quotation / request form was not approved by the Chief Executive, as required.

Risk Management (reasonable assurance)

This audit focussed on the risk managements arrangements in place within a sample of divisions within the Health Board.

Overall, we found good arrangements in place, but different approaches to the management of risk across the divisions sampled. In particular, we found different approaches to the recording of risk, although the key elements were still included.

We also found the lack of risks (and associated actions) being tracked and monitored at a divisional level.

Financial Sustainability (reasonable assurance)

We assessed the key controls in place for the financial management, development and monitoring of savings plans to achieve a sustainable position.

Overall, we found that the Health Board's budgetary controls and processes are well designed.

However, we identified exceptions with the acceptance of delegated budgets, within the budget delegation process.

Furthermore, we found that budgets were not always achieved. Whilst savings plans are in place to help achieve a balanced position, these were not always supported by action plans or monitored within the divisions sampled. Consequently, this impacts the accountability and ownership within the divisions.

Monitoring Action Plans (reasonable assurance)

This audit reviewed the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates (specifically Health Inspectorate Wales (HIW) and Health and Safety Executive (HSE)).

We found robust arrangements in place for the monitoring of actions related to the HIW.

With actions related to the HSE, we found monitoring arrangements in place, but we raised the following two matters:

- the lack of a standard operating procedure for managing HSE actions; and
- an inconsistent approach to the tracking of HSE actions.

Management of the Robotic Process Automation (reasonable assurance)

This audit determined if the Health Board had an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.

The RPA function was established as a pilot and has enacted good governance and controls. The key areas for improvement relate to ensuring good governance is maintained in the move from pilot status to a functional service.

The matters requiring management attention include ensuring:

- clarity over the benefits received from RPA to enable self-sufficiency;
- appropriate staff and robot resource is in place;
- the change management process is fully embedded across the Health Board; and
- the security requirements are included in governance documentation.

IT Strategy (reasonable assurance)

The audit sought to determine if an appropriate target operating model, to enable the delivery of the Digital Strategy, had been implemented.

The Health Board has defined a digital operating model, and operating framework which sets out a re-aligned Informatics structure to enable support and digital transformation. A revised process for managing requests for Informatics input has been designed and this will better enable the translation of external / national projects into local projects with associated benefits.

The implementation of the operating model has commenced, but been delayed by the pandemic and resource issues within the Health Board.

The matters requiring management attention include:

- Embedding the ownership structures for digital across the organisation.
- Developing the processes for aligning the Health Board's plans with other organisations' plans.

Cyber Security (substantial assurance)

The audit reviewed whether the Health Board is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

We found that a cyber security improvement plan is in place, which includes actions identified from the Cyber Assessment Framework (CAF). There is evidence that security has been improved, and continues to do so.

Overall, we found good arrangements in place, with cyber security improvements continuing to be made. We did not raise any recommendations.

Follow-up of High Priority Recommendations

We reviewed whether any 2021/22 internal audit recommendations scheduled to be completed after October 2021 and any 2022/23 recommendations due for completion before October 2022 had been implemented / recorded onto the Health Board's Audit Recommendation Tracking Tool (the 'Tracker').

Overall, we did not identify any issues. We included some management actions for consideration.

4. Replacement of the Urgent Care System Audit

We previously identified that the Urgent Care System audit would overlap significantly with a national external audit. Therefore, we proposed to replace the audit with an appropriate alternative, whilst ensuring key risks are considered.

We have now completed this process and identified Contract Management as the replacement audit.

The overall audit objective proposed is to assess whether budget holders are aware of their responsibilities in respect of contract management and whether risks associated with the management of contracts are being effectively managed.

We are now requesting **approval** for the Contract Management audit as the replacement audit.

5. 2023/24 Internal Audit Plan

The 2023/24 Draft Internal Audit Plan has been produced and is reported to the April Committee meeting for approval. The process for the development of the plan is the same as for previous years.

The draft Plan reflects the general risk profile of the organisation as shown in the corporate risk register and rotational coverage of key areas. The Plan may require revision, both in terms of coverage and timing when it is appropriate to do so. If required, this will be done through the established governance and approval processes.

6. 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
- liaison with senior management.

7. Recommendation

The Audit, Risk and Assurance Committee is invited to note the above, approve the 2023/24 Internal Audit Plan and approve the replacement audit, Contract Management.

Appendix A: Progress against 2022/23 Internal Audit Plan

Review	Status	Rating[1]	Summary of recommendations	Anticipated ARA Committee
Risk Management	Final Report	Reasonable	2 Medium, 2 Low Priority	April
Corporate Governance (Policy Management)	Final Report	Limited	2 High, 3 Medium, 2 Low Priority	February
Financial Sustainability	Final Report	Reasonable	5 Medium Priority	April
CF - Care Closer to Home	Work in progress			May
Clinical Audit	Final Report	Limited	3 High, 3 Medium, 1 Low Priority	December
Contract Management (replaced Urgent Care System)	Work in progress			May
Access to Primary Care	Merged with NCNs audit	Reasonable	1 High, 1 Medium, 3 Low Priority	February
Neighbourhood Care Networks (NCNs)	Final Report			
Mental Health Transformation	Work in progress			May
Dementia Services	Work in progress			May
Infection Prevention and Control	Work in progress			May
Use of off-contract Agency	Final Report	Limited	1 High, 3 Medium Priority	February
Quality Framework (replaced by Complaints Management)	Draft Report	N/A	Advisory review	May
Discharge Planning	Final Report	Limited	4 High, 5 Medium Priority	April
Integrated Wellbeing Networks	Work in Progress			May
Agile Delivery	Final Report	N/A	1 High, 3 Low Priority	October
Review of Bank Office and Temporary Staff	Work in progress			May
Job Evaluation Process	Final Report	Reasonable	1 Medium, 1 Low Priority	October

Subject to change on draft reports

Review	Status	Rating[1]	Summary of recommendations	Anticipated ARA Committee
Monitoring Action Plans	Final Report	Reasonable	1 Medium, 1 Low Priority	April
Follow-up of High Priority Recommendations	Final Report	N/A	N/A	April
Digital Benefits Realisation	Final Report	Substantial	1 Medium, 1 Low Priority	December
Cyber Security	Final Report	Substantial	No recommendations	April
Records Management	Final Report	Limited	2 High, 11 Medium, 2 Low Priority	February
Management of the Robotic Process Automation (RPA)	Final Report	Reasonable	4 Medium, 1 Low Priority	April
IT Strategy	Final Report	Reasonable	2 Medium, 2 Low Priority	April
Decarbonisation	Final Report	N/A	11 Matters arising	December
Bevan Health and Wellbeing Centre	Final Report	Limited	2 High, 8 Medium, 3 Low Priority	April
GUH	Final Report	Substantial	1 Low Priority	N/A
Integrated Audit Plans – YYF Breast Care Services	Final Report	Reasonable	6 Medium, 4 Low Priority	February
Integrated Audit Plans – Newport East	Final Report	Reasonable	1 High, 8 Medium, 7 Low Priority	February
Integrated Audit Plans – Satellite Radiotherapy Centre	Work in progress			May
Integrated Audit Plans – Endoscopy Services	Draft Report	Reasonable		May
From 2021/22 Internal Audit Plan				
Children and Young People's Continuing Care	Final Report	Reasonable	1 High, 2 Medium, 4 Low Priority	October
Waste Management	Final Report	Reasonable	10 Medium, 1 Low Priority	August

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.

Cyber Security
Final Internal Audit Report

April 2023

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

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Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To provide assurance that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

Overview

We have issued substantial assurance on this area.

A cyber security improvement plan is in place, which includes actions identified from the Cyber Assessment Framework (CAF). There is evidence that security has been improved, and continues to do so.

There are no matters requiring management attention.

Report Classification

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	Reasonable 2018/19

Assurance summary[1]

Assurance objectives	Assurance
1 Cyber security improvement plan	Substantial
2 Cyber security reporting	Substantial
3 Backup security	Substantial

[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 Cyber Security was completed in line with the 2022/23 Internal Audit Plan.

1.2 Cyber-security is the protection of information assets by addressing threats to information processed, stored, and transported by internetworked information systems. It is the protection of computer systems from the theft or damage to their hardware, software, or information, as well as from disruption or misdirection of services they provide.

1.3 Cyber-security includes controlling physical access to the hardware, as well as protecting against harm that may come from malware, viruses and unauthorised or inappropriate software.

1.4 A strong cyber awareness culture is one of the best defences against cyber-attacks. Regulations such as the Network and Information Security (NIS) Directive and the General Data Protection Regulation (GDPR) will increase the burden on organisations to ensure they have effective cyber-security strategies and culture in place, in addition to robust controls and policies, to prevent and remediate attacks.

1.5 The scope of the audit is to provide assurance to Aneurin Bevan University Health Board (the 'Health Board') that the mechanisms in place for ensuring cyber-security are appropriately designed, and procedures and controls have been implemented within the previously agreed timeframes, as outlined within the recent external review of cyber-security.

1.6 The potential risks considered in the review are as follows:

- poor or non-existent stewardship in relation to cyber-security;
- failure to comply with regulations such as the GDPR and NISD;
- loss of data and inappropriate access to information from entities internal to the organisation;
- risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities; and
- inappropriate / unauthorised software installed / increased risk of infection from introduction of malware.

2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below.

Audit objective 1: Appropriate progress has been made against cyber improvement plans, and the cyber security position within the organisation is improving.

2.2 Following an Audit Wales report during January 2021 on Cyber Resilience in Wales, where the Auditor General encouraged NHS organisations to use the report to compare their cyber resilience arrangements with good practice principles. The Health Board, in April 2021, secured consultancy through Templar to review holistically, the organisation's baseline in terms of information risk. The Templar report "Cyber Security Leadership and Governance Target Operating Model (TOM)" was approved by the Board during October 2021, to be delivered over the next two years.

2.3 The Cyber Assessment Framework (CAF) return was completed and submitted to the Cyber Support Unit (CSU) in October 2021. Since then, there have been ongoing and regular discussions with key Executives on the way to improve the position. The initial action was to use the identified deficiencies to create risks, which have fed into a CAF risk register. Progress has been recorded on the register as part of the regular risk management process. We noted when we requested the CAF register that it was dated September 2022 and whilst improvements had been made and reported there was no update specifically against the CAF register. This issue has been recently raised and the Board is considering reviewing the NIS CAF Risk Register again with a view to splitting into those actions that would require corporate oversight and those that need operational actions to address.

2.4 The Cyber Teams' fundamental aim has been to develop a cyber security culture within the Health Board. There has been collaboration with the Information Governance Department and the Data Protection Officer to build the reporting framework from the relevant governance and assurance groups to the Health Board's Office of the SIRO. For the introduction of the Target Operating Model and the establishment of the risk management and reporting framework.

2.5 The Health Board approved the Cyber Service Plan on 17th December 2022, which includes remediation actions identified from the CAF assessment. The Health Board are seeking to adhere to industry recognised Standards and Security Frameworks such as ISO 27001 and National Institute of Standards and Technology Cyber Security Framework (NIST CSF).

2.6 The plan focuses on five areas of activity, which support cyber security resilience within the Health Board. Those areas are:

- Compliance and Governance;
- Monitoring;
- Reporting;

- Incident Management and Incident Reporting; and
- Security Awareness and Education.

2.7 The Board has developed a Cyber Incident Response Plan, which was approved on the 15th November 2021. The Cyber Incident Management and Reporting Policy, and all other cyber related policies are currently under review. These enable regulatory compliance with NIS in terms of reporting cyber related incidents to the Digital Health Care Wales (DHCW) Cyber Resilience Unit (CRU). We also note that the Cyber Security Team is progressing the development of a Service Catalogue and Configuration Management Database (CMDB).

2.8 The Cyber Security Team has been working slightly under full capacity. Since the CAF assessment in October 2021 they have been without one senior analyst and shortly due to lose another. The Health Board has appointed three junior posts, and are in the process of recruiting a senior analyst and securing further resource. With the recent recruitment strategy there should be a full complement within the next twelve months.

Conclusion:

2.9 We are satisfied that since the beginning of the CAF return completion process the Health Board has made improvements in their cyber security position and has an appropriate reporting process in place to report on planned further improvements. Accordingly, we have provided **substantial** assurance for this objective.

Audit objective 2: There is appropriate reporting on cyber security, which presents an accurate picture of the current position.

2.10 The Health Board recognises the importance of building a well-trained cyber security workforce. The objective is to provide an extra layer of security beyond technical controls, with cyber resilience being the most important function to help protect the operations of the Health Board, from the increasing risks of a cyber-related attack. Any of these risks may impact the delivery of patient care and patient safety.

2.11 The adoption of the Templar report has assisted the Cyber Security Team in its efforts to begin to develop key pillars of its service support function, security awareness, training, governance and compliance.

2.12 The adoption of the TOM has resulted in a wider communication from the Cyber Security Team and ICT Support throughout its workforce. The Cyber Security Team now has representation in all Governance and Assurance Groups (GAGs).

2.13 The Cyber Security Team reports monthly to the Service Delivery Management Board on "Security Posture", which provides an analysis of patching, end of support of operating systems, vulnerabilities, handled calls, etc. There are key performance indicators (KPIs) and pictorial diagrams, which are colour coded, so that members can recognise easily whether the targets are being met. We note

that this reporting provides an overview of the Health Board's cyber security position.

2.14 The Health Board has regular daily reporting for incident management, which includes cyber security, built into daily procedures, including escalation reporting. There are regular monthly reports to the Service Delivery Management Board and updates on the progress of the delivery of the cyber service plan.

2.15 We note that an event on using "exercise in a box" was attended. Although the outcomes from this were not reported in a structured approach, we have been informed from the ICT Security Team's perspective that this was more of an introduction of the benefits to the various stakeholders. Going forward into 2023 and future exercises, will be more formally structured approach to provide documented lessons learned and improvements.

2.16 The Health Board recognises the importance of training and have acquired funding of £18k from SWP Palisade Fund for the training of ICT staff, and will be aiming to schedule cyber security awareness training to all of the workforce. We note that there are plans for the Welsh Government to introduce training through ESR, but there is no clear indication when the training will be available. The Health Board has deemed the lack of awareness training to be a risk and have implemented a training package accordingly.

2.17 In November 2022 the Cyber Security Team simulated a phishing campaign towards 110 ICT staff: 43 staff opened the email and 29 staff clicked on the link. This was recently replicated on 3,000 non-ICT staff, the results of which will be reported at the next Board meeting. Once the workforce as a whole have been provided with cyber security awareness programmes, the Health Board is consider introducing this as a KPI.

Conclusion:

2.18 The Health Board has a good governance structure in place and there is regular reporting. There is a training package for ICT staff being developed, with the intention of a cyber security awareness training being provided to all staff. We have provided **substantial** assurance for this objective.

Audit objective 3: Processes are in place to test back-ups and protect them.

2.19 The majority (99%) of business processes are backed up directly using a product the Health Board procured from Arcserve, "UDP". This is a disk to disk backup method (no tapes), a process termed "Forever Incremental".

2.20 Incremental backups are carried out daily via multiplex scheduling and a virtual backup completed monthly. As part of the back-up process there is automated testing of the backups through a product called Assured Recovery, with monitoring and notifications provided in the event of backup failure.

2.21 The Health Board has built-in resilience, with two active data centres which are interchangeable.

2.22 Backups are encrypted and stored on immutable storge which provides protection from ransomware attacks.

2.23 The Health Board is in the initial stages of cyber awareness training and support for clinical areas, to assist non-ICT clinical teams to capture and prioritise recovery of clinical critical assets. Whilst the team has forged sound connections to bridge the gap between ICT and clinical teams, to determine priorities and recovery times, the next stage of work is to catalogue all of the Health Board's assets. The status of the assets will be tagged utilising the gold, silver, bronze standard of priority.

Conclusion:

2.24 The Health Board has a process in place to test back-ups and protect them we are providing **substantial** assurance on this audit objective.

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.
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Prioritisation of Recommendations

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

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

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

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Robotic Process Automation
Final Internal Audit Report

April 2023

Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

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Executive Summary

Purpose

To ensure that the organisation has an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.

Overview

We have given reasonable assurance on this area.

The RPA function was established as a pilot and has enacted good governance and controls. The key areas for improvement relate to ensuring good governance is maintained in the move from pilot status to a functional service

The matters requiring management attention include:

- ensuring clarity over the benefits received from RPA to enable self-sufficiency;
- ensuring appropriate staff and robot resource is in place;
- ensuring the change management process is fully embedded across the Health Board; and
- ensuring the security requirements are included in governance documentation.

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

Report Opinion

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance	Reasonable
2	Sustainability	Limited
3	Design and Testing	Substantial
4	Live Monitoring	Substantial
5	Change Control	Reasonable
6	Continuity	Substantial
7	Security	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
2	Benefits	1	Design	Medium
3	Resources	2	Operation	Medium
4	Changes	5	Operation	Medium
5	Security	7	Operation	Medium

1. Introduction

1.1 In line with the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') a review of the processes in place for the development and management of the robotic process automation (RPA) function has been undertaken.

1.2 Robotic process automation (RPA) is a technology that uses software, or robots / "bots", to mimic the way humans interact with software to perform high-volume, repeatable tasks. The bots can log into applications, enter data, calculate and complete tasks, and copy data between applications or workflow as required. The use of RPA can produce significant efficiency savings for an organisation.

1.3 The risks considered as part of this audit are:

- investment in digital solutions does not produce the anticipated benefits to the organisation; and
- poor control over the RPA process leads to large numbers of errors or loss of data.

2. Detailed Audit Findings

The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1		-
Operating Effectiveness	-	3	1	-
Total	-	4	1	5

Objective 1: An appropriate process is in place to control the creation of robots and the resource use, with an assessment process to ensure only suitable processes are automated and benefits are defined and realised.

2.1 The RPA process uses Blue Prism robots. The pilot within Informatics started in 2020 and RPA has delivered approximately £600k in benefits so far. The current status of RPA is that it has advanced from the pilot stage but is not yet transitioned into a 'business as usual' service.

2.2 The governance processes for RPA are still being refined. There is a record of all processes which tracks from request to development, and there are development standards in place which set out good practice for Blue Prism developments. There is also a document set in place for design and development, although we note that these may not have always been followed. However, there is no formal procedure that sets out the end-to-end process for management of the RPA function. **Matter Arising 1**

2.3 Potential processes for automation are identified by staff making requests to the RPA team. We note that there are more requests received than can be developed and so there is a formal process for assessment and approval of the processes to be automated. We note that this assessment process has improved over time, and now there is a formal opportunity assessment document completed. This assesses the feasibility, the level of benefits which would be achieved, and the interactions required by the robot. As part of this a high-level solution diagram is produced.

2.4 The requested automations are taken to the Informatics "Front of House" group in order to check that there are no alternate developments in place that would negate the need for automation.

2.5 Governance of the RPA is led by the RPA Governance Board which is currently acting as a transition group and service management board. There are formal terms of reference for the group, and these clearly define an overseeing governance structure, including a gatekeeper and prioritisation role. We note however that these will need to be reviewed and updated as the RPA function moves into 'business as usual'. This has been raised as **Matter Arising 1**

2.6 Our review of the operation of the RPA Governance Board confirmed that it is operating appropriately and monitors the ongoing processes, pilot process and risks together with approving process to be automated and setting priorities.

2.7 Our testing of the governance for RPA noted that there is a pattern of improving governance and documentation, with newer processes being better and more standardised. Processes are subject to an assessment of feasibility along with the requirements in terms of systems and relationships.

2.8 An assessment of benefits is included within the governance process and the need for an Equality Impact Assessment (EQIA) is considered within the new standardised documentation, which is undertaken accordingly.

2.9 The benefits produced by automation comprise some cash releasing savings, however, benefits also include cost avoidance, releasing of staff time and quality and safety benefits. We note that the costs associated with the RPA function are held within Informatics, however the benefits are within the wider organisation. The current structures do not set out a process for ensuring that benefits are fully realised and recognised or enable the sharing of any cash releasing savings with the Informatics function. This has been raised as **Matter Arising 2**

Conclusion:

2.10 There is a governance structure in place for the RPA function which ensures potential developments are assessed, prioritised and subject to approval and monitoring. The structure has not been transitioned to an operational service and the benefits realisation process is not fully defined. Accordingly, we have provided reasonable assurance over this objective.

Objective 2: The RPA service is sustainable for the future, with staff training and retention in place to enable the continued uptake and create a centre of excellence.

2.11 The RPA Team currently consists of a Head of RPA, who also acts as a central developer, along with a developer within each of Finance, Clinical Coding and Health Records teams.

2.12 The current level of resource is not sufficient to transition to a 'business as usual' service and to fulfil the level of requests for automated processes. A business case has been produced which aims to gain funding to enable further recruitment. However, we note that recruitment is difficult, not least as RPA developer roles are in demand.

2.13 There are development standards in place which act as a guide to good practice, and the staff involved have received training on RPA and blue prism developments. There are also regular RPA team meetings which enable the sharing of information and tips. However, the Head of the RPA function is a contractor, and as such there is a risk to the ongoing sustainability of the function as this represents a point of resilience weakness. This has been raised as **Matter Arising 3**

2.14 We also note that the 11 robots in place are approaching capacity, and so a lack of robots will also act as a constraint in the future. This is compounded by the requirements for some of the automated processes to be run within specific timeframes. Should the robots be at capacity and a process then overruns there is a risk that a time constrained process may be missed and so a level of ring-fencing is required.

2.15 We note that the current robot resource level has led to a backlog within processes, with a backlog of approximately 30k vaccination records to be loaded which represents 216 hours of robot time. This has been included within **Matter Arising 3**

2.16 The stated intent for the RPA team within the Health Board is to become a centre of excellence and include a cross organisational structure. However, this is not yet in place, partly due to the risks to the longer-term sustainability of the function noted above.

Conclusion:

2.17 The RPA Team has received training, and there are guidelines in place for RPA development. However, the team size is not sufficient to meet demand and move to an operational service, with the Head of RPA being a contractor and therefore not employed by the Health Board. We also note the capacity constraint with the robotic capacity being almost entirely used. Accordingly, we have given this objective limited assurance.

Objective 3: Appropriate processes are in place to fully document the design of automated process and test the final product.

2.18 Our testing noted that improvements have made over time in documenting and standardisation of the design stages for the process automation. A formal design

document has been created which enables user department review and which both formalises the design and fully defines the process using flowcharts.

2.19 Business exceptions and alerts are considered as part of the design of the automated process.

2.20 Testing is undertaken on the created automated processes before a move to the live operation. The first stage is for the RPA Team to test their created process, and then users are asked to test the process. However, we note that sometimes involvement is not possible and so inputs and outputs are reviewed.

2.21 There is a formal process in place for signing off on the test stage with a go/no-go call with user involvement before a formal change request is raised via the CAB for a move to live operation.

2.22 The RPA development process uses a separate environment for development of the processes. However, we note that there is no separate test environment. This is due to the requirement for the robots to utilise a wide variety of systems access and it is not feasible to replicate the entire Health Board production environment and its data into a separate test environment.

Conclusion:

2.23 The design stage for RPA development is formally documented, with the process fully defined using flowcharts, and identifying business exceptions. The processes are subject to testing before being passed to live operation. Accordingly, we have provided substantial assurance over this objective.

Objective 4: The operation of robots is monitored to ensure they operate as expected.

2.24 There are processes in place to enable full, active monitoring of the operation of the robots. There is a dashboard (control room) in place to enable live monitoring of the robots and daily checks occur to ensure everything is operating appropriately. We note that pilot status of the RPA function has enabled the monitoring process, and we further note that the monitoring activities should be built into the SOP recommended within matter arising 1.

2.25 Processes are in place to enable full, active monitoring of the robots, with alert notifications generated should failures occur.

2.26 The control room clearly shows the robots in place, with those currently operational being highlighted in green and the processes currently running are shown. Processes that have terminated are easily viewable, and if a process terminates unexpectedly this will generate an event warning and notification mail.

2.27 The control room shows work queues for processes that have run and that are due to run and highlights successes and fails. We noted that hovering over specific failed processes will quickly show the reason for the failure.

2.28 Each process within the system maintains a log of operation which enables the easy tracking and resolution of failures.

2.29 We noted that as part of the design and development work, exceptions to business processes are considered and reports are created on success, failures and activity as appropriate for each process, along with the alerts for failures.

2.30 As part of the move to of a process to live operation the processes are scheduled, and this is done with a large amount of flexibility to avoid overruns impacting on subsequent processes. There is also enhanced monitoring for processes following a move to live operation to ensure that no unforeseen issues occur.

Conclusion:

2.31 Processes are in place to enable active monitoring of the operation of robotic processes, with a control room environment established. Reports are built as part of the design and development process and alerts are in place for processes that fail unexpectedly. Accordingly, we have provided substantial assurance over this objective.

Objective 5: An appropriate process is in place to ensure that changes to the environment in which the robot operates are assessed for the impact on the robot, and changes to robots are recorded.

2.32 A significant risk to the successful operation of RPA is that changes to the systems that the robots use mean that the process as designed ceases to work. The Health Board has put structures in place to minimise this risk and enable changes to be flagged to the RPA Team.

2.33 The change management processes within Informatics have been strengthened, with a change advisory board (CAB) in place, to which all changes are submitted, this enables the identification of potentially problematic changes, and we note examples of where this process has operated successfully. We further note that there is a Finance CAB to track changes within the financial systems which may impact on the finance robotic processes.

2.34 RPA is established as a service in the AB configuration management database (CMDB), and this aids in ensuring communication of potential changes, although we note that this is not working fully.

2.35 We note that there have been occasions where changes have been made which have caused processes to fail. Where these occur the RPA process is fixed as a bug without going via CAB.

2.36 We note that for Health Board managed services, the individuals responsible for management are aware of the RPA function and so are more likely to communicate changes, although this relies to an extent on individuals rather than a systemic control.

2.37 For systems managed outside of the Health Board, or for smaller systems managed outside of Informatics and Finance, there is less awareness of RPA and less control over the enactment of changes, which increases the risk.

2.38 We noted that the opinion of RPA staff is that the awareness and change management process in relation to RPA is improving, with better communications

across the board, however the arrangements should be further strengthened as RPA moves into an operational service. We have raised this as **Matter Arising 4**

Conclusion:

2.39 Change management is acknowledged as a risk area for RPA and processes have been improved to manage this risk. the improved processes have been successful and there is a defined mechanism for ensuring changes are notified. The structures have not been fully embedded across the Health Board however, accordingly we have provided reasonable assurance over this objective.

Objective 6: Appropriate continuity planning is in place to enable the organisation to operate in the event of the failure of the robot.

2.40 The robot provider is Blue Prism, and the Health Board has opted for the cloud-based version. This is a fully hosted and managed platform provided by the supplier, with the service being within Azure and accessed via site-to-site VPN. As such, resilience is built in and there is a contractual responsibility for continued provision of the service with responsibility for disaster recovery lying with the supplier.

2.41 Once a manual process is automated, the resource that was used is usually re-deployed elsewhere. This leads to a risk that should the automation fail there is a lack of resource in place to manually complete the task which can lead to delays in business processes.

2.42 We were informed that as part of the development process the RPA developers require the user departments to produce a business continuity / fall-back plan to be enacted in the event that the automated process fails.

2.43 Our testing confirmed that this check is in place, both from developer perspective and within the go-live approval process. However, we note that as there is no formal SOP for the RPA function the requirement for this check is not formally defined. As part of the resolution to Matter Arising 1, we note that a check on department continuity / fall back should be included.

Conclusion:

2.44 The provision of the robot service is highly resilient, and there are checks in place to ensure that user departments have continuity and fall-back procedures for use in the event of the loss of the automated process. Accordingly, we have provided substantial assurance over this objective.

Objective 7: Strong cyber security is maintained over the robot, and strong account management practices are in place for accounts used by robots.

2.45 The robots are in Blue Prism Cloud, this a managed installation and so robots are not installed on any HB owned infrastructure.

2.46 Good security is maintained over access to the RPA environment. Access to the RPA environment by staff, and to the network and systems by the robots is managed by active directory. Access is role based and the least privilege principle is applied.

2.47 Our testing confirmed that there are defined user roles within the Blue Prism environment, which allow privileges to be assigned from a basic level, up to system administration. Our review of the users assigned the roles noted that the access granted is reasonable, with privileged access restricted to two staff, and developer staff having the defined developer role.

2.48 The robots have been provided active directory accounts which are used to provide access into the network and systems in order to function, with login/logoff stages contained within each process to prevent the robots being granted full access.

2.49 We note that the Health Board is complying with good practice guidance in terms of RPA development, however security concepts are not explicitly defined within the development guidelines or procedure documentation, which may lead to a drop in security practices once RPA moves into a service. This has been raised as **Matter Arising 5**

Conclusion:

2.50 There is good security over access to the robots, and robot access to data, with the principle of least privilege being maintained. We note that security should be explicitly incorporated into development standards and procedure documentation to ensure that security is maintained in the future. Accordingly, we have provided reasonable assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Governance Board (Operation)			**Impact**
There is no formal procedure that sets out the process for the management of the RPA process. The RPA Governance Board terms of reference still relate to the pilot stage and do not set out a 'business as usual' governance arrangement linked to an operational service model.			Potential risk of: • Poor control over the RPA process.
Recommendations			**Priority**
1.1	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.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed- Upon successful investment case being made this will be addressed as part of the transition to Service Delivery.	June 2023	Chief Technology Officer

Matter Arising 2: Benefits (Design)	**Impact**
The current structures do not set out a process for ensuring that benefits are fully realised and recognised or enable the sharing of any cash releasing savings with the Informatics function.	Potential risk of: • Investment in digital solutions does not produce the anticipated benefits to the organisation.

Recommendations		**Priority**
2.1a	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.	**Medium**
2.1b	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1a	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.	June 2023	Chief Digital Officer
2.1b	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.	March 2023	Chief Digital Officer

Matter Arising 3: Resource level (Operation)	**Impact**
The current level of resource is not sufficient to transition to a 'business as usual' service and to fulfil the level of requests for automated processes. In addition, the Head of the RPA function is a contractor, and as such there is a risk to the ongoing sustainability of the function as this represents a point of resilience weakness. The 11 robots in place are approaching capacity, and so a lack of robots will also act as a constraint in the future. This is compounded by the requirements for some of the automated processes to be run within specific timeframes. Should the robots be at capacity and a process then overruns there is a risk that a time constrained process may be missed and so a level of ring fencing is required. The current robot resource level has led to a backlog within processes, with a backlog of approximately 30k vaccination records to be loaded which represents 216 hours of robot time.	Potential risk of: • Investment in digital solutions does not produce the anticipated benefits to the organisation.

Recommendations		**Priority**
3.1	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	**Medium**
3.2a 3.2b	The Health Board should consider the purchase of additional robot capacity. 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	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	A revised business case is expected to be submitted to Executive colleagues in Q4.	March 2023	Chief Digital Officer
3.2a 3.2b	The business case for submission in Q4 provides an option also to increase capacity of automation.	March 2023	Chief Digital Officer

Matter Arising 4: Changes (Operation)			**Impact**
Although the awareness and change management process in relation to RPA is improving, with better communications across the board, this has not been fully embedded across the whole organisation.			Potential risk of: • Investment in digital solutions does not produce the anticipated benefits to the organisation.
Recommendations			**Priority**
4.1	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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed. Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	March 2023	Chief Digital Officer

Matter Arising 5: Security (Operation)			**Impact**
Security concepts and requirements are not explicitly defined within the development guidelines or procedure documentation, which may lead to a drop in security practices once RPA moves into a service.			Potential risk of: • Poor control over the RPA process leads to large numbers of errors or loss of data.
Recommendations			**Priority**
5.1	The requirements for security should be included in development guideline and procedure documentation in preparation for transition to a service.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Agreed. Cyber security and service management arrangements will be reviewed following a successful case to executive colleagues.	June 2023	Chief Technology Officer

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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IT Strategy
Final Internal Audit Report

April 2023

Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

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

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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Executive Summary

Purpose

To ensure that the organisation has developed an appropriate target operating model to enable the delivery of the Digital Strategy.

Overview

We have given reasonable assurance on this area.

The Health Board has defined a digital operating model, and operating framework which sets out a re-aligned Informatics structure to enable support and digital transformation. A revised process for managing requests for Informatics input has been designed and this will better enable the translation of external / national projects into local projects with associated benefits.

The implementation of the operating model has commenced, but been delayed by the pandemic and resource issues within the Health Board.

The matters requiring management attention include:

- Embedding the ownership structures for digital across the organisation.
- Developing the processes for aligning the Health Board's plans with other organisations' plans.

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

Report Opinion

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives	Assurance
1 Governance	Reasonable
2 Operational Delivery	Reasonable
3 Skills	Reasonable
4 Programme Delivery	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Ownership	1	Operation	Medium
4	Plan Alignment	4	Operation	Medium

1. Introduction

1.1 In line with the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') a review of the implementation of the target operating model (TOM) for delivery of the Health Board's Digital Strategy has been undertaken.

1.2 The Digital Strategy was produced in 2019, and subsequent to that, work has been ongoing to deliver this. One of the key enablers for delivery of the Health Board's digital vision is the establishment of the TOM.

1.3 A target operating model is a description of the desired state of the operating model of an organisation, the primary purpose of which is to enable the delivery of a corporate strategy. It represents how the Health Board will be organised to deliver the strategy and enables the visualisation of the organisation from a variety of perspectives.

1.4 The main risk considered as part of this audit is that the investment in digital solutions does not produce the anticipated benefits to the organisation.

2. Detailed Audit Findings

The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	-	2	2	4
Total	-	2	2	4

Objective 1: The control and governance structure for digital ensure appropriate risk management, decision making and ownership of digital.

2.1 The organisation started the development of its Digital Strategy and operating model with the approval of the Digital Strategy in 2019. Subsequent to this there was a review undertaken by Channel 3 Consulting of the structure and readiness of the Health Board to deliver the aims within the Digital Strategy. The review covered an assessment of key themes including: governance; accountability; structures and relationships. The outcome of the review included a proposed target operating model, revised structures for governance and the Informatics Directorate and the inclusion of key roles such as Chief Clinical Information Officer (CCIO) and Chief Nursing Information Officer (CNIO).

2.2 Following this a period of time was spent reviewing each area to define local recommendations in relation to a structure for the digital operation within the Health Board.

2.3 During this process there were a number of updates on the digital strategy and its implementation, including the development of a TOM / target operating framework (TOF), provided to the Board. We note that these updates:

- reflected on the current situation;
- noted changes due to Covid and the rapid rollout of virtual consultations, the grange etc.;
- fed back a report on the TOM and sets out a proposed TOF for Informatics;
- brings in stakeholders etc. and sets out a proposed TOM; and
- provided updates on programmes and TOM delivery, noting governance changes and Informatics changes.

2.4 The implementation of the Digital Strategy and operating model has been affected by the pandemic. This was clearly set out within the reporting for recovery, which set out the pre-pandemic position, TOF and progress made towards the digital model including, how the pandemic changed the ways of working and noted the resultant changed priorities.

2.5 We note that the ownership and governance structures for both the Informatics Directorate and for digital across the organisation have been adjusted as set out within the TOM.

2.6 There is a nominated lead Executive Director for digital. We note that the Chief Executive has retained this role following the move from Director of Planning, Digital and IT, and there is a named Independent Member for digital responsibilities.

2.7 There is a Chief Digital Officer in place, however we note that this is not a Board member role, but reports into the Chief Executive. Given the importance of digital to the organisation in delivering on its overall strategy we note that consideration should be given to establishing a Digital Director at Board level. **Matter Arising 1**

2.8 There is a structure of ownership and responsibility with a senior information risk owner (SIRO) in place, this being the Director of Corporate Governance. There is also a CCIO and CNIO in place within the organisation, although we note that the CCIO role is not fully defined within a formal job description. The office of the CCIO is being established to enable this governance arrangement.

2.9 The Health Board has established a Clinical Informatics Council to enable the clinical ownership of digital and to be a key stakeholder group. This was originally formed in 2019, but paused due to the pandemic and has been re-booted to fit into the operating model. The group is not fully embedded yet, with attendance being inconsistent.

2.10 We also note that the operating model does not fully define a structure within divisions where there are leads acting to support the CCIO / CNIO in each area. **Matter Arising 2**

2.11 There is no dedicated committee for digital. The governance structure is formally defined, with oversight being by the Digital Delivery Oversight Board (DDOB) and

assurance being via the relevant committee for each aspect. Decisions are ratified by the Executive Team.

2.12 As noted, the Health Board has established the DDOB, which is led by an Executive, and is the key decision making and steering group. We note that the terms of reference for this group clearly state that its purpose is to provide direction, steer the strategy and provide and recommendations to the Executives. Our review of the business of the DDOB confirmed that it is discharging these responsibilities and enables the involvement of stakeholders.

2.13 There is a structure for the management of risk associated with digital. With the DDOB being assigned the responsibility for receiving and acting on risk escalations and providing assurance on risk mitigation. We also note that there is also a clinical assurance process SOP which clearly states how clinical risks associated with informatics are to be handled.

2.14 We note that a risk to the delivery of the Digital Strategy is the level of funding provided for digital within the Health Board, with the level of resource provided not matching the stated ambitions. Reporting on the TOM notes that funding is low, and this is also noted within the IMTP. The Health Board currently spends approximately 1% of resource on digital, compared to the recommended 3-4% (Wanless 2002) and a global average spend of 4.25% (Deloitte 2020). We also note that there are a number of programmes in place where funding has not been provided, which is resulting in an overspend for the Informatics Directorate.

2.15 However, we note that the level of funding has been improving over the years and a growth plan is, in principle, agreed. Work has also been undertaken within the Directorate to maximise the use of the resources in place.

2.16 Currently the TOF is not fully funded, with finance only provided for the top tier. We note that the requirements for funding have been established and set out within a paper which seeks funding.

2.17 We also note that there is not sufficient funding in place to enable the Health Board to keep up with technology and refresh equipment without incurring a technical debt.

2.18 The DDOB enables a forum for clarity over the impacts of underfunding, with this issue being discussed at the group.

Conclusion:

2.19 The digital operating model has been defined and has been adjusted to reflect change in working practices following the pandemic. Work has progressed to implement the model, with changes in the governance and decision making structures and enhancements to the ownership structure for digital, although we note that there are still weaknesses. We do note funding is a key risk, however this is acknowledged and reported both through the governance structure and within the IMTP. Accordingly, we have provided reasonable assurance over this objective.

Objective 2: The staffing and structure of the Informatics Directorate is appropriate to meet the support needs of Health Board staff and for delivery of digital transformation.

2.20 Following the C3 review and internal assessment process there were a series of workshops undertaken and a target operating framework was defined, which set out a proposed, amended structure for the Informatics Directorate. This proposed change was subject to a staff consultation, which invited comments.

2.21 The TOF set out a structure for the Directorate with four departments:

- Governance & Assurance;
- Service Delivery;
- Programmes; and
- Strategy, Planning & Design.

2.22 The Health Board planned to commence the implementation of the new structure in March 2020, however the pandemic prevented this from occurring. We note that the changes to operational practices forced by the pandemic have subsequently led to the TOF being adapted.

2.23 A target operating model and framework have thus been designed, and work has started to enact these. There has been some progress in implementing the new structure, with the top level posts within the Informatics TOF having been recruited to.

2.24 The structure as set out contains a number of vacancies, in particular within software development, where the vacancy factor is approximately 20%. There are also other gaps across the structure, with no ICT manager in place, gaps at senior level programme management and a high level of churn within Health Records.

2.25 We were informed that the Informatics Directorate is struggling to recruit fully. This is due to a number of reasons, but there is consideration of mechanisms to overcome this within Informatics which we note below.

2.26 Our review of the revised structure noted that the aim is to provide full support for the organisation, together with a structure that enables digital transformation. We noted the following points:

- there is an alignment of services to ensure professional support and best practice is adopted by each distinct function i.e., ITIL, Prince2, MSP;
- the Strategy, Planning and Design domain enables better links with the organisation's strategies and greater coordination of design work within the Directorate;
- a 'front of house' process is being developed to gain greater control over requests for digital support and to channel these efficiently though a dedicated route;
- a project management office (PMO) is being established and a portfolio register is under development. This will include all emerging and existing change initiatives / projects and allow the oversight of resources, dependencies and benefits; and

- processes are being developed for transition points between domains i.e. transition from a new request in Strategy, Planning & Design to programmes and transition from programmes to service delivery, to improve operational acceptance and allow projects to close.

2.27 A re-configuration of the Programmes Team has enabled the department to be reset, to provide project management time purely for programme delivery and business change, as operational support is being removed from the department. However, we note that this process to enact the TOF is only partly achieved with some support staff remaining with the Programmes Team due to a lack of capacity within the other departments.

2.28 We note that the principles of the overall digital operational model are appropriate, although there are some gaps and areas where implementation has lagged, including:

- some support staff remaining within programmes;
- the top tier of the structure does not yet reflect the intended model, with returning staff and the re-banding off staff;
- the front of house process, and planning and engagement structure is not implemented, without this in place the overall operating model for digital will not be operational; and
- the lower level structure is not always fully defined for each department.

Conclusion:

2.29 An appropriate digital operating model has been defined and work has started to enact this. This has been delayed due to the pandemic and there are areas where implementation has lagged due to the pandemic and resource constraints. Accordingly, we have provided reasonable assurance over this objective.

Objective 3: The knowledge and skills within the Informatics Directorate is appropriate to meet the Health Board's needs.

2.30 The identification of the required skills within the Directorate is an ongoing process and has been developed over time, as such we found that the directorate is aware of its skill needs.

2.31 The Directorate has created a skills matrix which sets out they key skills and training requirements for each role within the structure. The matrix covers all departments within the directorate and includes Health Records, technical services and strategy and planning, with each role within the Directorate identified.

2.32 The identification of required skills used recognised frameworks for digital and IT skills development, such as the Skills Framework for the Information Age (SFIAplus), the skills framework from the British Computer Society (BCS) and the Digital, Data and Technology Profession Capability Framework from the UK Government. The skills identified within these frameworks have been linked to the roles within the Directorate. Although we note that the matrix is still being developed as the TOF is being agreed.

2.33 We also note that the skills matrix links to the role job descriptions, PADR process and Agenda for Change requirements, to professional membership requirements and formal qualifications and competencies e.g. MSP, PRINCE2 etc.

2.34 Where a skills deficit is identified, training is provided. This is targeted, with the skills noted as essential within job descriptions being treated as a priority. We note that Informatics has recently been provided with a ring-fenced training budget. This resource is supported by building in training as part of business cases where appropriate, and the creation of standardised documentation and guidelines, such as the project management framework and change management framework.

2.35 The Directorate does not have all the roles filled, or skills in place. There is work ongoing to develop mechanisms to bring these into the Health Board, with the skills gap identified and work underway to close it. Furthermore, work is ongoing to establish apprenticeship programmes, to establish links with universities and the Health Board, which is also part of the Digital Health and Care Wales (DHCW) skills framework. However, whilst the current risk is low, we note that these workstreams should be formalised. **Matter Arising 3**

Conclusion:

2.36 The Directorate has developed a skills matrix that identifies the required skills for each post within the structure and so is aware of the gaps. There is work ongoing to fill the gaps and a training budget has recently been ringfenced. However, the gaps remain extant and as such we have provided reasonable assurance over this objective.

Objective 4: Processes are in place to enable the implementation of national products which translate actions and benefits from national case to local case and enable funding and business change.

2.37 The Health Board has a project management framework in place, which sets out the requirement for the development of local business cases in order to move forward with national programmes and this includes the identification of benefits and the actions required to show local value.

2.38 However, we note that this does not always work, with national programmes sometimes being mandated by the Health Minister. As they are not always in the IMTP, there is no allocated funding and thus a lack of resource, both within digital and for clinical staff for the implementation teams We were also informed that there are situations where approval has been given by the Executives, but no associated funding provided e.g. for Careflow which costs £420k. Consequently, there is an overspend.

2.39 The resources for digital programme delivery are constrained and we note that that there has been a historical loss of control over how these national / external items come into the Health Board, with programmes sometimes being included within workplans without associated resource. There are a variety of sources of these items with varying entry points into the organisation, such as:

- ministerial direction e.g. e-prescribing this year, WCCIS;
- DHCW's plan;

- NHS collaborations;
- Welsh Government delivery unit; and
- nationally hosted programmes in other Health Boards.

2.40 The alignment of the Health Board plan and DHCW plans has improved and continues to do so with regular meetings held with DHCW and an alignment plan in place. However, for other strands there is limited alignment. **Matter Arising 4**

2.41 As part of the implementation of the digital operating model the structures for digital programme delivery within the Health Board have been revised to better meet the needs of the organisation.

2.42 A mechanism for gaining better control over requests for digital projects, programmes and input has been designed. This includes all requests from external non regulation demands and opportunities, through to national programmes and innovation.

2.43 This is the front of house process noted previously and this sets out a way for collating all requests into a single evaluation process. These are further split into four categories for clarity and ease of assessment and prioritisation, these being:

- digital foundations;
- short notice requests to manage significant risks and issues;
- annual and three-year plan, corporate and clinical requests; and
- non urgent non IMTP requests.

2.44 The process as set out will enable full consideration of all requests including national / external items and prioritisation for inclusion into the digital plan in a holistic manner. However, we note that this has not yet been implemented due to resource constraints.

Conclusion:

2.45 The Health Board has revised its processes for benefits management, and there is a set process to move national programmes into local programmes with local business cases. There has been a historic loss of control over the mechanism by which national programmes enter the organisation, and funding does not always follow. However, a revised process for channelling and holistically prioritising these has been defined, but not yet enacted. Although the revised processes as defined are appropriate, they are not yet fully embedded and not enabling the Health board to control the transition of national programmes. Accordingly, we have provided limited assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Digital Director (Operation)			**Impact**
There is a Chief Digital Officer in place, however we note that he is not a Board member and reports into the Chief Executive. Given the importance of digital to the organisation in delivering on its overall strategy we note that consideration should be given to establishing a Digital Director.			Potential risk of: • Investment in digital solutions does not produce the anticipated benefits to the organisation
Recommendations			**Priority**
1.1	Consideration should be given to establishing a Board level Digital Director.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed. A Board level post has been agreed and to be advertised in Q4 2022/3	March 2023	Chief Executive Officer

Matter Arising 2: Ownership (Operation)	**Impact**
The role of the Chief Clinical Information Officer (CCIO) is not fully defined within a formal job description. In addition, the operating model does not fully define a structure within divisions where there are leads acting to support the CCIO and Chief Nursing Information Officer (CNIO) in each area. We also note that the Clinical Informatics Council is not fully embedded yet, with attendance being inconsistent.	Potential risk of: • Investment in digital solutions does not produce the anticipated benefits to the organisation.

Recommendations		**Priority**
2.1a	The role of the CCIO and CNIO should be fully defined.	**Medium**
2.1b	Leads within divisions should be established to work with the CCIO / CNIO.	
2.1c	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein.	

Agreed Management Action		**Target Date**	**Responsible Officer**
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.	June 2023	Chief Clinical Information Officer and Chief Nursing Information Officer
2.1b	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.	June 2023	Chief Clinical Information Officer and Chief Nursing Information Officer
2.1c	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 2.1b.	June 2023	Chief Clinical Information Officer and Chief Nursing Information Officer

Matter Arising 3: Skills (Operation)			**Impact**
There is work ongoing to develop mechanisms to bring the necessary skills into the Health Board. Work is ongoing to establish apprenticeship programmes, to establish links with universities and the Health Board, which is also part of the DHCW skills framework. We note that these workstreams are not formally defined.			Potential risk of: • Investment in digital solutions does not produce the anticipated benefits to the organisation.
Recommendations			**Priority**
3.1	The skills development work should be formalised into a skills development plan.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	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.	December 2023	Chief Technology Officer

Matter Arising 4: Plan Alignment (Operation)			**Impact**
There is minimal alignment of workplans for the majority of external sources of digital programmes. This can lead to excessive demands for resources or the approval of national programmes without provision of funding.			Potential risk of: • Investment in digital solutions does not produce the anticipated benefits to the organisation
Recommendations			**Priority**
4.1	The Health Board should seek to align plans with other sources of digital projects.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	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.	September 2023	Chief Digital Officer

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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Prioritisation of Recommendations

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

Priority level	Explanation	Management action
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Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Financial Sustainability
Final Internal Audit Report

April 2023

Aneurin Bevan University Health Board

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

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

We reviewed the key financial management controls within Aneurin Bevan University Health Board (the 'Health Board') including the development and monitoring of savings programmes required for financial sustainability.

Overview

We have provided **reasonable assurance** over this area.

The Health Board's budgetary control and savings plan processes are well designed.

However, we identified several areas where actions are required to comply, or demonstrate compliance, with the Health Board's Model Standing Orders Reservation and Delegation of Powers, Standing Financial Instructions and / or the Budgetary Control Financial Control Procedure. These include the following areas:

- budget delegation and acceptance; and
- setting and the monitoring of savings plans when budgets have not been met.

The assurance rating for this review relates to the processes in place for developing and monitoring the Health Board's financial position and delivery of savings.

The above points are detailed further in Appendix A.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Financial Control Procedures (FCPs)	Reasonable
2	Budget delegation	Substantial
3	Plans and their monitoring	Reasonable
4	Escalation and recovery processes	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Formal budget acceptance	1, 2	Operation	Medium
2	Savings plans	3, 4	Design / Operation	Medium

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

1. Introduction

1.1 In line with the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'), we focused on the fundamental processes underpinning financial and service sustainability, namely budgetary control (revenue budgets) and savings plans.

1.2 The Health Board commenced the financial year (2022/23) with an opening underlying deficit of £20m, with the aim to deliver recurrent savings to improve this position to £8m by the end of 2022/23. Due to the continuing pressures experienced during the year, the Health Board has been unable to deliver efficiencies to the level aspired to and has been forced to manage service pressures through higher cost solutions e.g. agency staff. As a result, there is an underlying deficit within the financial forecast of potentially c.£37m for the end of 2022/23.

1.3 The key risks considered in this review were as follows:

- non-compliance with financial control procedures;
- inappropriate service and financial planning and monitoring;
- corrective action for currently unsustainable services is not taken; and
- decisions are undertaken without sufficient financial scrutiny.

1.4 We also considered the Structured Assessment completed by Audit Wales and excluded any overlap with our review.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	-	1
Operating Effectiveness	-	4	-	4
Total	-	5	-	5

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: Appropriate Financial Control Procedures (FCPs) are in place for financial management and budgetary controls (including the delegation of budgets), with relevant sections adhered to.

Policies and procedures

2.3 The latest Budgetary Control Financial Control Procedure (the 'Budgetary Control FCP') was reviewed and updated during 2022. We also found that this document was available on the Health Board's internet and intranet sites.

2.4 We reviewed the Budgetary Control FCP and note that it included the expected control elements, such as the delegation of budgets, dealing with variances to budget (including escalation) and roles and responsibilities of the budget holders (including monitoring).

Training for budget holders

2.5 The divisional finance teams provide training to new budget holders. However, attendance on these courses is not tracked centrally and there is no refresher version of this training.

2.6 The Finance Business Systems Team also offers a 'FMS System overview' course on a weekly basis (including Oracle i-Procurement, the requisition approval process and FBI) to all new budget holders or as a refresher for existing budget holders when they change their role. The sessions are usually tailored to the audience (circa 60-90 minutes). We note that this type of course is also not actively advertised or promoted for existing budget holders. Whilst we have not raised this as a recommendation, there is a potential opportunity for improvement to update this going forward. For example, operate regular refresher training courses for existing budget holders.

2.7 We reviewed the training log for the 'FMS system overview' training course and found that it included detailed information on who attended the training. As at the 27th of February 2023, the training log showed that 97 staff attended the course from April 2022 to February 2023. This included 87 new budget holders (89.69%).

2.8 We found that the average time between sending out the training invite and attending the actual training course was 82 days (the longest time being 275 days). We were told that staff are chased to attend the courses and we saw evidence of this process in the training log.

2.9 The process is designed to send out reminder emails at a set time. However, the formal escalation of non-attendance on the course only commences with the third reminder. There may be scope to commence the escalation process sooner, e.g. after the second reminder, but overall, the automated arrangements in place were positive.

2.10 Furthermore, we were told that additional courses and one to one training sessions with the business partner accountants are also available for the budget holders.

Annual Budget Approval

2.11 The delegation of revenue budgets for 2022/23 was discussed and approved by the Board alongside the Integrated Medium Term Plan (IMTP) for 2022/25 during March 2023.

2.12 After the approval by the Board, both the budget and the IMTP was reported to the Welsh Government, together with the Minimum Data Set (MDS).

Budget delegation from the Chief Executive

2.13 The Board approved a revenue budget of £1.47bn for financial year 2022/23. This was in line with the first year plan included within the IMTP for 2022-25.

2.14 Based on the Health Board's Model Standing Orders Reservation and Delegation of Powers (the 'Standing Orders'), Standing Financial Instructions (SFI) and Budgetary Control FCP. The Chief Executive formally wrote to the Executives and senior managers to notify them of their budget allocation. As part of this exercise ten delegation letters were issued on the 28th April 2022. These letters were signed by the Interim Chief Executive, with a set deadline to accept the delegated budgets by the 12th May 2022.

2.15 We note that four of the ten budgets set out within the delegation letters were accepted during May and June 2022, after the deadline. This has been raised as matter arising one in Appendix A.

2.16 We also found that two delegated budgets were not formally accepted in line with the requirements set out in the Budgetary Control FCP and the delegation letters. These budgets related to 'Therapies and Health Science' and 'Planning, Digital and I.T.' areas. However, we confirmed that the non-acceptance of the delegated budgets were formally tracked, with a log of details maintained. The justification for non-acceptance for the two budgets was that the proposed budgets were undeliverable. This has been included within matter arising one in Appendix A.

2.17 We also note that at the time of the budget delegation for the year, the Director of Planning, Digital and I.T. was also the Deputy Chief Executive, who subsequently became the Chief Executive during September 2022.

2.18 We note that the budget disclosed in the delegated budget letters matched the budget approved by the Board for the year. However, there were three areas that were not covered. These three areas are detailed below:

Ref.	Area	Allocated budget £'000
1	Capital Charges	2,839
2	Reserve Funding	23,725
3	Chief Executive and non-officer members	44,503
	TOTAL	**71,067**

We were informed that all these areas fall under the Chief Executive's responsibilities, therefore, they did not require any delegation letters.

2.19 The delegation letters included expenditure funding totals for the relevant areas. Regarding savings plans, they did not include tailored figures for the different

areas. However, they included a reference to the total of the agreed organisational savings (£26m) for the year and also made references to the overall budget responsibilities in general.

2.20 As expected, we confirmed that the delegation letters excluded expenditure related to wage award, exceptional costs (e.g. energy prices) and COVID-19.

2.21 A budget update was reported to the Board on the 27th July 2022 indicating changes to the budget allocations. The report flagged a risk of funding gaps and difficulties of meeting savings opportunities. As a result, the original delegation letters were redrafted, but were not formally issued to the directors. See matter arising one in Appendix A.

2.22 Furthermore, we note that the original delegation letters made references to budget holders' responsibilities, and that this will be disclosed in the budget holder's performance appraisal and development review (PADR).

Conclusion:

2.23 We identified matters arising regarding limited adherence to the formal budgetary procedure. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: Budgets have been delegated to a separate level to align with spending authorities.

Budget sub-delegation

2.24 As detailed above, we saw evidence that wording for the divisional delegation letters had been drafted centrally, but these letters were not necessarily issued to their budget holders.

Cost centres and budget holders

2.25 An authorised signatory list (ASL) is in place that details the budget holders, their allocated cost centres, and financial limits. We were told that the ASL is updated as, and when, it is required. In addition, the Financial Governance Team carries out reviews on the ASL on a three-monthly basis through reconciliation against data held in the Health Board's systems.

2.26 We reviewed the costs centres to determine how operational budgets are established within the divisions. There were 2,570 open cost centres as at 14th February 2023. The breakdown of these cost centres are as follows:

Balance type	Number of Cost Centres
Positive (debit)	1,639
Negative (credit)*	45
No balance	862
Pennies (between 1 and -1)	24
TOTAL	**2,570**

*: negative balances represents income

We also found that all of the cost centres had allocated budget holders regardless of their value, and some of the cost centres had up to eight layers of budget delegation levels.

2.27 However, 862 cost centres have no annual budget assigned. We randomly selected 25 cost centres for a detailed review and found that 44% of the cost centres (11 of the sample) were legacy cost centres with no transactions posted against them this year. Whilst the risk associated with this is negligible, there is scope for undertaking periodic housekeeping.

2.28 During testing we raised the above point. We have now confirmed that this is in the process of being updated, with the Business Systems Team undertaking a review of the cost centres. In addition, the Financial Control Procedure, General Ledger has been updated to include the annual review requirements. Therefore, we have not raised a recommendation.

2.29 Since the beginning of the year, 70 new cost centres were opened. This represents 2.72% of the existing cost centre population. We randomly selected five new costs centres (7.14%) and reviewed evidence of their approval. We found that all of the cost centres were authorised prior to their creation date. Two of the new cost centres were authorised by a handwritten signature and three of them had an email confirmation. We also note that only one of them was not authorised using the dedicated template.

2.30 We randomly selected 25 budget holders for detailed testing and found that all of the samples had formal authorisation prior to their ASL update. We note that, except in four cases, the requests were made through the dedicated template. We also note that in one case there was a budget holder restatement.

2.31 We were told that the process to add / change budget holders is through the 'Governance inbox' which is monitored on a daily basis. Any correctly approved requests are usually actioned on the ASL on the same or next day (e.g. if the request was received late afternoon). We note that there is no formal KPI or service level agreement to monitor the processing time, and the acceptable level of processing time is not formally defined. However, whilst we have not raised a recommendation, this could be an area for further consideration going forward (e.g. establish target times).

Conclusion:

2.32 We identified matters arising regarding limited adherence to the formal budgetary procedure, but this has been factored into the conclusion for audit objective one. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 3: Service areas have sustainable expenditure plans, with effective monitoring and scrutiny in place, with savings plans / arrangements identified if required to produce a balanced budget.

Savings Plans reporting

2.33 Within our sample we found that where projected budget deficits were identified, savings plans and the associated opportunities were not always achieved.

Furthermore, there were no action plans in place to address the recovery of the deficit. This has been raised as matter arising two in Appendix A.

2.34 A three year plan within the IMTP set out the total of the savings plans for 2022/23 as at £26m. This included recurrent savings of £18m and non-recurrent savings of £8m.

2.35 We reviewed the '2022/23 Minimum Data Set' (MDS) report for April 2022, which was submitted to the Welsh Government for April 2022 and note that the total of the savings plans agreed to the figure disclosed in the IMTP and the 33 savings plans listed on the tracker. See further details of these plans by service areas below:

Services areas	"Green" rated plan	"Red" rated plan	Total number of plans
Clinical Support	2	1	3
Commissioning	0	1	1
Mental Health	1	0	1
Non Clinical Support (Facilities/Estates/Corporate)	8	1	9
Planned Care	3	9	12
Primary and Community Care (Excl Prescribing)	1	-	1
Unscheduled Care	2	4	6
TOTAL	**17**	**16**	**33**

We also note that 87.88% of the plans (29) were scheduled to be started on the 1st of April 2022, with one plan in July 2022 and three plans in October 2022.

2.36 We found that progress updates on the savings plans were provided to:

- the Welsh Government as part of the Monthly Monitoring Report (MMR);
- the Finance and Performance Committee (F&PC) on the 6th of July 2022 and the 5th of October 2022, 48 plans were reported;
- the Board, including green and amber rated savings schemes, with a summary provided below:

Reporting month	"Green" rated plans	"Amber" rated plans	Total number of plans
August (Month 5)	24	24	**48**
October (Month 7)	38	40	**78**
December (Month 9)	62	13	**75**

The report for December (month 9) included a list of savings plans which were marked as "red" and were subsequently terminated. There were 13 plans rated as 'amber'. Of the 13 plans, 11 related to either Medicine or the Scheduled Care service areas.

2.37 On the 27th of July 2022, it was reported to the Board that some of the savings plans did not perform as well as expected over the first quarter and there was a significant risk with the delivery of a number of savings opportunities. As a result, the value of the anticipated savings was lowered to £23.1m. We were informed that, in line with these changes, the Monthly Monitoring Report (MMR) to the Welsh Government was updated.

2.38 Furthermore, savings of £11.5m were achieved in December (versus the revised plan: £9.3m) However, the achievement of savings opportunities remained an issue and represents an on-going risk for the Health Board. This risk was reported to the Board on the 25th of January 2023.

Individual Savings Plans

2.39 From the savings plans reported to the Board during January 2023, we randomly selected a sample of ten plans for review. We found that two of the plans were rated as amber in terms of performance. However, there were no formal action plans to improve their performance. This has been raised as matter arising two in Appendix A.

2.40 Furthermore, we found that ownership and objectives of the selected plans were linked to transformation programmes, but were not clearly defined to divisional levels. This has been included within matter arising two in Appendix A.

2.41 We were also told that the savings plans were signed off by the Executive Team, as the highest level delegated budget holders, and the Board as part of the minimum data set (MDS) report to the Welsh Government.

Virements

2.42 The Central Management Accounts Team maintain a central register of budget journals recording the division, journal reference number and link to evidence of authorisation on Sharepoint.

2.43 The Budgetary Control FCP notes that where budget funding is transferred between budget holders, a virement form must be completed to formally record the agreements and transfer the funds.

2.44 From the latest budget journal register (received on the 27th of February 2023, included 442 entries), we randomly selected a sample of ten virements for detailed testing. We found that two virements did not have formal authorisation, however, this was in line with the budget journals guidance. In addition, the recording for one of the virements was incorrect (e.g. the mail column was ticked, not the virement form column), but this did not represent an authorisation issue.

Conclusion:

2.45 We identified matters arising regarding the non-achievement and retrieval of budgets. We also found a lack of formal action plans for the savings plans when the budget has not achieved. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: Where financial sustainability (balance) is not achieved, there is a process of escalation (including to the Chief Executive, if required) and recovery (consistent with the Budgetary Control Policy). Underlying reasons are investigated, and service /operational actions are taken for redressing within an appropriate timescale.

Individual Budget Holder Monitoring

2.46 All budget holders have access to financial performance information via Oracle / FBI. We were told that FBI access is periodically monitored. However, this monitoring is not necessarily evidenced.

2.47 The relevant Business Partner Accountant meets with the primary budget holders on a regular basis. While these meetings are usually not evidenced, we were able to see some calendar invites to confirm that such meetings took place during the year.

Directorate monitoring

2.48 There are monthly directorate and divisional assurance meetings, where the Business Partner Accountants provide updates on the financial position.

2.49 Each division is required to produce their management information (MI) pack each month, which is then reported to the respective Finance Team. We selected two service areas (Estates & facilities and Scheduled Care) and confirmed the existence of their MI packs for July, October and December 2022.

Committee and Board Reporting

2.50 We reviewed three Board and three Finance and Performance Committee reports for the financial year 2022/23 and note that all included the relevant finance performance reports. We note that these reports included a summary of performance against key financial targets, a financial assessment of the risks and opportunities in delivering the year-end financial balance, and the actions required to achieve this.

2.51 We also reviewed the mid-year presentation slides for October to the Board, which highlighted action plans to mitigate and achieve the financial deficit forecast. We note that this presentation also included updates on anticipated allocations and Covid-19 schemes, which were excluded from the original budget allocations at the start of the year.

2.52 While there are clear signs of escalations in place (e.g. information on deficit reporting), there is no consequence to the budget holders for not meeting allocated budgets or not delivering on agreed savings plans. We also note that no formal actions were agreed and documented for savings plans that were behind. This has been included within matter arising two in Appendix A.

2.53 As noted within Objective One and matter arising one in Appendix A, two budget holders did not accept their budget delegations at the beginning of the year.

Conclusion:

2.54 We identified one medium priority matter arising, regarding the lack of actions taken to achieve a balanced budget. Therefore, we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Budget acceptance	Impact
Quarter-1: Ten delegation letters were issued by the Chief Executive to the Executives and other applicable senior staff. We also found that: • no delegation letters were issued to three areas: 'Capital charges', 'Reserve funding', and 'Chief executive and non-officer members', totalling £71m. As expected, these areas are the responsibility of the Chief Executive in the absence of the delegation letters; • four out of ten budgets were accepted after the deadline set, during May and June 2022. • two delegated budgets were not formally accepted. • the delegation letters did not cover certain expenditures (e.g. wage award, COVID-19 and exceptional costs – e.g. energy price increases), but this was disclosed. We also reviewed some divisional delegation letters for the year and found similar issues. ***Quarter-2:*** A revised budget was approved by the Board on the 27th of July 2022 and as a result, new delegation letters had been drafted. However, these letters were not formally issued. ***Quarters-3&4:*** Further changes were made to the budget, which were authorised by the Board, but no formal delegation letters were drafted or issued.	Potential risk of: • Limited responsibility and accountability to deliver within budget. • Increased risk that savings will not be achieved.

Recommendations	Priority
1.1 The budget delegation letters should be completed as soon as possible after the start of the financial year.	Medium (Operation)
1.2 All delegated budgets should be formally accepted. Non-acceptance of a delegated budget should be reported to the Finance and Performance Committee and / or the Audit, Risk and Assurance Committee.	Medium (Operation)

1.3	Delegation letters should be formally reissued when significant changes are made to the budget.	Medium (Operation)

Management response		Target Date	Responsible Officer
1.1	Accepted. We will ensure the delegation letters are completed as soon as possible after the start of the financial year.	April 2023	Director of Finance, Procurement and Value
1.2	Accepted for Executive level delegation letters.	May 2023	Director of Finance, Procurement and Value / Chief Executive
1.3	Accepted. The value / definition of 'significant' will be considered and letters formally reissued if this threshold is met.	May 2023	Director of Finance, Procurement and Value

Matter arising 2: Achievement of Budgets	Impact
We found some service areas within our sample that were in a deficit position, as budgets were not met. This was contributing to the projected year end Health Board deficit of c.£37m. We sought to ascertain the actions completed, through divisional management team meetings and more formal savings plans (115 in total across the financial year), to achieve a recovery position on a sample of the deficits. Whilst we reviewed the financial position for all service areas, we also focussed on Scheduled Care and Estates and Facilities. We selected a sample of ten savings plans throughout the Health Board that were reported to the Board on the 25th of January 2023 (during month nine, when 61 plans were in continued operation) and found no evidence for clear ownership or formal objectives for the plans. We also note that two of the plans within the sample were reported to be falling behind (rated amber) in December 2022 (eight were rated as green). However, we found no action plans and related monitoring to turn them around, as underperforming plans are sometimes replaced with new ones. We were also informed that action plans are usually not prepared for savings plans that are not delivering to set targets. During January 2023, 13 of the 61 plans were rated as amber, in terms of achieving a successful outcome and 11 of these related to either Medicine or Scheduled Care service areas. Furthermore, we found that ownership and objectives of the selected plans were linked to transformation programmes but were not clearly defined to a divisional level and thus, there was no responsible officer. Overall, whilst there is regular reporting of financial performance and oversight of spending, we found that budgets were not always met.	Potential risk of: • Lack of ownership and objective setting • Limited responsibility to deliver on targets • Budgets are not met, increasing the overall deficit.

Recommendations		Priority
2.1	Savings plans should be set with clear ownership (e.g. appropriate / senior individual) and SMART objectives (where appropriate). A more formal process should be developed to ensure this.	Medium (Design)
2.2	Where a budget has not been achieved, clear actions should be set, with a responsible owner to implement them. Formal action plans should be developed where savings plans fall behind on delivery. Summary of these action plans and related progress updates should be formally reported to the Finance and Performance	Medium (Operation)

Committee (e.g. as part of the MI packs). Assurance should be provided to the Finance and Performance Committee and the Board that plans are in place to turn around poor performing savings plans.

Management response		Target Date	Responsible Officer
2.1	Accepted. The revised accountability framework will provide greater management focus on savings delivery. Whilst the IMTP identifies the savings plans at a divisional level for 2023/24 and current FCPs already identify the need to operate within delegated budgets, we will ensure objectives are appropriate.	May 23	Savings allocation – Director of Finance, Procurement and Value Accountability framework – Chief Executive
2.2	Accepted. The current Budgetary Control FCP includes the expected process of remediation to manage within the budget limits.	Complete	
	Reporting to Board and F&PC is in place for savings plans and performance and mitigating actions where developed.	Complete	
	More detailed reporting to the Board and F&PC on mitigation plans will be considered as part of the accountability framework, but should be the responsibility of the relevant budget holder. The newly proposed Financial Improvement & Efficiency Board will support this.	May 2023	Accountability Framework – Chief Executive Financial Improvement & Efficiency Board - Director of Finance, Procurement and Value

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Risk Management
Final Internal Audit Report

March 2023

Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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Executive Summary

Purpose

To provide an opinion on the effectiveness of the risk management arrangements in place within a sample of Divisions. To complete this, we considered key sections of the Risk Management Strategy and Framework (the 'Framework').

Overview

We have issued reasonable assurance on this area.

Overall, we found good arrangements in place, but we found different approaches to risk management across the Divisions sampled. We also found clear lines of escalation if there are specific risks that cannot be managed at an operational level.

Within the sample tested, we identified the following matters:

- A lack of formal reporting of risks and the management of risks / associated actions within the Divisional Management Team meetings and at the Divisional Quality, Patient, Safety and Experience Meeting.
- Different approaches to the recording of risks identified, although the key elements were recorded as expected.

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

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔

Assurance summary[1]

Assurance objectives	Assurance
1 Identification and scoring of risks	Reasonable
2 Management and evaluation of risks	Reasonable
3 Escalation of risks	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Divisional Management of Risk	1, 2	Design	Medium
2	Divisional Risk Management Approach	1, 2	Design	Medium

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

1. Introduction

1.1 The Risk Management review was completed in line with the 2022/23 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that appropriate risk management arrangements are in place within the Divisions.

1.2 The risks considered as part of this review were:

- key risks are not identified, assessed, recorded and / or escalated throughout the Health Board;
- risks identified are not effectively managed resulting in patient harm / poor patient experience, increased financial costs and / or reputational damage to the Health Board and a negative impact on staff; and
- lack of awareness of the requirements of the Risk Management Strategy and Framework.

1.3 The Risk Management Strategy and Framework was reviewed as part of the Risk Management Audit during 2021-22, therefore this audit only focussed on adherence to the Framework's requirements within the Divisions sampled.

1.4 The Divisions of Family and Therapies and Complex Care have been chosen as the main focus of this review.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	1	3
Operating Effectiveness	-	-	1	1
Total	-	2	2	4

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: Risks at a divisional / service level are appropriately identified and assessed in accordance with the Framework

Family and Therapies

2.3 Risks are held on Datix and are scored by senior managers in each area of the Division e.g. Maternity and Sexual Health, Child Health etc. The Health Board's

scoring matrix is used. The matrix assesses both the likelihood and severity of the risk to provide a score from 25 (25 being the highest level of risk identified).

2.4 We selected a sample of risks entered onto Datix and confirmed all had been appropriately scored and added to Datix. All risks had an inherent risk score and then once mitigating controls had been included, the residual risk score was assessed.

2.5 The Quality and Patient Safety Lead for Family and Therapies ensures those noted as the responsible owner for the risk on Datix updates the risk when required, including providing status updates when the risk cannot be completely mitigated.

2.6 There are a number of risks on the risk register which are over 12 months old. A walkthough of some of these risks confirmed that they were still appropriate and required continuing management, for example asbestos in ceilings.

Complex and Long Term Care

2.7 Risks are not held on Datix, but rather, a spreadsheet is maintained with a virtual / remote assessment process in place. This approach is in place until the All-Wales risk management module within Datix has been rolled out. However, there is currently no formal meeting that takes place where risks are scored / discussed or tracked, including actions. This has been included within **matter arising one**.

2.8 We were informed that this was due to a change in the Divisional structure, but also that risks are managed on a daily basis through ongoing discussions with colleagues. Through interviewing multiple senior staff within Complex Care, we were satisfied that the highest risks were well understood, but we were unable to evidence the ongoing, operational management of the risks. This has been included within **matter arising one**.

2.9 The Complex Care risk register differs from that held by the Family and Therapies Division. The Complex Care register does not include an inherent risk score or a residual/target risk score. Instead, it details just one figure as the overall risk score. This has been raised within **matter arising two**.

2.10 There has been a significant delay in the roll out of the new risk management Datix module. This has led to Divisions utilising a variation of approaches to risk management and a lack of consistency across the Health Board. The Health Board should clarify its position on the preferred risk management approach, if any. This has been included within **matter arising two**.

Conclusion:

2.11 There is a clear process in place for risks to be scored and updated within the Family and Therapies Division. There is scope to strengthen the ongoing management / tracking of risks within the Complex Care Division. We have provided **reasonable assurance** for this objective.

Audit objective 2: There is appropriate management and evaluation of risks identified at a divisional level

Family and Therapies

2.12 Risks are managed daily through discussions with colleagues. There are risk leads within each service who update Datix if any risks are identified. The risk register is reviewed formally monthly at the Divisional Management Team meeting. Within this meeting any new and high risk areas are discussed.

2.13 The Division presents its top three risks to the Quality, Patient Safety and Operational Group (QPSOG). These are not always the Division's highest scoring risks, but are always the risks that are the most relevant at the time of the meeting.

2.14 We reviewed a sample of the minutes and papers submitted to the QPSOG and undertook a comparison to the Division's risk register. We confirmed that the risks identified and reported to the QPSOG meetings are appropriate.

Complex and Long Term Care

2.15 We were informed that due to resource challenges the formal noting / discussion of risks has not always taken place within the last 12 months. The Division is in the process of rectifying this and will be reporting the risk register to its fortnightly Divisional Management Team meetings. This has been included within **matter arising one**.

2.16 However, we did confirm that the risk register is being updated throughout the year, including details of the highest risks.

2.17 As with the Family and Therapies Division, the Complex Care Division submit their top three risks to the monthly QPSOG meetings for discussion. We confirmed that significant risks are escalated.

2.18 We noted good practice in the forms submitted to the QPSOG meetings from both Divisions. The template to complete to submit the risks was a standard template to be used by all Divisions and this enables a consistent approach for risks to be submitted and reviewed.

Conclusion:

2.19 We confirmed that risks within the Complex and Long Term Care Division are recorded, however greater documentation and formal monitoring of these risks is required. We have provided **reasonable assurance** for this objective.

Audit objective 3: There is appropriate escalation and reporting of risks

Family and Therapies

2.20 A highlight report is sent to the Patient Quality, Safety and Outcomes Committee (PQSOC) from the QPSOG. At the PQSOC, the Divisional Quality and Patient Safety Leads escalate Divisional risks and concerns related to quality and patient safety.

2.21 Staffing resources has been a key risk raised by the Division within the QPSOG meetings. This has been escalated to the Corporate Risk Register.

Complex and Long Term Care

2.22 The process for the Complex and Long Term Care Division is the same as noted for the Family and Therapies Division. Any risks that cannot be managed at the QPSOG would be raised within the highlight report, which is issued to the QPSOC.

2.23 Also as noted above, staffing has been raised as one of the Division's main risks.

Conclusion:

2.24 There is a clear process for escalating risks further within the Health Board, therefore we have provided **substantial assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Divisional Management of Risks – Complex Care (Design)	Impact
Whilst we found that risks are identified, recorded and updated within a spreadsheet by the Complex and Long Term Care Division (the 'Division'), there is no formal monitoring or discussion of these risks (or associated actions) at the Divisional Management Team meetings. Instead, due to resource constraints, risks are managed / discussed on an ad-hoc basis or indirectly via the subject matter within the agendas (e.g. caseload numbers or safeguarding concerns). Furthermore, we confirmed that the top three risks are reported to the Quality and Patient Safety Operational Group (QPSOG), but the overall risk register is no longer formally reported into the Divisional Quality, Patient Safety and Experience Group for the Division (although we did identify the top three risks being tabled, prior to submission to the QPSOG).	Potential risk of: • Risks are not discussed by the appropriate managers. • Actions to manage risks are not monitored.

	Recommendations	Priority
1.1	The Complex and Long Term Care Division should monitor and assess the risk register at the Divisional Management Team meetings and ensure that the risk mitigation actions still remain appropriate. Consequently, any risks that requiring updating / removal should be formally discussed and agreed upon at each Divisional Management Team meeting.	Medium
1.2	The Complex and Long Term Care Division should report the full risk register, on a periodic basis, to the Divisional Quality, Patient Safety and Experience Group.	Low

	Management response	Target Date	Responsible Officer
1.1	Agreed. The Complex and Long Term Care Division will monitor and assess the risk register and make necessary amendments at the Divisional Management Team meetings.	30th April 2023	Head of Business & Performance
1.2	Agreed. The Complex and Long Term Care Division will report the full risk register to the Divisional Quality, Patient Safety and Experience Group.	30th April 2023	Divisional Nurse – Complex and Long Term Care

Matter arising 2: Divisional Risk Management Approach (Design / Operational)	Impact
The Complex and Long Term Care Division (the 'Division') does not record an inherent or a residual / target risk score, but instead the overall risk score is detailed. This is a different process to the Family and Therapies Division, where this information is recorded. We were informed that the Health Board is waiting for the All-Wales risk module to be fully implemented within Datix (i.e. a different version to the current system).	Potential risk of: • Risks not being effectively managed or assessed.

	Recommendations	Priority
2.1	The Complex and Long Term Care Division should ensure that there is no additional risk exposure through the current approach of recording divisional risks.	Medium
2.2	The Health Board should clarify how Divisions will record risk in the meantime.	Low

	Management response	Target Date	Responsible Officer
2.1	Agreed. The Complex and Long Term Care Division will ensure there is no additional risk exposure through the current approach of recording divisional risks.	30th April 2023	Divisional Nurse – Complex and Long Term Care
2.2	In the absence of an electronic risk management system, the provision for recording risks is outlined within the current corporate template for a risk register. This has already been shared with the Complex Care Team.	Complete	Head of Corporate Services, Risk and Assurance
	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.	31st May 2023	Head of Corporate Services, Risk and Assurance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Monitoring Action Plans
Final Internal Audit Report

March 2023

Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates (specifically Health Inspectorate Wales (HIW) and Health and Safety Executive (HSE)).

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- A standard operating procedure should be developed to set out how HSE actions are monitored, tracked, escalated and overall assurance provided.
- An inconsistent approach and a lack of evidence to the tracking of HSE actions by the respective committees.

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

There are robust controls in place for the monitoring of HIW actions, reporting and escalation.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A – First review in this area

Assurance summary[1]

Assurance objectives	Assurance
1 HIW and HSE reporting	Reasonable
2 HIW and HSE escalation	Reasonable

Key matters arising

	Assurance Objectives	Control Design or Operation	Recommendation Priority
1 HSE SOP	1, 2	Design	Medium

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

1. Introduction

1.1 The review of the Monitoring Action Plans for Aneurin Bevan University Health Board (the 'Health Board') was completed in line with the 2022/23 Internal Audit Plan.

1.2 Reports and management actions are received from multiple external sources. However, this review focussed specifically on the Healthcare Inspectorate Wales (HIW) and the Health and Safety Executive (HSE) actions. The progress over the implementation of these actions is typically monitored by the applicable sub-committees of the Board, e.g. Patient Quality, Safety and Outcomes Committee.

1.3 The risks considered as part of this review were:

- insufficient assurance / reporting to the Board of actions raised, including the significance of them;
- failure of implementing actions resulting in patient harm / poor patient experience, increased financial costs and reputational damage to the Health Board; and
- actions are not measured or monitored resulting in a delayed implementation.

1.4 The audit did not review or test the operational management and implementation of external actions raised, but rather assurance is provided on the framework in place for managing the actions. In particular, how actions are identified, reported, monitored and escalated to an appropriate committee.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	1	2
Operating Effectiveness	-	-	-	-
Total	-	1	1	2

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

2.3 Our audit focussed on two objectives, each incorporating testing of the controls for the reporting and escalation regarding HIW and HSE. However, if we analysed the HIW and HSE components of the testing completed we would provide assurance over the controls for each area as follows:

Health Inspectorate Wales	Substantial
Health and Safety Executive	Reasonable

The overall assurance rating remains as reasonable assurance, but the above information is intended to help direct the focus with the implementation of the recommendations.

Audit objective 1: Effective arrangements are in place for identifying, monitoring and implementing actions received from external inspectors (specifically HIW and HSE)

HIW Reports

2.4 During the past financial year there have been five HIW inspections. All reports are received by the Chief Executive's office and then distributed to the relevant staff. HIW reports also incorporate action plans, which require implementation. The Director of Nursing has delegated lead responsibility for HIW relationships, co-ordinating inspections, maintaining a corporate tracker, monitoring compliance with improvement plans and managing constraints etc.

2.5 There is a clear process in place for responding to HIW reports and the Health Board has a standard operating procedure (SOP) on how to comply with their inspections and the subsequent reports. A database is maintained, which includes all HIW correspondence, dates for submission of evidence, action plans and evaluation dates. The Corporate Nursing Team review every draft report response, prior to submission to the HIW.

2.6 All HIW correspondence is shared with the Director of Nursing, Assistant Director of Nursing, Quality and Safety and the Corporate Nursing Assistant Director.

2.7 An assurance update was provided to the Patient Quality, Safety and Outcomes Committee (PQSOC) at the end of 2022, which notes that the Health Board had been compliant with all deadlines set by HIW, with timely submission of information.

HSE Reports

2.8 HSE reports are sent by the HSE to the Chief Executive's office. The Health Board has received two reports during 2022/23. The reports are sent to both the Director of Therapies & Health Science and to the Head of Health, Safety and Fire.

2.9 The Head of Health, Safety and Fire usually coordinates the responses to the HSE. However, there is no detailed procedure or process in place setting out the process for managing HSE inspections or responding to actions, unlike with the HIW inspections. This has been raised as **matter arising one.**

2.10 We were informed that it is the responsibility of the Health and Safety Committee to track the HSE actions. Whilst the Health and Safety Committee does receive reports / letters issued from the HSE and often an update is provided on actions completed, the process of action tracking is not formalised – particularly

compared to the approach adopted for that of HIW actions. No action tracking reports are taken to any of the Health Board's committees.

2.11 We did confirm responses were provided to the HSE and so rather than action tracking / monitoring not occurring, it is more likely that the controls around the process need to be tightened and formalised to create an audit trail. This has been included within **matter arising one.**

Conclusion:

2.12 Robust controls are in place regarding HIW action tracking. A more formalised and documented approach to action tracking for HSE actions should be implemented. The overall assurance rating for objective one is **reasonable assurance.**

Audit objective 2: Appropriate escalation of actions reported to the Board or Committee with delegated responsibility and the resolution therein are embedded, including overdue deliverables.

HIW Escalation

2.13 There is evidence of continuous reporting at a number of levels within the Health Board. Verbal updates on the status of HIW reports and the actions within are provided at each Quality Patient Safety Operational Group (QPSOG) by the Deputy Director of Nursing.

2.14 Formal updates are provided to the PQSOC which include, but not limited to:

1. overview of what the report details;
2. list of HIW inspections completed since the last committee;
3. an action tracker which details all of the current, outstanding HIW actions and which audits / divisions they relate to;
4. the actions are then detailed individually and an update for each is provided; and
5. time provided for the committee to scrutinise and raise any questions.

2.15 A twice-yearly status update report is also provided to the PQSOC, which details the progress with the delivery of recommendations. It also includes and outstanding actions from the HIW inspections conducted across the Health Board.

2.16 We did identify a slight discrepancy between the number of HIW actions noted within the update reports sent to PQSOC and the number of actions actually within the HIW reports. The discrepancy was consistently one less than in the HIW reports. We have raised this as **matter arising two**.

2.17 The escalation and monitoring of HIW actions is robust, with a clear process and a strong audit trail of governance over this area.

HSE Escalation

2.18 We were informed that action plans for HSE reports are held at a directorate / divisional level. Whilst we have focussed on the corporate arrangements, we have

not seen any consistent or clear escalation reporting to the Health and Safety Committee.

2.19 We recognise that the volume of HSE inspections can vary and during the period that we tested, there were just two visits. However, assurance reports provided to the Health and Safety Committee or any other committees regarding HSE reports, were isolated. We did confirm that an update was provided to the February 2023 PQSOC, but we did not identify any further reports from the sample period tested. We have included this within **matter arising one.**

2.20 We were informed that a positional update on HSE activity will be included within the Health and Safety Annual Report. This will be presented to the Executive Team within the next couple of months.

2.21 Minutes confirm that HSE reports are discussed at the Health and Safety Committee, although this evidence is not available for all HSE reports given to the Health Board within the last couple of years. However, the Chair of the Health and Safety Committee is also a Board member and would be able to raise any issues, if required.

Conclusion:

2.22 There are clear and concise assurance reporting around HIW reports. HSE reports require a more formalised assurance process. The overall assurance rating for objective two is **reasonable assurance**.

Appendix A: Management Action Plan

Matter arising 1: HSE SOP (Design)	Impact
There is no standard operating procedure (SOP) in place to detail the process for responding to an HSE inspection visit / report. Furthermore, this also applies to the tracking and monitoring of issues raised and the corresponding actions therein. Whilst we observed updates being provided to the Patient Quality, Safety and Outcomes during February 2023, this was the only example identified. Finally, HSE assurance reports are not regularly reported to the relevant committees, although we identified that updates / outcomes from HSE visits are provided in a less formal approach e.g. verbal updates to the Health and Safety Committee. There would a benefit to stipulating how assurance regarding health and safety matters should be provided and to which committee(s).	Potential risk of: • Inconsistent approaches to implementing actions or responding to the HSE. • Staff unaware or unsure of their responsibilities. • Insufficient assurance provided to the respective committees.

Recommendations	Priority
1.1 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.	Medium

Management response	Target Date	Responsible Officer
1.1 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.	May 23	Scott Taylor

Matter arising 2: HIW action reporting (Design)	Impact
There is a slight discrepancy between the number of HIW actions noted within the update reports sent to the Patient Quality, Safety and Outcomes Committee (PQSOC) and the number of actions actually within the HIW reports. The discrepancy was consistently one less than in the HIW reports.	Potential risk of: • Actions not being implemented.

Recommendations		Priority
2.1	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.	Low

Management response		Target Date	Responsible Officer
2.1	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.	May 23	Tracey Partridge Wilson

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*

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Discharge Planning
Final Internal Audit Report

April 2023

Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

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

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Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the discharge planning process of Aneurin Bevan University Health Board (the 'Health Board'). It has focussed on the management and delivery of planned discharges and has included sample testing of patients admitted in during April and May 2022.

Overview

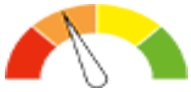
We found that discharge planning practices were not supported by the out-of-date Discharge Policy, there was no compliance audit programme and reporting. Furthermore, the evidential support of the discharge process was lacking, based on the results of our sample testing.

In addition, we raised comments on the simple and complex pathways approach, the use of checklists, and improvement in the reporting, analyses and actions to address avoidable re-admissions.

All findings are detailed in matters arising in Appendix A.

Report Classification

Limited



More significant matters require management attention

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	The Policy is up to date and the responsibilities of staff are clearly set out	Limited
2	The Policy is adhered to ensure a timely discharge in particular, completion of discharge summaries, an expected date of discharge is documented, discharge approach is documented, and discharge planning meetings are arranged in a timely manner	Limited
3	Ongoing monitoring of Discharge Planning, including performance and compliance assessment is undertaken.	Limited

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

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Discharge Policy Out of Date	1	Design	High
2	No Formal Discharge Planning Training	2	Operating Effectiveness	Medium
3	Incomplete Evidence of Discharge Process	2	Design	High
4.1	Simple / Complex Cases	2	Design	Medium
4.2	Simple / Complex Cases	2	Design	High
4.3	Simple / Complex Cases	2	Design	Medium
5	Discharge Planning Checklists	2	Operating Effectiveness	Medium
6	Monitoring of compliance with the policy	3	Operating Effectiveness	High
7	Re-admission Metric	3	Design	Medium

1. Introduction

1.1 This internal audit has provided an opinion over the discharge planning process and was completed in line with the 2022/23 Internal Audit Plan.

1.2 The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that operational procedures and policy are adhered to.

1.3 Discharge is an essential component of the patient pathway, and minimising delays associated with it is a priority. The Health Board aims to provide a safe, effective and timely discharge of patients into an environment that is appropriate to the individual's needs. A Discharge Policy ABUHB/Clinical/0714 Issue 3 (the 'Policy') is in place that applies to all health care professionals and support staff and covers all clinical environments.

1.4 We previously undertook a review of discharge planning (entitled 'Patient Discharge Process') during 2017/18, which was rated as limited assurance.

1.5 The risks considered in the review included:

- discharge planning is not considered prior to or at the point of patient admission;
  the expected date of discharge is not reviewed regularly, and ongoing care requirements are not actioned promptly, leading to a delay in discharge;
- relevant information relating to discharge is not captured within the patient records; and
- performance relating to the discharge process is not regularly monitored.

2. Detailed Findings

The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	3	3	-	6
Operating Effectiveness	1	2	-	3
Total	4	5	-	9

Objective 1: the Policy is up to date and the responsibilities of staff are clearly set out

2.1 The Discharge Policy (the 'Policy') was due for review by 25 September 2022, but this has not yet happened, and that the Policy is currently out of date. We understand that any review will occur once an All Wales Policy on this area is issued by the Welsh Government, which is imminent. However, no extension to

the existing Policy has been approved pending any subsequent updating, approval, and reissue.

2.2 We also noted that the Policy was issued in September 2019 and that significant changes to discharge planning practice and approach have been adopted by the Health Board in recent years, but that no amendments to the Policy have been made to reflect these changes. For example, the movement away from Estimated Date of Departure to Medically Fit Date for Discharge and the adoption of simple and complex pathways approach. As a result, roles and responsibilities of staff defined in the Policy are no longer fully aligned with current practice and approach.

2.3 There is a need to ensure that the Policy is reviewed urgently, and within established timelines going forward, and that significant changes to practice and approach are recognised with the Policy. In addition, a formal approval of any extension should be sought from the Clinical Standards and Policy Group, as the responsible forum. We have raised these findings in matter arising 1 in Appendix A.

Conclusion:

2.4 We found that the Policy is out of date and whilst responsibilities are defined and an updated All Wales policy is due to be shortly issued, the Policy does not reflect the current practice nor does it reflect the significant evolution in process and approach that has occurred in recent years. Therefore, we have provided **limited assurance** over this area.

Objective 2: the Policy is adhered to ensure a timely discharge in particular, completion of discharge summaries / re-submissions is promptly undertaken, an expected date of discharge is documented, discharge approach is documented, including for complex discharge arrangements, and discharge planning meetings are arranged in a timely manner

2.5 We tested a sample of patients admitted in April and May 2022 across the Health Board, to determine if a consistent approach was adopted to discharge planning purposes. However, we were unable to test to determine if the expected date of discharge (EDD) was completed, as this has been superseded by a medically fit date for discharge (MFDD). The MFDD is not retained on a patient's record once they have been discharged, as it is automatically removed. Therefore, we were unable to test the completion and accuracy of this date.

2.6 Our testing of day cases and inpatients identified an incomplete evidence of discharge notifications, copies of which are given to the patient's GP, the pharmacy, if required, and to the patient or patients' representatives, to help facilitate care after discharge. Of the 14 day-cases tested, these infrequently generated discharge notifications, and whilst the 15 inpatients sampled did, we noted two discharge notification were produced weeks after the actual discharge.

For one patient we were not able to locate evidence of a discharge notification. We have raised these findings in matter arising 3 in Appendix A.

2.7 There is no formal discharge planning training provided. This matter is exacerbated by the lack of current policy and procedural documentation available to support training and to provide effective continuing reference material. As a consequence, our testing results varied partly in response to the variation in practices encountered across the Health Board sites and wards. We have raised this finding in matter arising 2 in Appendix A.

2.8 In addition, we identified that discharge planning meetings to discuss needs and the establishment of care packages were poorly evidenced. There was a presumption that these actions were not required in those cases assessed as simple, but there was no evidence that such actions were not required. We have also raised this finding in matter arising 3 in Appendix A.

2.9 Currently there are two main pathways developed on which to plan discharge activity, simple and complex. There were four cases within our sample that were identified as complex. Complex cases are detailed on a Complex List, being a web-based page with patients added manually by services functions comprising of Discharge Team members, liaison and assistants. We noted the following findings and raised these in matter arising 4 in Appendix A:

- There is no control over adding patients to ensure that all patients assessed as complex (requiring identified support services to facilitate discharge) are added to the list promptly. There is no control operating to ensure that the Complex List is a complete and accurate subset of the Clinical Work Station (CWS) record that details all admissions, as patient records on CWS are not required to be recorded with a status of simple / complex, so cannot be easily cross checked;
- The recording of a patient as discharged on CWS automatically updates the Complex List and removes the patient. We noted that from the sample of discharges tested, that some patient transfers between sites were reflected as discharges on CWS. There is a need to ensure that such transfers recorded as discharges in CWS are not removing patients from the Complex List in error; and,
- The creation and management of the Complex List provides source data for monitoring discharges and for providing statistical reporting inside and outside of the Health Board. However, this approach assumes that discharges of simple cases never incur delays in discharge due to manageable clinical, pharmacological, or communications related issues. There is no system in place to monitor whether such instances occur and therefore would not report such discharges as delayed were the delay over 48 hours.

2.10 The Policy does not require the mandatory use of discharge checklists, although a version is used regularly to guide staff through the process. We identified that discharge checklists were in general not retained on file, and in numerous cases were present, but incomplete or unsigned. Where checklists were being used, we

also noted that there was no consistency in the checklist format being used across the wards and departments. The use of checklists to provide oversight of the simple and complex pathways would aid the delivery of a consistent approach across the Health Board, with evidence retained. We have raised these findings in matter arising 5 in Appendix A.

Conclusion:

2.11 We have raised four matters arising under this objective relating to the delivery of a consistent discharge planning approach across the Health Board that is effectively and efficiently evidenced, with specific comment on opportunities to improve control and effectiveness of current practices. Therefore, we have provided **limited assurance** over this area.

Objective 3: ongoing monitoring of Discharge Planning, including performance and compliance assessment is undertaken

2.12 The Discharge Policy states that there is a requirement for an audit programme with lessons learnt being reported to the Patient Quality, Safety, and Outcomes Committee ('PQSOC'). However, we noted that learning from any Health Board compliance audit of the Discharge Policy had not been reported to the PQSOC within the last 12 months. Furthermore, we were not able to evidence the existence of a rigorous compliance audit programme as referred to in the Discharge Policy.

2.13 We were informed that key managers were aware of the ability to escalate matters to the PQSOC if they deemed it were required, but our review of the PQSOC minutes did not identify any such escalated matters recorded during 2022. We have raised the lack of effective compliance audit review and reporting in matter arising 6 in Appendix A.

2.14 In addition, we noted that the re-admission metric had historically been reported to the Board within the Performance Dashboard, based on the definition patient re-admitted within 28 days of discharge. However, this metric was no longer being tracked and reported. We have commented on the need to retain the broad metric, to undertake analyses to identify trends in administrative and or clinical issues that may be exacerbating the re-admission of patients, and to take action to address any such manageable issues identified. We have raised these findings in matter arising 7 of Appendix A.

2.15 We were informed that the formal reporting of the Delayed Transfer of Care (DToC) metric was paused during the pandemic, but is due to be reinstated fully from January 2023.

Conclusion:

2.16 We have raised two matters arising under this objective, the lack of an effective compliance audit review and reporting and consequent inability to provide assurance to the Board. Furthermore, we have recommended improvements to identify trends and reasons for the re-admission of patients within an agreed period of time. Therefore, we have provided **limited assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Discharge Policy Out of Date (Design)	Impact
The Discharge Policy (Policy No: ABUHB/Clinical/0714 Issue 3) was due for review by 25 September 2022, but has not been reviewed by this date and no extension has been approved pending the release of an All Wales Policy by the Welsh Government. We also noted that the Discharge Policy was issued in September 2019 and has not reflected significant changes to current practice and approach to discharge planning adopted by the Health Board in recent years. For example: • movement away from the Estimated Date of Departure to Medically Fit Date for Discharge; • the adoption of a two-pathway approach for simple and complex cases, and policy related matters including guidance on how cases are assessed and subsequently reviewed during a patient's stay; and • the addition of patients to the Complex List, updating of patient related information on the Complex List and removal of patients from the Complex List. There has been no attempt to review and update the policy for significant changes during the period September 2019 to September 2022. As a result, roles and responsibilities of staff defined in the Discharge Policy are no longer fully aligned with the practice and approach of discharge planning currently adopted by the Health Board.	Potential risk of: The actual practice and approach to discharge planning adopted by the Health Board are not compliant with the Discharge Policy published. Current procedures adopted are not subject to the effective scrutiny, approval and documentation, as required of policy revisions. Steff are not able to refer to policy and related procedural documentation that reflect the operational position hindering understanding of process.

Recommendations	Priority
1.1 We recommend that Health Board ensure that: a. Where a Health Board policy is to expire that an extension to the document is formally granted, with a revised review by date established. Such policy extensions should be reported to the Board or designated Committee and checks made to ensure that the policy remains as relevant as possible, pending any formal review. b. The Discharge Policy is updated, approved and reissued, to be compliant with the All Wales policy, when issued. c. The Discharge Policy is updated, approved and reissued, to reflect current practice and approach to discharge planning adopted by the Health Board (Medical Fit Date for Discharge, simple and complex	High

case approaches, and the management of the Complex List) and the related roles and responsibilities of staff.

Management Responses		Target Date	Responsible Officer
1.1	a. The Health Board's clinical policies have a review date rather than an expiry date, and whilst the review date may have elapsed, the policy remains extant and does not require a formal extension. However, whilst the Policy remains extant, we recognise there may be differences between the Policy and current practice. Therefore, the current process will be reviewed and compared to the existing Policy. Where gaps are identified, these will be risk assessed and mitigation implemented to reduce risk to an acceptable level. We anticipate this will include an interim update to the Policy. Following this process we will provide assurance to the QPSOG over actions to be implemented, with regular updates provided on implementation status.	May 2023	Head of Patient Discharge
	b. 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.	3 months from receipt of the All Wales Policy	Head of Patient Discharge
	c. In the interim we will identify the gaps between current practice and the current policy and ensure that it is updated. We will then ensure the Policy is approved by the appropriate Committee. Once the All-Wales Policy is published, we will ensure that any requirements are incorporated into the Health Board's Policy. The revised policies will be re-issued with training overseen by the Head of Discharge and Divisional Nurses. We will continue to monitor the implementation of the policy and update training requirements as required.	May 2023	Head of Patient Discharge

Matter arising 2: No Formal Discharge Planning Training (Operating Effectiveness)	Impact
There is no formal Discharge Planning training provided. Whilst discharge planning forms an integral element of the patient pathway, there is no formal training provided by the Health Board, to ensure that staff are fully trained on discharge planning principles, procedures and any changes thereto. This matter is exacerbated by the lack of current policy and procedural documentation available to support training and to provide effective continuing reference material.	Potential risk of: The lack of training of staff results in inconsistency of process with: • incorrect or ineffectively implemented processes resulting in possible legal impact; and, • inefficient implementation of processes adversely impacting the timing of discharges.

Recommendations	Priority
2.1 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.	Medium

Management Responses	Target Date	Responsible Officer
2.1 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.	October 2023	Assistant Medical Director for Planning

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.		
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.	April 2024	Executive Director of Nursing
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.		

Matter arising 3: Incomplete Evidence of the Discharge Process (Design)	Impact

From our sample testing of day cases and inpatients, we identified the inability to locate all evidence in support of discharges sampled and we were not able to evidence the correctness of the discharge approach actioned.
In particular, we noted the following:
• Discharge Notifications are not completed, or not completed in a timely manner.
  ○ From a sample of 14 day cases there was one notification completed on the day and two completed later (in one case over 2 weeks late) and 11 did not result in a discharge notification (four cases where the appointment was not recorded on CWS).
  ○ From our sample of 15 inpatient cases there were nine notifications completed on the day and four completed later (one case was over two weeks and in the case of a deceased patient over 17 weeks), with two cases that did not result in a discharge notification. In addition, with one patient selected there was no record or documentation provided to audit.
• Our sample testing also identified that discharge planning meetings, to discuss needs and the establishment of care packages, were poorly evidenced. There was a presumption that these actions were not required in those cases assessed as simple, but there was no evidence that such actions were not required.
	Potential risk of:
	Delays in the production of discharge notifications, or the lack of the creation of documentation, results in serious consequences in relation to health and wellbeing of discharged patients and consequent reputational and legal consequences for the Health Board.
	The lack of locatable, process evidence limits any retrospective review of practice and hinders effective compliance testing.

Recommendations	Priority
3.1 We recommend that Health Board ensure that: a. All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification. b. 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. c. A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites.	High

Management Responses		Target Date	Responsible Officer
3.1	a. 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.	April 2024	Medical Director/Assistant Medical Director for Planning
	b. 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.	April 2024	Executive Director of Nursing
	c. 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.	April 2024	Assistant Medical Director for Planning

Matter arising 4: Simple / Complex Cases (Design)	Impact
Complex cases are detailed on a Complex List. The Complex List is a (web-based) page with patients being added manually by service functions comprising of Discharge Team members, liaison and assistants. Team members add patients to the Complex List as and when the patient's assessment indicates that the discharge is a complex case, i.e. support identified to facilitate discharge. There is no control over adding patients to the Complex List promptly, where they are assessed as complex. Furthermore, there is no control to ensure that the Complex List is a complete and accurate subset of the Clinical Work Station (CWS) record, as patient records on CWS are not recorded with a status of simple / complex. Therefore, they can not be easily cross checked. From the sample of discharges tested, we noted that some patient transfers between sites were reflected as discharges on CWS. The recording of a patient as discharged on CWS updates the Complex List and removes the patient. There is a need to ensure that transfers recorded as discharges in CWS are not removing patients from the Complex List in error. The creation and management of the Complex List provides source data for monitoring discharges and for providing statistical reporting inside and outside of the Health Board. This approach assumes that discharges of simple cases never incur delays in discharge, due to manageable clinical, pharmacological or communications related issues. There is no system in place to monitor whether such instances occur and therefore would not report such discharges as delayed, were the delay over 48 hours.	Potential risk of: Not all patients identified as being a complex case are listed on the Complex List or listed in a timely manner. Patients on the Complex List may be removed in error when a patient is transferred between sites if the CWS record is updated to reflect a discharge event. Simple cases may be incurring delays in transfer that are not being captured by any monitoring and reporting procedure.

Recommendations	Priority
4.1 We recommend that the Health Board ensure all patients admitted and recorded on CWS should have either 'simple' or 'complex' discharge status noted.	Medium
4.2 The recording of transfers between sites as discharges in CWS should be investigated to determine that it is not adversely impacting the Complex List by removing patients in error when in fact they remain under the care of the Health Board.	High

4.3	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported.	Medium

	Management Responses	Target Date	Responsible Officer
4.1	The complex list is an operational tracking tool to ensure that patients who may require support on discharge are captured and all appropriate assessments completed as required. All potential complex patients are added to the complex list, so that by default the remaining patients are simple discharges. Status can change during admission as patients may deteriorate or circumstances change so that patients are added to the complex list during their admission. The allocation of a 'simple' or 'complex' label may be difficult to assess on admission and would be of little benefit operationally. In December the Health Board recommenced shadow reporting to Welsh Government for Pathways of Care Delays (replaced DTOC reporting) and provides an audit / monitoring process for all patients with a delayed discharge status. This process also includes an action plan overseen by the Discharge Improvement Board, supported by improved operational information in the discharge dashboard.	Completed	N/A
4.2	There are acknowledged limitations within the Health Boards CWS system, whereby patients need to be discharged from one hospital to be admitted to another hospital on transfer. This has been the case since the inception of CWS, and forms part of the training provided to staff on induction. Mitigation of this risk is provided as all hospital staff are aware of the need to readmit to the receiving hospital on arrival. All acute and community wards have an allocated Hospital Discharge Assistant who ensures that transferred patients who may require support on discharge are captured on the complex list. For community hospitals transfers, patients are always added to the complex list by default as they are by nature complex cases. The mitigation described ensures that patients are not lost to the complex list, and we have evidence to support this. The new discharge dashboard demonstrates that the	Completed	N/A

	majority of our patients are included as part of the complex list either pending assessment or provision of discharge arrangements.		
4.3	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.	April 2024	Executive Director of Nursing

Matter arising 5: Discharge Planning Checklists (Operating Effectiveness)	Impact
The current policy does not set out the mandatory use of discharge checklists, although they are tool that is used throughout the Health Board. Consequently, we identified from our sample testing that discharge checklists were in general not retained on file, and in numerous cases were present, but incomplete or unsigned. Where checklists were being used, we also noted that there was no consistency in the checklist format. The use of checklists could be tailored to cover the complex and simple case pathways, to help evidence the delivery of a consistent approach to discharge planning across the Health Board. Where we sought in our sample to assess whether the discharge approach performed was in agreement with that planned for the sample selected, we were not always able to locate the relevant supporting documentation. The use of a discharge checklist could improve control in this regard, capturing who did what and by when, and where any related documentary evidence was retained, making its recovery efficient and effective.	Potential risk of: Lack of the completion of a mandatory checklist increases the Health Board's inability to efficiently and effectively: • evidence discharge planning procedures actioned; • evidence compliance with policy; and • assess consistency of procedures adopted across the Health Board.

Recommendations	Priority
5.1 We recommend that Health Board management consider: 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.	Medium

Management Responses	Target Date	Responsible Officer
5.1 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.	October 2023	Executive Director of Nursing

Matter arising 6: Monitoring of compliance with the policy (Operating Effectiveness)	Impact
The Discharge Policy comments that there is a requirement for an audit programme with lessons learnt being reported to the Patient Quality, Safety, and Outcomes Committee (PQSOC). We noted that learning from any Health Board compliance audit of the Discharge Policy had not been reported to PQSOC in the last 12 months. Furthermore, we were not able to evidence the existence of a rigorous compliance audit programme, as referred to in the Discharge Policy. We were informed that key managers were aware of the ability to escalate matters to the PQSOC if they deemed it were required, but our review of the PQSOC minutes did not identify any such escalated matters.	Potential risk of: Lack of effective monitoring of the discharge planning process could result in non-compliant activity not being identified and promptly corrected. Incorrect, inefficient or ineffective activity remains undetected to the detriment of the discharge planning function.

Recommendations	Priority
6.1 We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout.	High

Management Responses	Target Date	Responsible Officer
6.1 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.	3 months from receipt of the All Wales policy	Executive Director of Nursing

Matter arising 7: Re-admission Metric (Design)

Historically, a re-admission was classified as a patient who was re-admitted within 28 days of discharge and this metric was detailed in the Performance Dashboard, as reported to the Board. We found that the re-admission rates were irregularly reported, but a summary from our sample period is presented below:

Month of Performance Dashboard Period	National Target	Current Performance	This Month Actual	Last Month Actual
Sept 21 reported Nov 21	Jul 21 0.12	0.12	11.7% Jul 21	11.6% Jun 21
Nov 21 reported Jan 22	Jul 21 0.12	0.12	11.7% Jul 21	11.6% Jun 21
Jan 22 reported Mar 22	Nov 21 0.11	0.10	10.3% Nov 21	10.2% Oct 21
Mar 22 reported May 22	Feb 22 0.11	0.11	10.5% Feb 22	11.4% Jan 22

The metric provided trend information, but did not provide detailed reasoning for re-admissions limiting the ability to identify themes and learn lessons. Re-admission may be a failure of the discharge planning process or could be a clinical matter, or both. Alternatively, a re-admission may arise because the patient was admitted for a different reason to the initial admission and not due to any adverse event related to the earlier visit. Without this analysis the re-admission metric reported is of limited value.

We also noted that the above metric was no longer reported in September 2022. Measures are now reported in a graphical format covering emergency re-admissions within 28 days following hip fracture and heart failure re-admissions within 30 days.

Impact

Potential risk of:

Re-admission rates are not reported consistently and not analysed, limiting the ability of the Health Board to identify themes and gain benefit from lessons learnt to prevent future re-admissions.

Recommendations	Priority
7.1 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.	Medium

Management Responses	Target Date	Responsible Officer
7.1 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.	October 2023	Planning Director / Head of Performance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Bevan Health & Wellbeing Centre
Final Internal Audit Report

March 2023

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Bwrdd Iechyd Prifysgol Aneurin Bevan
University Health Board

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Executive sign-off:	Chris O'Connor, Interim Executive Director of Primary Care, Community and Mental Health (Senior Responsible Officer)
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Committee:	Audit Committee

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

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

The audit sought to review the management arrangements in place to progress the Bevan Health & Wellbeing Centre.

Overall Audit Opinion and Overview

Limited assurance has currently been determined at this review.

This assessment primarily recognises the significant delays in the delivery of the project (currently circa 30 weeks), and associated current cost pressures. Whilst currently forecast to be delivered £380k (2%) over the approved budget, there remain further significant risks. These are not currently accommodated within the forecast outturn cost projections, and the associated delay in achieving the anticipated business case objectives. Whilst noting the same, it is acknowledged that the delays are not currently being attributed to Health Board actions.

Assurance at other areas, notably equipping, has been reduced due to identified non-compliance with the Health Board's Standing Orders / Standing Financial Instructions and delegated authorised limits.

Other key matters arising at the project include the need to:

- review and define key project roles and responsibilities and the constitution, capacity and function of the Programme Board;
- enhance risk monitoring and management arrangements to include e.g. quantified risk against remaining contingency;
- review the accuracy and clarity of cost reporting to enable appropriate scrutiny and challenge;
- clarify change control procedures & confirm compliance;
- confirm the potential impact of outstanding Compensation Events; and
- monitor appropriate action in relation to site safety.

Other recommendations are detailed within the report.

Report Classification

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved	2021/22

Assurance summary [1]

Assurance objectives		Assurance
1	Project Performance (time/cost/quality)	Limited
2	Follow-up	Reasonable
3	Governance	Limited
4	Valuation	Substantial
5	Site management	Reasonable
6	Change management	Reasonable
7	Equipping	Limited

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	To review the constitution, capacity and function of the Programme Board - *See Newport East Health and Wellbeing Centre Audit Report MA2 issued December 2022*	*3*	Design	**Medium**
2.1	The key Heath Board project roles and responsibilities should be fully defined and approved by the Project Board.	*3*	Design	**Medium**
2.2	Operation and membership of the commercial, technical and progress meetings should be defined at the Project Execution Plan.	*3*	Design	**Medium**
3	The introduction of enhanced risk monitoring and management arrangements.	*3*	Operation	**High**
4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	*3*	Operation	**Medium**
5.1	Management should review the Project Progress Return submissions to Welsh Government to ensure accuracy.	*3*	Design	**Medium**
5.2	The current cost reports should be reviewed by the Health Board and the Cost Adviser and enhanced to improve clarity to afford greater scrutiny by the Programme Board and Health Board officers.	*3*	Design	**Medium**
9.1	The Health Board will ensure compliance with the Health Board's Scheme of Delegation (at the management of all Compensation Events) and any issues of non-compliance reported to an appropriate forum.	*6*	Design	**Medium**
9.2	Change control procedures should be reviewed and updated to ensure consistency (i.e. between the NEC form of Contract, Health Board Standing Orders/Standing Financial Instructions, and the Project Execution Plan).	*6*	Design	**Medium**
10	Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions.	*7*	Operation	**High**

1. Introduction

1.1 The audit reviewed the management arrangements in place to progress the Bevan Health & Wellbeing Centre (formerly referred to as the Tredegar Health & Wellbeing Centre). This audit was commissioned in accordance with the agreed Audit Plan (and associated fee) provided within the approved Full Business Case (FBC) for the project.

1.2 The Welsh Government (WG) approved the FBC on 18th March 2021 with a capital cost of £19.488m. The main works contract specified commencement on 4th May 2021, with completion due 22nd August 2023 (120 weeks).

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

- The failure to achieve key project objectives through poor governance and project management controls;
- The Health Board may be in breach of Welsh Government Funding stipulations, Standing Orders or Standing Financial Instructions;
- The target cost may not provide sufficient value for money; and
- Project costs may escalate uncontrollably through an absence of adequate cost monitoring and reporting

2. Detailed Audit Findings

Project Performance:

2.1 At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review are suitably designed and applied effectively.

2.2 At this stage of the Bevan Health & Wellbeing project, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.3 The project is currently being progressed significantly outside of its original target time parameters, with the completion date continuing to extend during the time frame of the audit.

2.4 Significant issues were encountered during the demolition phase of the project, including the need to remove extensive unknown asbestos materials hidden within the structure, basements/ductways. These were buried within the ground following decades of development and only become exposed during the current demolition process.

2.5 Furthermore, there have been structural integrity issues surrounding the retained portion of the former Tredegar Hospital (referred to as the 'Heart Building' – subject to a conservation order, as the historic origin of the NHS). These have required additional stabilisation works causing further delay.

2.6 The Project Manager advised that the SCP contract with the Health Board provided cost / time provisions for the above.

2.7 Whilst noting the above, performance against key targets may be summarised as:

	Business Case	**Contract**	**At prior audit**	**SCP current programme** (M05.02)
Commencement	May 2021	4th May 2021	-	4th May 2021
Completion	April 2023	22nd August 2023	22nd August 2023	February 2024
Duration	-	120 weeks	-	150 weeks

2.8 The SCP has submitted two Compensation Event requests, totaling 27 weeks associated with:

- Brickwork – 17 weeks 3 days; and
- Foundations – 9 weeks and 4 days.

2.9 To date, Compensation Events have only been issued extending the contract completion by 2 weeks and 1 day - in respect of disruption to brickwork supply (in November 2022). The Project Manager has declined the request associated with the foundations and reported that he had not been provided with sufficient information that would extend the contract completion date further (via appropriately supported Compensation Events). Accordingly, at the time of the audit, the significant portion of the delay was being attributed to SCP performance.

2.10 However, we have been advised that the SCP is likely to take this decision to arbitration.

Cost

2.11 The forecast out-turn position (as summarised at both the October 2022 Cost Report, and Welsh Government Project Progress return) was:

Costs	**WG Approvals £m**	**Forecast outturn £m**
Works	12,753,520	13,332,693
Fees	2,078,699	2,087,386
Non-works	845,436	895,103
Equipment	189,585	189,585
Contingency	643,675	386,679
VAT (incl. reclaim)	2,977,057	2,975,827
Total	**19,487,972**	**19,867,274**
Anticipated (over) / underspend		**(379,302)**

2.12 Accordingly, a marginal over-spend of £379k (2%) was being reported at the time of the current review.

2.13 The SCP's cost assessment of the submitted Compensation Event requests (above) was for:

- Brickwork – £670,000; and
- Foundations – £752,582.

2.14 As indicated above, the request relating to the foundations has been rejected by the Project Manager, and £64k assessed in respect of brickwork. The additional costs had yet to be included within cost reporting (also noting the potential appeal – as above).

2.15 No additional provision had been made at the project risk register associated with these events.

2.16 A further 23 matters were reported as un-costed Early Warning Notifications (including inflation). Accordingly, the total risk value could not therefore be assessed against remaining project contingency (**MA 3**).

Quality

2.17 The original investment objectives (included within the business case) were to:

- Support the co-location and potential merger of GP Practices within Tredegar;
- Support the increased provision and improved integration of Health and Well-Being Services within Tredegar;
- Address the significant estate infrastructure issues that exist at the Tredegar Hospital site; and
- Support the effective use of clinical and non-clinical resources that are delivered within Tredegar.

2.18 While there are delays to intended enhancements to service provision and the estate, existing services continue to be provided elsewhere.

2.19 Recognising the current stage of construction, **limited assurance** has been determined in respect of project performance. This assessment primarily acknowledges the significant delays in the delivery of the project, the associated current cost pressures, and the delay in achieving anticipated business case objectives (it is acknowledged that these are currently not being attributed to Health Board actions).

2.20 The following sections of the report further outline the key observations that have contributed to the above – matters which require management attention, with moderate impact on residual risk exposure until resolved.

Follow up: *confirmation that previously agreed recommendations have been appropriately actioned by management (**Appendix B**).*

2.21 The table below provides an overview of progress in implementing the previously agreed management actions in relation to the 2021/22 audit report (published in November 2021).

Original Priority Rating	Number of Recommendations	Implemented	Not implemented	Closed / superseded
High	3	3	-	-
Medium	5	2	2	1
Low	2	1	1	-
Total	**10**	**6**	**3**	**1**

2.22 Recommendations requiring further action are detailed at **Appendix B.** The two outstanding "medium priority" recommendations related to:

- performance monitoring (**8.1**) – the need for the Project Board / Project Team to review Key Performance Indicators. With several large Compensation Events claims and increasing delays at the project, SCP performance would appear to require particular focus (i.e. this has acquired a more significant profile since the control recommendation was initially made – e.g. see **MA 8**); and
- cost reporting clarity (**3.1**) - the ongoing need to enhance the clarity of cost reporting as the project has become increasingly complex (e.g. in terms of funded and un-funded elements – as detailed at the "Cost" section above).

2.23 Recognising the action taken to address the three "high priority" issues, **reasonable assurance** has been determined in relation to previously agreed actions.

Project Governance: *Assurance of appropriate governance arrangements including effective reporting and accountability lines, and approvals.*

2.24 Project governance arrangements were defined via the Programme Execution Plan (PEP) which included the programme objectives, structures and key roles. The established governance structure included operational management by the Project Team with technical support from the Commercial Team.

2.25 Oversight was provided by the Primary Care & Community Estates Programme Board ('the Programme Board'), with onward reporting to the Strategic Capital & Estates Programme workstream.

2.26 The Programme Board has a number of strategic responsibilities in relation to the Primary Care estate, including acting as the 'Project Board' for both this project and the Newport East Health & Wellbeing Centre. However, the 'Project Board' role and associated responsibilities had not been defined at the Terms of Reference. It was also noted that the forum did not meet with sufficient frequency during the period reviewed (June to November 2022) to provide the level of scrutiny and oversight required for major projects. Recognising the range of responsibilities assigned to the Programme Board (including current oversight of two major projects, with a further three awaiting approval), the constitution and capacity (and associated effectiveness) of the Board should be reviewed to ensure it can provide appropriate scrutiny and challenge as the project(s) progress (**MA 1**) (**see Newport East Health and Wellbeing Centre report for associated recommendation**). The Strategic Capital & Estates Programme workstream was attended by the Project Director, the Director of Planning; the Director of Workforce; and the Head of Capital Finance. These members of the senior management team provided strong corporate linkage with exception reporting to the Executive to enable effective decision making.

2.27 While the lead roles were outlined, there would be benefit in providing full roles and responsibilities of these key appointments. The oversight remit of the Strategic Capital & Estates Programme Board in context of this project could also usefully be defined (**MA 2**).

2.28 Project Team membership included the Project Manager, Capital Accountant, Estates personnel, and user representation. Accordingly, it was well constituted for operational management of the project.

2.29 However, the Project Execution Plan did not define the remit and intended operation of key groups (interfacing with the external advisers and the SCP) (**MA 2**).

Risk management

2.30 A risk register was published at the monthly Project Manager reports. However, as previously noted, the potential values of Compensation Event claims, and Early Warning notifications (best, worst and likely case scenarios) had not been included within the risk register. Accordingly, the total risk value could not be assessed against remaining project contingency and ultimately the anticipated project out-turn costs (**MA 3**).

Design sign-off

2.31 Users had been effectively engaged in design sign-off, including GP's, dental, and pharmacy tenants, though final agreements remained to be signed (subject to finalising the legal draft at the time of audit) (**MA 4**).

Cost reporting

2.32 It has been recommended that the accuracy of the Welsh Government Project Progress Returns be affirmed, and that the associated cost reports be reviewed by

both the Health Board and the Cost Adviser and enhanced to improve clarity for scrutiny by the Programme Board and Health Board officers (**MA 5**).

Benefits realisation

2.33 While a benefits register had been compiled, it had yet to be fully quantified. It had not been updated since its inclusion within the business case in September 2021. It has been recommended therefore that the benefits register is fully quantified to ensure delivery of the intended outcomes (**MA 6**).

2.34 Noting the above issues, **limited** assurance has therefore currently been determined in relation to governance arrangements applied at the project during the period of review.

Interim valuation and payments processes: *assurance that adequate processes and procedures are in place to ensure that the contractor is correctly reimbursed in accordance with the contract.*

2.35 Timely payment certificates were evidenced for works payments, appropriately supported by evidence of costs incurred.

2.36 Noting the delayed SCP delivery, time related / preliminary costs (such as skips and portacabins) have been spread over the extended period in accordance with best practice. This has involved disallowing a portion of currently claimed costs at monthly valuations to avoid the contractor being over-paid and ensuring on-going commercial incentive for delivery in the latter stages.

2.37 In the case of plant and materials, payment was made on the basis of SCP ledger prints. It has therefore been recommended that some sampling should be made to further evidence such costs in accordance with the provisions of the contract (e.g. invoices) (**MA 7**).

2.38 With the exception of the above observations, noting good practice in relation to the valuation assessment and payment processes applied, **substantial assurance** has been determined in relation to interim valuation and payments processes.

Site management: *assurance that adequate site safety is maintained through to project completion for the Contractor, Health Board and other staff.*

2.39 Site safety procedures were extensively detailed within the contract. Accordingly the Supply Chain Partner (SCP) had assigned site responsibility, and provided monthly updates of incidents, accidents, and inspections, with one accident reported to date.

2.40 Risks at the project have included ground instability, ground contamination, and the structural integrity of neighbouring buildings (risk of collapse).

2.41 Details of inspection reports (and associated observations and recommendations) were not currently provided to the Health Board for review/scrutiny. Noting the potential reputational risk to the Health Board of incidents at their project not being satisfactorily addressed, it has been recommended that these are provided for ongoing scrutiny and assurance of appropriate SCP actions (**MA 8**).

2.42 While noting the above, **reasonable assurance** is determined in relation to site management.

Change Management: *assurance that changes are processed / authorised in accordance with the contract and local internal control procedures.*

2.43 The change management process (Compensation Event / Early Warning Notice) was detailed within the NEC form of contract, with the Health Boards internal authorisation process documented at the Project Execution Plan (PEP).

2.44 A sample of project changes showed appropriate completion of Health Board change control forms, and detailed analysis and support, as reviewed by the Project Manager.

2.45 It was evident that Compensation Events were subject to challenge by the Project Manager in accordance with the NEC contract. Similarly good practice was observed in the maintenance of a Change Control Tracker by the external Project Manager.

2.46 However, there was a need to confirm compliance and consistency with the Health Board's Standing Orders / Standing Financial Instructions; delegated authorised limits; and the PEP, at the authorisation of Compensation Events – noting an apparent (isolated) instance of non-compliance (**MA 9**).

2.47 Noting the above, **reasonable** assurance has currently determined in relation to change management.

Equipment procurement arrangements: *assurance that equipment requirements have been fully considered within the design development; tendering and quotation exercises are undertaken in accordance with Health Board / procurement regulation requirements; and sufficient time has been afforded to procure the required equipment.*

2.48 An equipment schedule had been prepared and costed in consultation with the users (as previously noted). This was formally approved as part of the Full Business Case, and included an assessment of appropriate equipment transfers. The assessed values remain significantly within the budgeted allocation.

2.49 With the exception of dental equipment, all items were of low value, and as such, not requiring significant lead times to procure.

2.50 A Single Tender Action was completed for £149k of key dental equipment to ensure consistency across the Health Board. However, while this request was signed by the Head of Procurement, this had not been approved by the Chief Executive in accordance with Capital Procedures and Standing Financial Instructions/Scheme of delegation (**MA 10**).

2.51 However, noting a non-compliance with Standing Orders / Standing Financial Instructions, **limited assurance** has currently been determined in relation to equipment procurement arrangements.

Appendix A: Management Action Plan

Matter Arising 1: Governance – Project groups (Design)	**Impact**
Operation of both a Project Board and Project Team were defined in the Project Execution Plan (PEP). The Programme Board has a number of strategic responsibilities in relation to the Primary Care estate, which were defined in the Terms of Reference. However, its role as Project Board had not been sufficiently defined, with the Terms of Reference only stating that the Board will *"Act as the Programme Board / Project Board for a range of major capital developments which are being led by either the Capital Planning Division or Operational Divisions."* Whilst the Terms of Reference define a six-weekly meeting schedule, during the period reviewed the Board only met on three occasions: June, September and November 2022. This is not considered sufficiently frequent to provide the oversight required for major capital projects. It is also noted that there are a further three major capital Primary Care pipeline projects awaiting approval, which once 'live' will significantly increase the responsibilities of the Programme Board in providing Project Board responsibilities for five major projects in total. The current structure, including the constitution and capacity of the forum to effectively undertake the Project Board's scrutiny, challenge and approval role, should be reviewed and confirmed. Whilst recognising that this would be a reversion to the prior structure, individual Project Boards (or in the case of Newport East and Tredegar, a joint Project Board), may provide more effective control.	Potential risk of: • Insufficient oversight and scrutiny of major capital project performance.
Recommendations	**Priority**
See Newport East Health and Wellbeing Centre Audit Report MA2 issued December 2022.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
Agreed. The issue was raised at the February meeting of the Programme Board in the absence of the Director of Primary Care, Community and Mental Health services. Proposed to separate the Project Board function from the wider remit of the Programme Board.	30th June 2023	Director of Primary Care, Community and Mental Health services.

Matter Arising 2: Governance - Roles and responsibilities (Design)	**Impact**
While certain key roles and responsibilities were detailed within the Project Execution Plan (PEP), full definitions and associated remits were not detailed (notably in relation to the Senior Responsible Officer, the Project Director, and the Programme Manager). An Estates lead was referenced, but not named or subsequently included within the project contracts grid. The PEP also specified a Technical Compliance Team, a Commercial Team, and Project Progress meetings. Membership of the Commercial Team was provided, evidencing appropriate attendance, including by the Project Director, and Head of Capital Finance. Details of operation of the Technical Compliance Team, or the Project Progress Team were not evidenced. Membership of these groups was not specified at the PEP, and minutes of matters discussed were not produced to inform the Project Team & Project Board of discussions (as the responsible bodies for project delivery). The ongoing role of the commercial meetings and the interaction with the Project Team, Project Progress and Project Board meetings through construction to completion should be defined within the PEP. This could also include onward oversight expectations of the Strategic Capital & Estates Programme workstream.	Potential risk that: • Effective governance is not operated.
Recommendations	**Priority**
2.1 The key Heath Board roles and responsibilities i.e. Senior Responsible Officer, Project Director, Project Manager, Estates lead, and Head of Capital Planning etc., should be fully defined and approved by the Project Board.	**Medium**

2.2 Operation and membership of the commercial, technical and progress meetings should be defined at the Project Execution Plan to include: (a) the requirement to minute meetings; (b) define Health Board officer membership, and (c) interaction with other key project groups e.g. the project team.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed. The Project Execution Plan is to be updated to reflect the recommendation.	30th June 2023	Project Director
2.2 Agreed. The Project Execution Plan is to be updated to reflect the recommendation.	30th June 2023	Project Director

Matter Arising 3: Governance - Risk management (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance (WHC 2018 – 043) states: *"Risk registers…. must be completed, shared, and monitored, with reference not only to time, cost, and quality but also operational/service impacts, functionality, and benefits realisation"* The Project Execution Plan also stated that: *"Where possible the Cost Adviser will apply a quantification calculation to each risk, which in turn will inform the project contingency allowance."* As the project progresses, and requirements become firmer, so the risks in future works and commitments are reduced. The estimated contingency requirement should be periodically updated to reflect this. Management provided two risk registers for review: • Operational risk register – this version contained generic operational risks. It was un-costed, and was titled as an Opening Risk register, for the Project Team to track mitigating actions for assigned risk owners. • Capital cost risk register – the register was provided within Project Manager reports, delineating between client and SCP risks, but not further identifying risk owners or action dates. While it contained costs, these were not totalled, to enable comparison of remaining client risk with Health Board contingency. While it included a listing of Early Warning Notices, it did not include assessment of their values. Consequently, two such Notices, which were included elsewhere within project reporting assessed at £670k and £752k (in respect of brickwork, and foundations respectively), were not included within the quantified risk assessment.	Potential risk that: • Risks are not appropriately assessed and managed. • Appropriate contingency funding is not in place.

It is recognised that the former may include un-costed operational risks, and Health Board actions. However, where risks are common e.g. construction risks, the assessment and numbering should correspond between the registers (for ease of reference, and to avoid duplication in assessment). Both the projected project over-spend of £379k and the "un-funded" sum of £842k were based only on known cost items (either agreed or awaiting assessment), and were not therefore projections of out-turn based on assessed remaining risks.		
Recommendations		**Priority**
3 Risk monitoring should include: • quantification of all known risks (best, worst, likely case scenarios) where possible; • the quantified total of mitigated risks reported against remaining contingency; • risk costs, risk owners (named individuals), and time parameters for risk mitigations at risk registers; • an exception report of targeted risk mitigations not achieved; and • corresponding numbering / referencing of common risks at project management, and contractual versions of the register.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
3 Agreed noting that the service and capital risk registers are quite different in context and content, the former will be addressed via the Project Team, the latter via the Commercial Meeting and the external Project Manager.	30th June 2023	Project Director

Matter Arising 4: Governance - User agreements (Operation)		**Impact**
The business case included the need for occupancy by a pharmacy, together with dental, and GP practitioners. The Pharmacy has been budgeted to provide £49k per annum, and other occupants are vital to achieving its aims. While lease agreements (Heads of Terms) have been drafted for the parties, these have yet to be agreed and signed. In context, it is recognised that one of the two GPs is directly employed by the Health Board, (i.e. risk of non-signature is minimal), and budgeted Pharmacy income at £83k represents less than 10% of running costs.		Potential risk that: • Users are not appropriately engaged to deliver the intended outputs.
Recommendations		**Priority**
4 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
4 Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	30th June 2023	Project Director

Matter Arising 5: Governance Cost reporting (Design)	**Impact**
Good practice was identified in the submission of Welsh Government Project Progress Returns (PPR). However, this included some errors / inconsistencies e.g.	Potential risk that: • Management are not appropriately informed

	Approved Budget	Forecast out-turn	Variance
Contingency	**0.644**	**0.387**	**0.257**
SCP	0.257	0.000	0.047
Health Board	0.386	0.387	0.084

The PPR summary was supported by the Cost Adviser's Commercial Report.

Variances were noted between the data provided at the PPR and the Commercial report e.g. the Commercial report forecast an additional referenced £138,750 of fee uplifts pending agreement, not included within the PPR forecast (fee out-turn).

Whilst noting the same, through discussions with the Health Board management, difficulties in the interpretation of the information presented at the Commercial Report were highlighted e.g.

- noting the considerable amounts of data presented, the reports required a significant amount of interpretation (in the absence of accompanying narrative);
- cost reports provided a focus on current year expenditure with costs committed to date and in-year variances to budget.
- successive tables categorised costs differently, and variously included or excluded VAT, precluding comparison;

• for fees, budget to out-turn was not shown only in total, not by fee category to enable further analysis; • while total budget was provided by cost category, this was set in a table of current year monthly expenditure i.e. not providing comparison with out-turn; • expenditure to date, and remaining expenditure did not sum to total anticipated expenditure; • base budgets differed from funding approval letters; • performance against contract was not apparent; • a forecast contract over-spend with remaining contingency; • an un-explained figure of £842k stated as not funded by Welsh Government (stated as £1.2m at the PPR).	
Recommendations	**Priority**
5.1 Management should review the Project Progress Return submissions to Welsh Government to ensure accuracy.	**Medium**
5.2 The current cost reports should be reviewed by the Health Board and the Cost Adviser and enhanced to improve clarity to afford greater scrutiny by the Programme Board and Health Board officers.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
5.1 Agreed and already actioned.	30th June 2023	Project Director
5.2 Agreed. The Cost Adviser has been requested to provide a summary report as are available on other projects.	30th June 2023	Project Director

Matter Arising 6: Governance - Benefits realisation (Operation)		**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) outlines the "*requirement*" for the service delivery model to be supported. The funding approval letter from Welsh Government (of 15th December 2020), additionally stated the need to specify agreed benefits. While a benefits register has been produced, this had yet to be fully quantified e.g. several specified the baseline as the "*current position*" without inclusion of data.		Potential risk that: • Benefits are not realised
Recommendations		**Priority**
6 Quantified, measurable and achievable targets should be set to appraise project benefits.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
6 The Benefits register will be updated to reflect quantified targets as at the end of March 2023.	30th June 2023	Project Director

Matter Arising 7: Open Book valuation validation (Operation)	**Impact**
The contract requires the Cost Adviser to make monthly assessments for payment of valuations presented by the SCP. To effect this, the Project Execution Plan states that "*the Cost Advisor will challenge the cost elements on an Open Book approach*". The October assessment was tested, and found to be appropriately substantiated (as reviewed by the Cost Adviser). However, in the case of Plant, Materials and miscellaneous items, while these were reconciled to ledger entries, invoiced / original substantiation of costs was not available. To prevent inclusion of undue accruals (notably at final account), a sample should therefore be made by the Cost Adviser of supporting documentation (e.g. at project closure).	Potential risk that: • Valuations are over-stated

Recommendations	**Priority**
7 The Cost Adviser should provide assurance that appropriate sampling has been made of supporting documentation for costs claimed in respect of Plant and Materials (utilising an Open Book approach as specified at the Project Execution Plan).	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
7 Agreed. The Cost Adviser has been requested to provide such assurance.	30th June 2023	Project Director

Matter Arising 8: Site management - Health & Safety (Operation)	**Impact**
The Project Execution Plan recognises that while site safety is the contractual liability of the SCP, that all parties to the project have a responsibility to support these aims. The project has involved high risk activities such as demolition, and propping of walls and ceilings. Site safety was reported by the SCP e.g. in September 2022 including: • Safety Visits internal / external • 13 Advisory Inspections • 13 Site Safety inspections • 7 Senior Manager Visits • HSE/NRW/EHO - No activity in period • 4 Public Protection Audit & • 3 CDM Visit / Audit Records (of these site inspection audits etc) were not presented to project forums to enable scrutiny of any action points arising and protect against reputational risk to the Health Board (as the project owner).	Potential risk that: • Site safety issues are not recognised and addressed • Reputational risk to the Health Board
Recommendations	**Priority**
8 Records of site inspections and audits should be presented to project forums for appropriate scrutiny and action.	**Low**

Agreed Management Action	Target Date	Responsible Officer
8 Agreed. The appropriate forum, the monthly Progress Meeting, will receive these records in future, for escalation as appropriate.	30th June 2023	Project Director

Matter Arising 9: Change management (Design)	**Impact**
The change management process (Compensation Event / Early Warning Notice) is detailed within the NEC form of contract. The Scheme of Delegation (forming part of Standing Orders / Standing Financial Instructions) provides the following limits of authorisation:	Potential risk that: • There is breach of Standing Financial Instructions • Changes are not optimally agreed

General Delegated Financial Approval Limits:

Committee / Post	**General Financial Limit £'000**	**Individual Patient Placements (Including CHC) Annual Contract Limit £'000**
Board	1,000 (note 1)	N/A
Chief Executive and Chairman / (Deputy Chief Executive/ Vice Chairman in their absence)	500	N/A
Chief Executive / Deputy Chief Executive	100	500
Executive Team Members	75	250 (note 2)
Divisional Directors/General Managers / Assistant Directors	50	50
Other Delegated Budget Holders	25 and below	N/A

Note (1) above: urgent issues between scheduled Board meetings should be referred to the Board Secretary to seek approval via chairs action.
Note (2) above: this relates specifically to the Chief Operating Officer.

The Health Boards internal authorisation process was also documented at the PEP. The Programme Director (PD) of Strategic Capital was authorised to approve:

"any contract variation up to £50,000 .. other than those due to Employer scope and briefing changes" with *"any proposed changes to Employer scope or brief tabled at Project Team for decision or escalation to Programme Board".*

The PEP also indicates that:

- The Project Team "*consider, and if appropriate recommend, any changes in scope ..up to £50,000*".
- The Project Board "*manage and action the change control process in line with the decision making rights"* (note: these are not further defined at the PEP).

The PEP further states that *"All agreed Compensation Events will be recommended for approval to the Employer."*

Excepting the addition of the "core works" contract (added by way of variation), contract changes to October 2022 totalled £735,116, including several high value items i.e.:

Agreed Compensation Events	£	Authorisation
Culvert diversions & drainage	88,164	PM, PD & CEO
Artist appointment	42,558	PD
Electric Vehicle Charging Installation (EV)	76,515	PM PD & CEO
Grouting	69,140	Subsequently rejected by PD
Inflation		
Groundworks inflation	168,500	
Steelworks inflation	97,722	PM, PD & CEO
Flat roof inflation	31,188	PD
Other (22%) (not tested)	161,329	
Total changes	**735,116**	

Note – PM = External Project Manager, PD = Project Director

Appropriate authorisation to all of the Compensation Events, with the exception of the Groundworks inflation, was observed.

The Grouting Compensation Event was recorded as "implemented" at the Project Manager's report (not arising from a client requested change). However, it was subsequently rejected by the Health Board Project Director. The Project Director has confirmed that the Groundworks Inflation Compensation Event did not follow the appropriate Scheme of Delegation. In context, the contract made allowance for inflation to be assessed, and technical assessment was made by the advisers. In mitigation, it could also be argued that the above items currently fall within the Welsh Government approved funding allocation. However, the PEP does not vire from the requirements of the Health Board's Scheme of Delegation (above), and does not distinguish project changes within pre-approved funding. It is recognised that certain of the above (e.g. inflation) may be deemed as technical in nature, and not representing a change in scope, and whilst Compensation Events were notified to both the Project Team and the Project Board, authorisation of "*All agreed Compensation Events*" by the "*Employer*" as required at the PEP was not evidenced. Additionally, further Compensation Events / inflationary additions may now fall outside pre-approved funding.	
Recommendations	**Priority**
9.1 The Health Board will ensure compliance with the Health Board's Scheme of Delegation (at the management of all Compensation Events) and any issues of non-compliance reported to an appropriate forum.	**Medium**
9.2 Change control procedures should be reviewed and updated to ensure consistency (i.e. between the NEC form of Contract, Health Board Standing Orders/Standing Financial Instructions and the Project Execution Plan).	**Medium**

Agreed Management Action	Target Date	Responsible Officer
9.1 Agreed. Change control procedures have been reviewed, updated and actioned. This Audit report will also be taken to the next Programme Board where this issue will be highlighted.	30th June 2023	Project Director
9.2 Agreed, Change control procedures have been reviewed, updated and actioned.	30th June 2023	Project Director

Matter Arising 10: Equipping - Single Tender Action (Operation)		**Impact**
Standing Orders / Standing Financial Instructions require approval of Single Tender Actions by the Chief Executive Officer on the advice of the Head of Procurement. A Single Tender Quotation / Request form (ABU-STA-131633) was completed in the sum of £149,106 to authorise procurement of dental equipment "*for consistency of equipment across the Health Board*". However, in this case the Single Tender Quotation / Request form was completed by the Head of Procurement but not authorised by the CEO, as required by the form instructions and Finance Capital Procedures and Guidance Notes.		Potential risk that: • There is breach of Standing Financial Instructions
Recommendations		**Priority**
10 Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
10 Agreed. Non-compliance to be advised to the Programme Board via submission of this audit report and the Director of Finance.	30th June 2023	Project Director

Appendix B: Status of previously agreed recommendations (2021/22)

Tredegar Health & Wellbeing Centre (November 2021)					**Previously providing**
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
1.1	**Project Execution Plan**	The Project Execution Plan should be updated to reflect the current stage of the project / programme.	**Superseded** While a revised Project Execution Plan was issued for the construction stage, this did not contain the required amount of detail (see **2.1** below, and **MA 2**). Accordingly, this recommendation has been superseded by **recommendations 2.1** & **2.2** of the current audit.	N/A	**Medium**
2.1	**Project Team / Project Board**	To enhance current arrangements, the terms of reference for the Project Team and Project Board should be reviewed and updated accordingly to include: • Coverage of frequency of meetings. • Quoracy for decision making.	**Outstanding** While terms of reference have been compiled, these do not contain the agreed detail.	Project Director 30th June 2023	**Low**

Tredegar Health & Wellbeing Centre (November 2021)					Previously providing
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
		• Requirement for delegated deputies to be in attendance when there are periods of absence; and • The correct membership (named as generic roles / departments) reflective of both the project named management and current stage of the project.			
3.1	**Cost Adviser Reporting**	The Cost Adviser reports should be updated to incorporate a summary cumulative position to better visualise the current financial position of the project. ***Prior management response***: Agreed. Whilst there is additional information available to the project team to understand the financial position, it would be helpful to have the 'snapshot' in the Cost Adviser report. Will liaise with the Cost Adviser to include within the reports.	**Outstanding** The Cost Adviser reports have remained un-changed since prior audit. While reporting to Welsh Government included total costs, it did not profile cumulative costs to date e.g. by cost category, such as the current works, fees, and in total. The Cost Adviser has commented that both prior year and in-year costs are profiled, and that	Project Director 30th June 2023	**Medium**

Tredegar Health & Wellbeing Centre (November 2021)					Previously providing
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
			management focus is on management of the in-year spend. It is also recognised that the position against the current contract is stated at the valuation (as provided to Finance, who manage both payments and Cash Resource Limit Management, and are an integral part of the project team). However, the recommendation was made in context of presentation of information to the Project Team to facilitate effective scrutiny / enquiry (also see **MA 5**).		
5.1	**Contract Documentation**	Confirmation Notice 1 should be finalised as soon as possible for both the Cost Adviser and Project Manager.	**Actioned** Contracts were in place for both the Cost Adviser and Project Manager.	N/A	**High**
5.2	**Contract Documentation**	Recognising that main construction works have commenced on site,	**Actioned**	N/A	**High**

Tredegar Health & Wellbeing Centre (November 2021)					Previously providing
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
		Confirmation Notice 2 should be executed as soon as possible.	Confirmation Notice No. 2 was in place for main construction works.		
6.1	**SCP Contract – Delay Damages**	The proposed delay damages (Option X7) should be reviewed for accuracy, agreed by all parties and updated in the contract documentation prior to signing by the Health Board.	**Actioned** Delay damages were reviewed by the Health Board in conjunction with their advisers and specified within the contract at £2,150 per day.	N/A	**Medium**
7.2	**Contract Documentation – Enabling Works**	The Project Director should advise the Health Board of the actions taken to award the Enabling Works element of the contract and the non-compliance with the NHS Wales Investment Infrastructure Guidance. ***Prior management response***: Agreed. The issue was raised at Project Board and will be raised / discussed further in the first instance at the Strategic Capital and Estates Workstream. It should be noted that the demolition process was conducted via a separate contract and the	**Actioned** Management confirmed that the non-compliance in award of the enabling works had been notified to the Audit Committee.	N/A	**High**

Tredegar Health & Wellbeing Centre (November 2021)					Previously providing
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
		provision of compensation event for the subsequent grouting was, and is considered to be, the correct approach. It is accepted that the Advance Works should have had a separate contract.			
8.1	**Key Performance Indicators**	Post submission of KPIs, the Project Board should discuss the collective output [and trend of previous submissions] to ensure issues with performance are reviewed and addressed in an appropriate and timely manner. ***Prior management response***: Agreed. Collective discussions are now being held for the returns on all current projects. It would be preferred if these discussions were held prior to submission of returns to NWSSP:SES, but it is acknowledged this is not the expectation for collation of Building for Wales data.	**Outstanding** No evidence was provided of discussion of Key performance indicators at Project Team meetings. However, with several large Compensation Events in dispute, and increasing delays at the project, SCP performance would appear to require particular focus. (e.g. see **MA 9** & **Cost** section).	Project Director 30th June 2023	**Medium**

Tredegar Health & Wellbeing Centre (November 2021)					Previously providing
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
9.1	**Project Risk Register**	The risk register should be reviewed to incorporate applicable costs; with the costs regularly reviewed to facilitate monitoring of the project.	**Actioned** The project risk register published by the Project Manager report now included individual risk costs (being formerly un-costed). The costed risk register is included in the Project Team papers with the top five detailed on the Project Team Update.	N/A	**Medium**
9.2	**Project Risk Register**	The risk register should be updated to reflect the current risk regarding the financial position of the project, and the proposed mitigating actions / countermeasures.	**Actioned** Risk mitigations were contained within the risk register at the Project Manager report.	N/A	**Low**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Annual Internal Audit Plan: Draft Internal Audit Charter

April 2023

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 Bae Abertawe
Swansea Bay University Health Board

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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 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.

1. Introduction

This document sets out the Internal Audit Plan for 2023/24 (the 'Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the 'Health Board Chief Executive') is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the 'Standards') require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2023/24. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the organisation, assurance needs, identified

concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance and Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed

for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee and the Patient Quality, Safety and Outcomes Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit, Risk and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executives and Independent members to discuss current areas of risk and

related assurance needs. Meetings have been held, and planning information shared, with the Health Board's Executive team, the Chair of the Audit, Risk and Assurance Committee and the Chair of the Board.

The draft Plan has been provided to the Health Board's Executive Management Team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2023/24

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Team and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by the Health Board in its business case submission.

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2023/24 and:

- approve the Internal Audit Plan for 2023/24;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Simon Cookson

Director of Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2023/2024

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Director of Corporate Governance	Q4
Savings Programmes	1	CRR016	To provide assurance that the savings programmes are specific, realistic and measurable and that monitoring arrangements are effective.	Director of Finance and Procurement	Q3
Financial Controls	2	CRR016	An audit of the controls in place to ensure appropriate financial reporting. This audit will focus on a sample of balance sheet items.	Director of Finance and Procurement	Q2
Decarbonisation	3		To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan. Following on from the advisory review delivered in 2022/23, the proposed scope will include governance, strategy progress and implementation.	Director of Finance and Procurement	Q3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Asset Management (including medical equipment and devices)	4		To assess the implementation of the electronic tagging and tracking of financial assets and medical equipment and devices across the Health Board.	Director of Finance and Procurement / Director of Therapies and Health Science	Q2
Risk Management and Assurance	5		To assess on the effectiveness of the risk management and assurance arrangements in place within the Health Board in order to ensure that strategic objectives are achieved.	Director of Corporate Governance	Q4
Follow-up of High Priority Recommendations	6		To assess whether high priority internal audit recommendations have been implemented.	Director of Corporate Governance	Q4
The Health and Social Care (Quality and Engagement) (Wales) Act	7		To determine if the requirements of the Act regarding Duty of Candour are being adhered to.	Medical Director / Director of Nursing/ Director of Therapies and Health Science	Q3
Integrated Medium Term Plan (IMTP)	8		To assess the controls to ensure the delivery of the IMTP / strategic objectives.	Director of Planning and Performance	Q1

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Integrated Performance Dashboard – Data Quality	9		To assess the accuracy of a sample of data utilised within the Integrated Performance Dashboard.	Director of Planning and Performance	Q3
Business Continuity Planning	10	CRR033	An audit of the arrangements that the Health Board has in place to maintain business continuity in the event of a major incident, including how learnings from the Covid-19 pandemic have been considered.	Director of Planning and Performance	Q2
Safeguarding	11	CRR028 CRR030	To review the arrangements in place to ensure that the Health Board discharges its statutory responsibilities.	Director of Nursing	Q1
Waiting List Management	12	CRR019	To establish whether all patients on the waiting list have been assessed and assigned an appropriate priority rating in line with the Royal College of Surgeons guidance. To include the arrangements in place to communicate and support patients.	Chief Operating Officer	Q1
Directorate Review - Theatres	13		To undertake an audit of compliance with key policies and procedures and the management of risk within the Theatres directorate.	Chief Operating Officer	Q2
Job Planning	14		To provide assurance that arrangements are in place and operating effectively for consultant job planning.	Medical Director	Q2

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Clinical Coding	15		To determine if appropriate controls are in place for the timely recording of Finished Consultant Episodes, in accordance with clinical coding standards.	Director of Digital	Q1
Providing Care to Asylum Seekers and Refugees	16	CRR019 CRR042	To provide an opinion over the arrangements in place for providing care to asylum seekers and refugees and applicable guidance is being adhered to (e.g. Policy Implementation Guidance: Health and wellbeing provision for refugees and asylum seekers, issued by the Welsh Government).	Chief Operating Officer	Q1
Early Supported Discharge - Stroke	17	CRR019	To assess whether the arrangements in place to support early support discharging are operating effectively, with a focus on stroke patients.	Director of Therapies and Health Science	Q2
Intra-site Patient Transfers	18	CRR037	To assess if the arrangements in place are appropriate for the transfer of patients between sites within the Health Board.	Chief Operating Officer	Q1
Regional Partnership Board	19	CRR019 CRR028 CRR043	To determine how the Health Board responds to its Population Needs Assessment through the development and implementation of the corresponding area plan. The audit will also seek to provide advice on	Director of Planning and Performance	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			improvements that can be made to the current governance arrangements.		
Long Term Sickness Absence Management	20	CRR002 CRR043	To review the compliance with policy, and assess mechanisms in place to provide assurance that the health board is acting promptly, managing the interests of all parties and working in accordance with the wider wellbeing strategy.	Director of Workforce and OD /	Q4
Maternity (Action Plan)	21	CRR019	The internal audit will review the governance arrangements in place within Maternity Services to ensure performance is being monitored effectively and risks managed appropriately. This review will consider the completion of the self-assessment action plan.	Director of Nursing	Q3
Flexible Working	22	CRR002	An advisory review to determine if the requirements of the Flexible Working Policy and Guidance are being applied consistently across the organisation.	Director of Workforce and OD	Q4
Allegations against Staff Policy	23	CRR002	An advisory review of the best practice arrangements for an allegation against staff policy.	Director of Workforce and OD	Q1
Network Infrastructure (VPN)	24		To ensure that all risks associated with the provision of virtual protocol networks (VPNs) are appropriately mitigated.	Director of Digital	Q2

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Stakeholder Engagement on IT Projects	25		To review the framework in place for stakeholder engagement on key IT projects.	Director of Digital	Q3
LINC Programme	26	CRR045	An audit of the arrangements in place to for the mitigation of risk associated with the non or late delivery of the LINC programme of work.	Director of Digital	Q3
Bevan Health and Well Being Centre	27		Recognising the current forecast (extended) completion date of February 2024, the audit will consider the overall delivery of the scheme, associated risks and out-turn cost position at the project.	Chief Operating Officer	Q3
Estates Assurance - Estate Condition	28		Recognising the high profile afforded to the condition of the NHS Estates and the associated risks, focus during 2023/24 will be targeted to the Estate Condition. The areas of review may include for example, Estates Strategy, Scale of the issue, Risk Exposure, Records management, delivery of EFAB funding and progress in addressing key risk areas.	Chief Operating Officer	Q3
Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	N/A		In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the UHB to "assess the risk profile of the scheme and provide appropriate levels of		

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			review". A small provision of days is included within the 2023/24 plan to enable us to work with the UHB to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.		
Please note: Capital audits agreed with our specialist Capital & Estates Team and the national audits undertaken at DHCW, NWSSP, WHSSC and EASC will be added later.					

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2023/24
Audit plan 2023/24 agreed/in draft by 30 April	✓	100%
Audit opinion 2022/23 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit, Risk and Assurance Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Aneurin Bevan University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk and Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Aneurin Bevan University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Corporate Governance.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Aneurin Bevan University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance

arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk and Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Finance and Risk Committee on behalf of the Board. Such functional reporting includes the Audit, Risk and Assurance Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk and Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the

Audit, Risk and Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit, Risk and Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk and Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit, Risk and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Risk and Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit, Risk and Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit, Risk and Assurance Committee or management, this may include areas of

concern identified in the corporate risk register;

- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit, Risk and Assurance Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit, Risk and Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit, Risk and Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit, Risk and Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit, Risk and Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk and Assurance Committee requirements; and

- The Audit, Risk and Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Director of Corporate Governance 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Director of Corporate Governance and Chair of the Audit, Risk and Assurance Committee.
- If non-compliance continues, the Director of Corporate Governance and the Chair of the Audit, Risk and Assurance Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit, Risk and Assurance Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response.

Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.

- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.

- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit, Risk and Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk and Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on

activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit, Risk and Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit, Risk and Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2023

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Archwilio Cymru
Audit Wales

Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: April 2023

Document reference: 3503A2023

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board. We presented our most recent Audit Plan to the committee in April 2022. We will present an Outline Audit Plan to the committee on 18 April 2023; and present a detailed Audit Plan at the subsequent meeting.

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
Planning	Rob Holcombe – Director of Finance and Procurement	This work involves undertaking risk assessment procedures to identify risks of material misstatement within your financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk.	Ongoing	Detailed Audit Plan 2023 presented to the committee in June 2023
Audit of Accounts	Rob Holcombe – Director of	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to	Not yet started	Audit of Accounts Report presented

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
	Finance and Procurement	Auditor General to provide his opinions on the financial statements of the health board.		to committee in July 2023
Charitable Funds: • Planning • Audit of Charitable Fund Financial Statements	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 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.	Not yet started	To be confirmed

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2022	Nicola Prygodzics – Chief Executive Officer	The structured assessment work assessed the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Managing the workforce, digital, resources, estates, and other physical assets.	Completed	Findings presented to the committee in February 2023 and to the Board in March 2023
Review of Arrangements for Securing Efficiencies	Rob Holcombe – Executive Director of Finance and Procurement	This work considered whether the Health Board's arrangements for securing efficiencies are robust, including the impact of new ways of working on planned efficiencies.	Completed	Findings presented to the committee in February 2023.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Annual Audit Report 2022	Nicola Prygodzics – Chief Executive Officer	Summarises the findings from the Auditor General's 2022 work at Aneurin Bevan University Health Board undertaken to fulfil his responsibilities under the Public Audit (Wales) Act 2004.	Completed	Findings presented to the committee in February 2023 and to the Board in March 2023
Orthopaedic Follow-Up Review	Leanne Watkins – Director of Operations	This review examined the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges and consider the impact of the pandemic and orthopaedic service recovery.	Completed	Both the national and Aneurin Bevan University Health Board's local report to be considered by the committee at this meeting.
Unscheduled Care Arrangements	Leanne Watkins – Director of Operations / Chris O'Connor – Interim Executive Director of Primary Care,	This work has been carried forward from the 2020 Audit Plan and will initially look to provide a high-level whole system overview of the unscheduled care. The overview will be informed by the development of an interactive database covering all aspects of the unscheduled care pathway. Further	Fieldwork	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
	Community and Mental Health	work will then be undertaken on specific elements of unscheduled care pathway, with a likely focus on activities to signpost patients to the most to appropriate care setting, and to manage patient flow through the system.		
Follow-Up of Primary Care Services	Chris O'Connor – Interim Executive Director of Primary Care, Community and Mental Health	Follow-up of recommendations made in our Primary Care services review	Fieldwork	To be confirmed
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	Fieldwork	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		the responsibilities of individual NHS bodies in respect of workforce planning.		

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
Digital Inclusion in Wales and **Key questions for public bodies**	March 2023
Learning from Cyber Attacks The key messages will be summarised in a separate paper to be considered in the Audit, Risk and Assurance Committee private meeting in April 2023	October 2022

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Audit Wales Annual Plan 2023-24	April 2023

8 There are no relevant Audit Wales consultations currently underway.

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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

Aneurin Bevan University Health Board

Outline Audit Plan 2023

Audit year: 2022-2023

Date issued: March 2023

This document is a draft version pending further discussions with the audited and inspected body. Information may not yet have been fully verified and should not be widely distributed.

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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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.

About Audit Wales

Our aims:

Assure

the people of Wales that public money is well managed

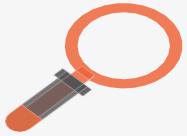
Explain

how public money is being used to meet people's needs

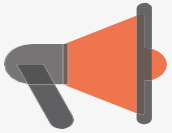
Inspire

and empower the Welsh public sector to improve

Our ambitions:



Fully exploit our unique perspective, expertise and depth of insight



Strengthen our position as an authoritative, trusted and independent voice

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Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend sharing a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends undertaking to address the audit risks identified and other key areas of audit focus during 2023.

Adrian Crompton
Auditor General for Wales

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

My planning work for the audit of your financial statements commenced in February and is currently ongoing. Audit risks identified from my initial financial audit planning work are set out in **Appendix 1**.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2023 I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates and also highlights the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 2**.

I will provide an estimate of your fee in my Detailed Audit Plan in May 2023 along with an update regarding any further audit risks my audit teams identifies, following completion of my detailed risk assessment.

Your engagement team:

Richard Harries	**Engagement Director & Audit Director (Financial Audit)**
Dave Thomas	**Audit Director (Performance Audit)**
Tracy Veale	**Audit Manager (Financial Audit)**
Andrew Doughton	**Audit Manager (Performance Audit)**
Neall Hollis	**Audit Lead (Financial Audit)**
Nathan Couch	**Audit Lead (Performance Audit)**

There is one potential conflict of interest that I need to bring to your attention. Nathan Couch's wife is an Assistant Divisional Nurse within the Unscheduled Care Division at the Health Board. Appropriate restrictions on audit practice have been identified to mitigate any audit independent risks arising from this.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	March 2023	March 2023
2023 Detailed Audit Plan	February – April 2023	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May - July 2023	July 2023 (ARAC planned for 15 July and Board meeting on 19 July)
Performance audit work: • Structured Assessment, incorporating a deep dive into a specific thematic area which will be confirmed in the detailed plan in May 2023. • All-Wales thematic review of planned care, following on from my previous work in this area in 2022. • Local project work – We will follow up our previous quality governance review recommendations and we will include the arrangements for implementing the duty of candour and duty of quality within the scope of the work.	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD[1] and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2022.

.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

[1] QAD is the Quality Assurance Department of ICAEW

Appendix 1 – Financial audit risks identified from my initial financial statements audit planning work

Financial audit risks (Significant audit risks)	Proposed audit response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	We will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and evaluate the rationale for any significant transactions outside the normal course of business.
There is a significant risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 11 shows a deficit position of £33.77 million with a forecast deficit position at the year-end of £37 million. This, combined with the outturns for 2020-21 and 2021-22, predicts a three-year deficit of £36.5 million. Where you fail this financial duty, 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 judgements and estimates could be biased in an effort to reduce the predicted year-end deficit.	We will focus our testing on areas of the financial statements which could contain reporting bias.

Financial audit risks (Other areas of audit attention)	Proposed audit response
There is a risk that the disclosures within the Remuneration Report will be incorrect. Our 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. We understand that for 2022-23, the Health Board has continued to experience a significant number of changes at Senior Management level.	We will review the completeness and accuracy of the Remuneration Report.
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 our review of asset lives, our 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 was potentially materially overstated. During the audit, further work undertaken by the Finance Team to provide assurance that the GBV was not materially miss-stated resulted in a £5.1 million amendment to the financial statements and uncertainty over asset existence to a further value of £1.5 million, leading to a potential error of 25% (£6.6 million out of £25.9 million asset verification responses). Extrapolation of this error rate to the remaining £24 million assets for which no confirmations were received from departments, indicated a potential misstatement of £6 million, which was below our materiality for the financial statements. Whilst asset tagging has been implemented during 2022-23, not all assets have been tagged by 31 March 2023 and manual asset verification will need to be undertaken by departments for those areas whose assets have not been tagged.	We 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.

Financial audit risks (Other areas of audit attention)	Proposed audit response
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 was as at 1 April 2022. To reflect the requirement to update the 1 April quinquennial revaluation figures to reflect changes to 31 March 2023 the 2022-23 tangible asset note should disclose the • quinquennial revaluation on the revaluation line: and • subsequent indexation adjustment on the indexation line. Both being applied from the 1 April 2022. On the basis of discussions with the District Valuer, the indices should be applied: • on the 1 March 2023; • to the post quinquennial valuation figures before any depreciation applied; • depreciation then should be applied as normal; • the buildings element should be applied to specialised properties only.	We will review the valuations undertaken to obtain assurance that there are no material misstatements in accounting and reporting.
The application of IFS16 – *Leases* – applies to NHS Wales bodies from 1 April 2022. IFRS 16 provides enhanced disclosure requirements to give a basis for users of financial statements to assess the effect that leases have on the financial position, financial performance and cash flows of lessees and lessors. The 2022-23 accounts will be the first year to include such discloses.	We will review the completeness and accuracy of the disclosures.

Appendix 2- the key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation.

Key change	Potential impact on your organisation
	On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

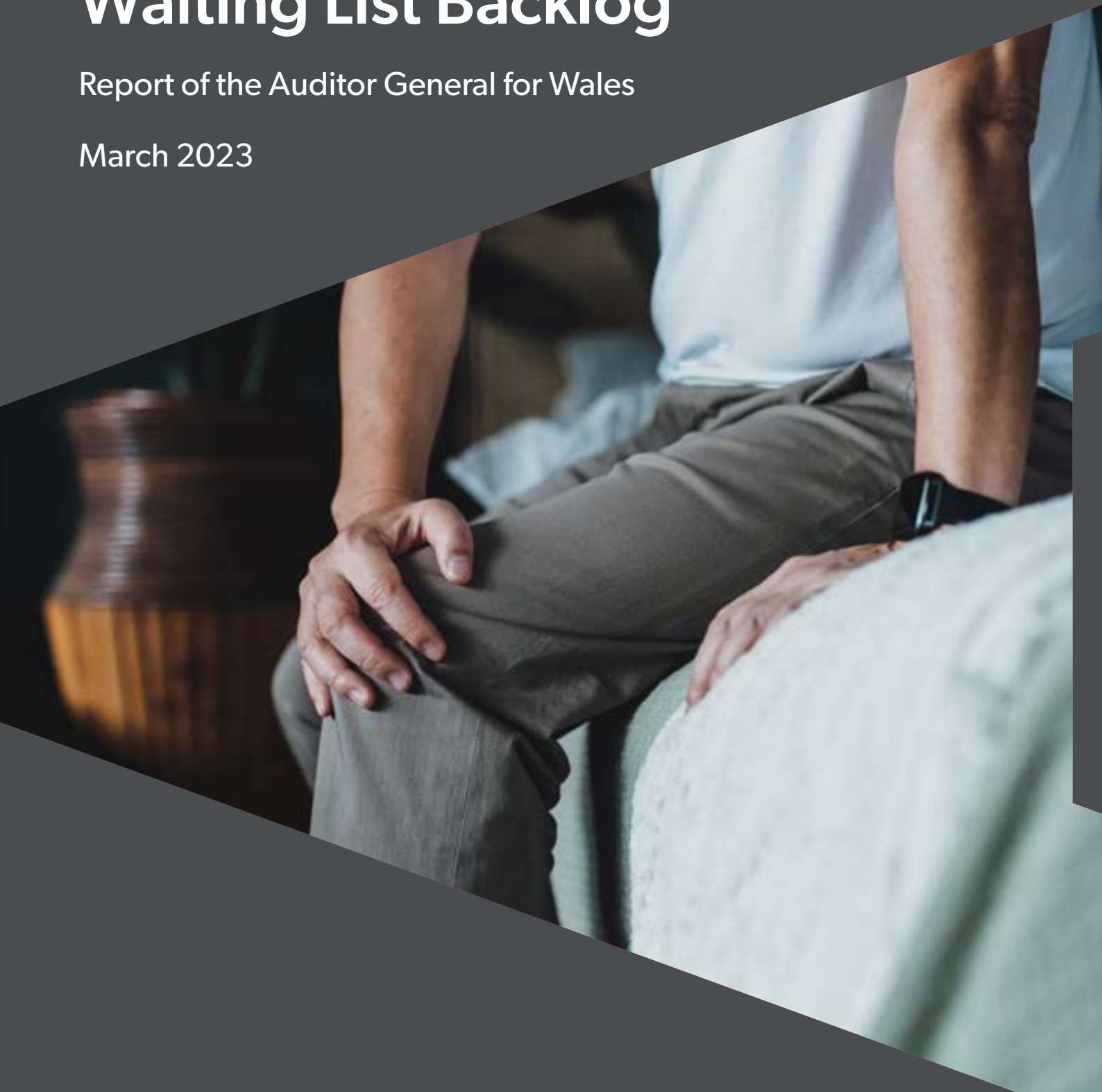
Archwilio Cymru
Audit Wales

Archwilio Cymru
Audit Wales

Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Report of the Auditor General for Wales

March 2023



This report has been prepared for presentation to the Senedd under the Government of Wales Acts 1998 and 2006.

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The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Summary report

Context

1 Orthopaedics is the branch of surgery that relates to musculoskeletal conditions. Common surgical procedures include hip and knee joint replacement, and diagnostic intervention such as arthroscopy. Orthopaedic surgeons tend to sub-specialise focussing on areas such as major joints, or foot and ankle, shoulder, or wrist.

2 NHS Wales orthopaedic spend had grown year on year to 2019-20 peaking at nearly £396 million. The pandemic saw reduction in activity and spend the following year. But even with the increases in spend pre-pandemic, the size of orthopaedic waiting lists was one of the biggest challenges facing the NHS in Wales. This challenging pre-pandemic position has further deteriorated because of the impact of COVID-19 on planned care activity. In November 2022, of the 748,271 people on the NHS waiting list in Wales, 101,014 were waiting for orthopaedic services.

3 At the time the UK went into lockdown in March 2020, we were concluding our work to follow up progress against our 2015 reports on waiting times for elective care and orthopaedic services. Across both reviews we had found the same story: many patients still face long waiting times. Some progress has been made in specific areas, but we had not seen the sorts of whole system change that is needed to make the planned care system sustainable.

4 In September 2020, we published a report setting out Ten Opportunities for Resetting and Restarting the NHS Planned Care System. We then prepared a broader commentary on Tackling the Planned Care Backlog in May 2022.

5 This report provides a commentary on orthopaedic services. It describes the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the recent nationally coordinated work to modernise services. The report also sets out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services. In some instances, we use long term trends to help illustrate change over time.

Key messages

A note on patients and pathways

Throughout this report we talk about patients waiting for treatment. Our figures are based on NHS Wales's 'open' referral to treatment measure. The measure counts the number of pathways which have started but not yet completed treatment, rather than people. Each pathway represents a patient waiting but patients may have more than one health condition and therefore be on the waiting list more than once. As a result, the total number of people waiting for treatment will be lower than the total number of pathways.

6 Meeting demand for planned orthopaedic services has been a significant challenge for the NHS in Wales over the last 20 years. The impact of COVID-19 has elongated what was already a lengthy waiting list, such that patients are now facing exceptionally long waits to be seen and treated. For many people this means living in pain and discomfort, with a life-limiting condition.

7 Proportionately, there are more than twice as many people waiting in Wales for orthopaedic services as there are in England. In fact, proportionately, there are more people waiting over 36 weeks in Wales than are waiting in England in total[1]. Month on month, the orthopaedic waiting list has been increasing, peaking with 102,699 patients on the waiting list in September 2022. Referral rates dropped during the pandemic, and we estimate that there are around 135,000 potentially 'missing' referrals that could come back into the system, putting further pressure on the waiting list.

1 Statement by the British Orthopaedic Association, on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022. Direct comparisons are not available with Northern Ireland and Scotland due to differences in the way in which waiting lists are reported.

8 Services have been slow to restart as the immediate impact of the pandemic has lessened, operating on average at around 60% of pre-pandemic activity levels. There is unexplained variation of orthopaedic waits across Wales depending on where you live and the type of procedure you are having. Necessary infection control regimes will continue to have an impact on patient throughput in settings such as operating theatres, but there is scope for current capacity to be used more efficiently by making appropriate use of day case procedures and looking to safely reduce lengths of stay.

9 In the past, the Welsh Government has allocated temporary additional monies to health boards to try and fill the gap between capacity and demand. Whilst this resulted in short term improvements, it did not achieve the sustainable changes to services that were necessary and referral to treatment time waiting list targets[2] for orthopaedics have never been met since the targets were first established in 2009. There needs to be a realistic assessment of capacity. Funding for orthopaedic services has not reflected growing demand and with a predicted 27% growth in over 75s between now and 2030, services need to be sustainably designed to meet that need.

10 We have repeated the wider modelling exercise presented in our Tackling the Planned Care Backlog report in May 2022 for orthopaedic services in order to estimate how long it will take to recover these services. Our optimistic scenario modelling suggests that it could take three years to return orthopaedic waits to pre-pandemic levels. This is based on both a significant drive on community-based prevention, which has shown to have a positive impact on demand, and a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels, noting that current activity is below pre-pandemic levels. Our more realistic scenario indicates that it could be nearer to five years, and our pessimistic scenario indicates that services may never return to pre-pandemic waiting list levels. The scenarios highlight the scale of the challenge facing orthopaedic services in respect of managing demand and building additional capacity.

11 There is some hope, however. NHS Wales has commissioned an in-depth review of orthopaedic services with the Getting It Right First Time team[3] outlining numerous service efficiency, effectiveness, and productivity improvements for acute orthopaedic services. They set out a comprehensive suite of recommendations in their national report and have also provided reports and recommendations to each of the health boards in Wales. Their work sets out the immediacy and urgency needed.

2 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks.

3 Getting It Right First Time is a national programme designed to improve the treatment and care of patients through review and benchmarking.

12 Aligned to this, the Welsh Government commissioned the Welsh National Orthopaedic Society to prepare a National Clinical Strategy for Orthopaedics. This thorough and honest appraisal of the current position and service options for the future sets out in the strongest terms the perilous state of services and gives a clear clinical voice on what needs to be done. It will require brave and bold leadership at a ministerial level all the way through to operational and clinical leaders in hospitals to deliver it.

13 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.

14 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively, including primary, community and diagnostic services. New technology and improved estate need to be prioritised and health boards must work together to develop regional solutions to help tackle the backlog. In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.

> Securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with COVID-19 making this significantly worse. It is positive to see that there is a clear commitment to improve orthopaedic services, but 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.

Adrian Crompton
Auditor General for Wales

Key facts[4]

37% of people waiting **over 12 months** for orthopaedic treatment[5]

101,014 Total number of people on an orthopaedic waiting list

60% of people waiting **over 26 weeks** for orthopaedic treatment

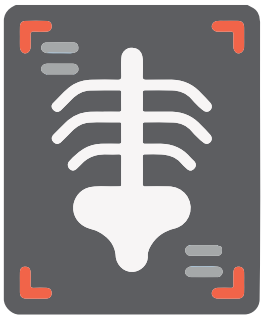
The number of people waiting for orthopaedics accounts for 1/7th of the total NHS waiting list

£395.8m Annual musculoskeletal spend at its peak in 2019-20[6]

£37.2m Annual primary and community musculoskeletal spend in 2020-21[7]

14,639 Number of people waiting more than **two years** (105 weeks) or more for orthopaedic treatment

12,500 Average number of referrals for orthopaedics during 2021-22



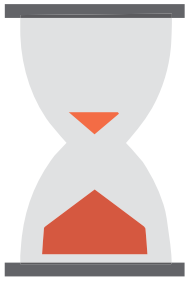
13% variation in the percentage of people waiting **two years or more** across health board areas

10% of people waiting **two years or more** in the Cardiff and Vale area

compared to

23% of people waiting **two years or more** in the Swansea Bay area

29-fold increase in the number of people waiting **over 14 weeks** for physiotherapy between March 2020 to November 2022



56% increase in total numbers waiting for orthopaedics from March 2020 to November 2022

4 Data as of November 2022 unless otherwise stated. Data is all-Wales.

5 Welsh Government data used is over 53-week data. The true 12-month position will be marginally higher.

6 The following year (2020-21) spend decreased to £308.2 million. The reduction in expenditure is a direct consequence of reduction in orthopaedic activity during the pandemic. Source: Stats Wales NHS Programme Budget for Musculoskeletal system problems (excluding Trauma)

7 Primary and community musculoskeletal spend forms part of the total annual musculoskeletal spend.

Recommendations

15 The box below sets out recommendations that we think are needed to strengthen the delivery of orthopaedic services. These recommendations are meant to complement those already made in the Getting It Right First Time reports and the new National Clinical Orthopaedics Strategy.

Recommendations

For the Welsh Government

R1 Actions previously taken to tackle orthopaedic performance have had a short-term focus, not delivered sustainable services, and lacked 'buy-in' from local clinical teams. The new national clinical strategy for orthopaedics sets out clinical solutions to deliver sustainable services. We recommend that the Welsh Government now needs to:

a prepare a clear national delivery plan which sets out the priority actions to be taken over the next three to five years to achieve the clinical strategy. The plan needs to include key deliverables and milestones, and clearly defined roles and responsibilities at a local and national level.

b ensure that the national delivery plan includes a clear direction for regional models to recognise the opportunities that exist to maximise available capacity and provide centres of excellence that deliver better outcomes.

c ensure that the national delivery plan encompasses the wider service input needed to deliver effective orthopaedic services. This should include but not be limited to primary and community care capacity, diagnostic capacity, capital and estates, and digital services.

d ensure that the national delivery plan is reflected in NHS planning guidance and health boards are held to account for implementation through routine performance management arrangements.

Recommendations

R2 The Getting It Right First Time reports at a national and health board level set out clearly a range of recommendations which will help drive improvements in the hospital element of the orthopaedic pathway across Wales, but many of the areas of focus are not new. We recommend that the Welsh Government needs to:

a ensure mechanisms are in place to obtain assurance from health boards that the Getting It Right First Time recommendations are being implemented.

b place a significant and constant focus on improving efficiencies and productivity in orthopaedics through its challenge and scrutiny of health boards. This needs to be supported by regular benchmark reporting, and an agreed set of orthopaedic procedures that have been shown to have limited clinical value.

For Health Boards

R3 The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to:

a ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and

b ensure that clear action plans are in place to address the things that get in the way of improvement.

Recommendations

R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to:

a ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and

b ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.

R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to:

a ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level;

b ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and

c put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.

What is the scale of the challenge?

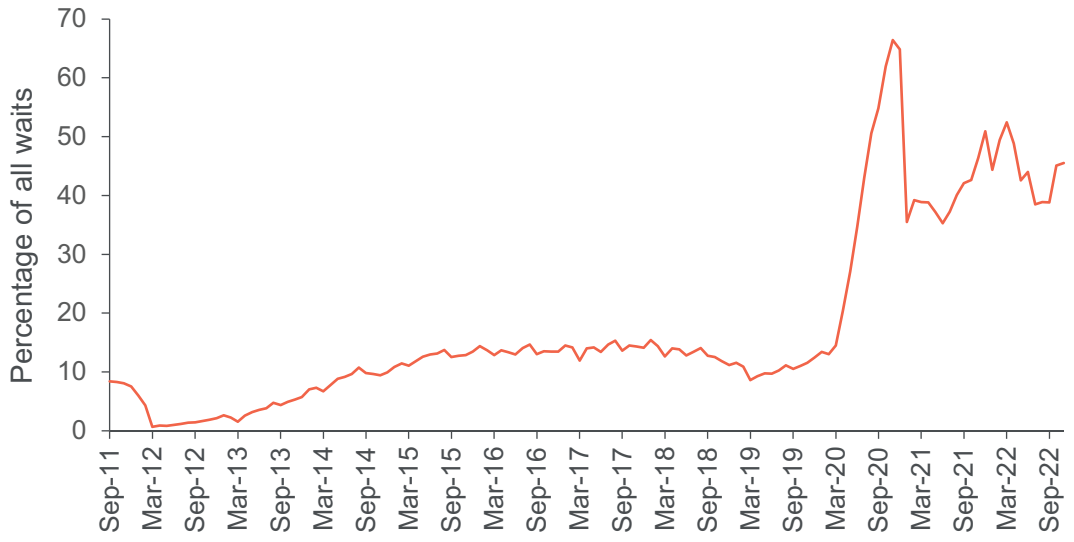
01

Orthopaedic waits have dramatically deteriorated from an already poor position prior to the pandemic

16 Orthopaedic services have not been in a position where they have been able to see and treat people within target timescales since well before the onset of the pandemic. National data show a long-term trend in deteriorating performance against waiting time targets. Since 2011, the national targets of 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks have never been met. At its best, in 2012, 88% of orthopaedic patients were waiting no more than 26 weeks, and 11% waiting over 36 weeks across Wales[8].

17 Immediately before the pandemic, in March 2020, 14% of patients were waiting over 36 weeks. But the pandemic has made a bad position worse. The latest (November 2022) data shows that for those waiting to receive orthopaedic treatment, 46% were waiting over 36 weeks (**Exhibit 2**). This position peaked at 66% in November 2020.

Exhibit 2: Percentage of patients waiting over 36 weeks for orthopaedic treatment by month across Wales, September 2011 – November 2022

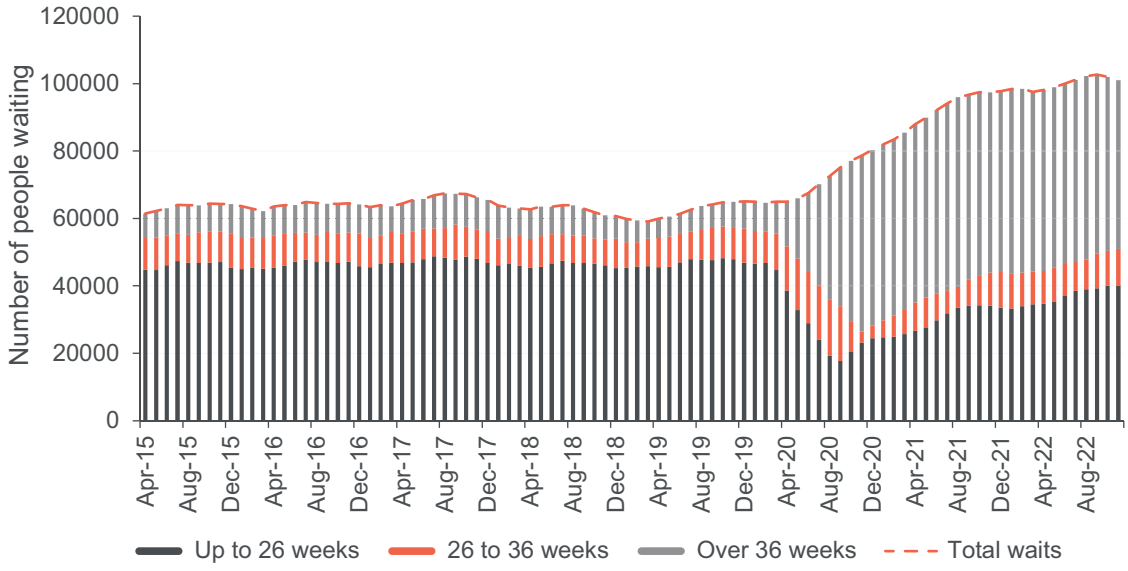


Source: Audit Wales analysis of StatsWales data

8 Data source: Stats Wales, Referral to treatment open pathway data for Trauma and Orthopaedics

18 In March 2020, there were 64,942 people on the orthopaedic waiting list. By September 2022, this had increased to 102,699 people (**Exhibit 3**). This position had slightly improved to 101,014 patients in November 2022. Of those, 50,024 (45.5%) have been waiting more than 36 weeks. More concerning is that of those waiting more than 36 weeks, 37,396 have been waiting over 12 months, and 14,639 have been waiting two years or more.

Exhibit 3: Number of patients waiting for orthopaedic treatment across Wales, April 2015 – November 2022



Source: Audit Wales analysis of StatsWales data

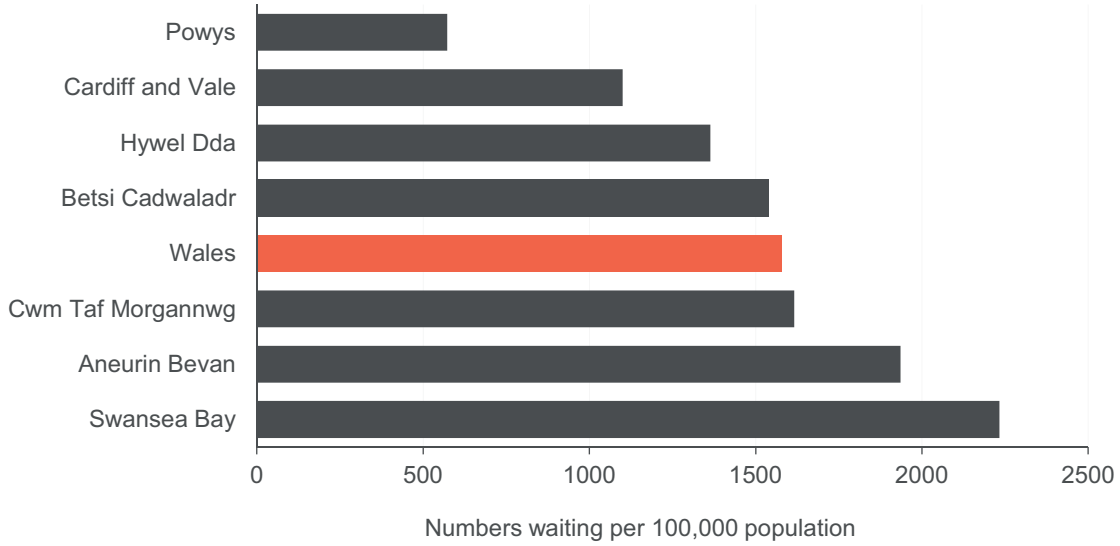
19 To give a broader perspective of the extent of the challenge, in March 2022, 1.3% of the population in England were on an orthopaedic waiting list. In Wales, 3% of the population were on an orthopaedic waiting list[9]. In November 2022 proportionately, there were more people waiting for orthopaedic treatment in Wales over 36 weeks (1.6% of the population) than there were waiting in total in England. These figures do however not take account for the health and age of the respective populations, with the Welsh population generally older and sicker than those in England.

9 Statement by the British Orthopaedic Association, on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022

The extent of the orthopaedic waiting list shows significant geographical variation across Wales

20 A comparison across health board areas of the total numbers of patients waiting over 36 weeks per 100,000 population shows some stark geographical variations (**Exhibit 4**).

Exhibit 4: Number of patients waiting over 36 weeks for orthopaedic treatment per 100,000 population, by Health Board of residence (November 2022)



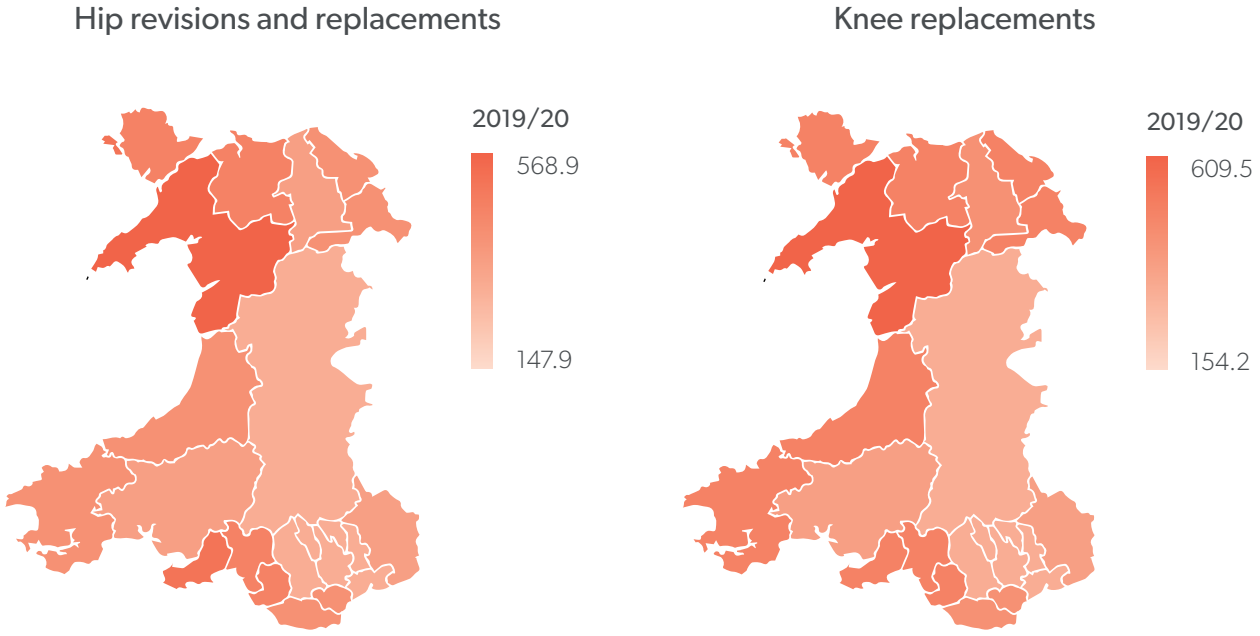
Source: Audit Wales analysis of StatsWales data

21 This geographical variation is equally as noticeable when considering specific orthopaedic procedures such as hip or knee replacement surgery. **Exhibit 5** shows average waits in Wales for hip replacement in 2019-20[10] varied from around 148 days for Powys residents[11] to almost 567 days for Gwynedd residents. A similar, though slightly worse position is observed for patients receiving knee replacement procedures with waits varying from 154 days for Powys residents to almost 610 days for Isle of Anglesey residents in 2019-20.

10 2020-21 procedure level wait data is currently incomplete. We have therefore used the most recent pre-pandemic dataset.

11 Note that some Powys residents will receive treatment from English providers where waiting times are shorter than in Wales.

Exhibit 5: Mean waiting times in days for hip revisions and replacements, and knee replacements for 2019-20, by local authority area



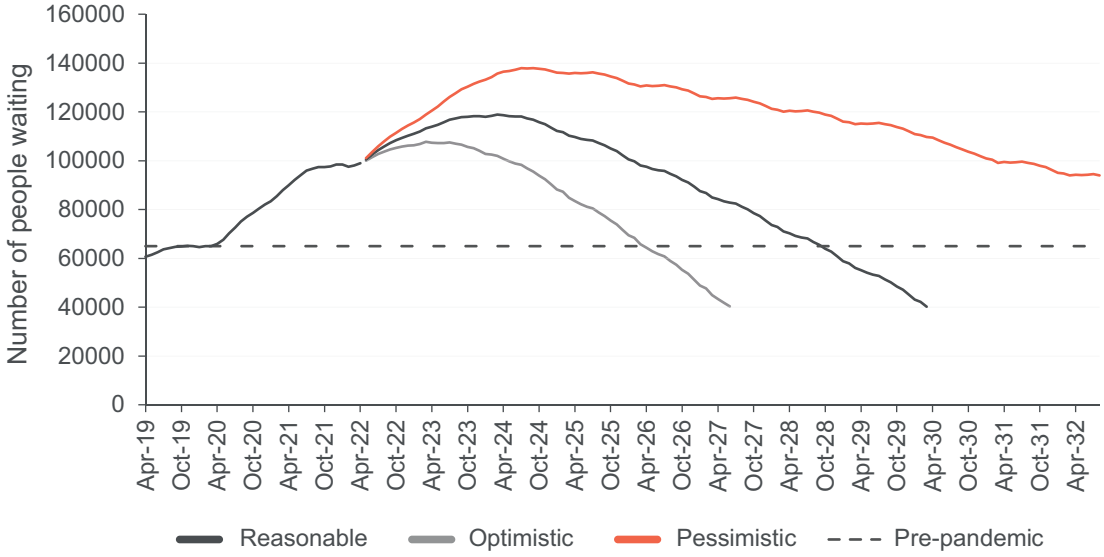
Source: Health Maps Wales, Common Procedure dataset

22 Health Boards are using all possible means to try to reduce the waiting lists. This includes outsourcing, where Health Boards are seeking third-party organisations to provide services on their behalf, such as private healthcare providers or NHS Trusts in England. Outsourcing provides a short-term solution, but this potentially could further widen inequalities of access to care. People living in deprived communities may not be able to travel further to receive their care and those with complex comorbidities may require their procedure in a hospital with intensive care facilities. This may mean those groups of patients face potentially longer waits for their treatment.

Without significant intervention, orthopaedic waits may never return to pre-pandemic levels

23 We have used national data to work out how long it could take NHS Wales to get orthopaedic waiting lists back to March 2020 levels[12]. We developed three illustrative scenarios: **reasonable**, **pessimistic**, and **optimistic**. The modelling (**Exhibit 6**) for our optimistic scenario suggests that the orthopaedic waiting list could peak in 2023 but return to pre-pandemic levels by 2026. The reasonable model would see waiting lists return to pre-pandemic levels by 2028, noting that pre-pandemic performance was itself not meeting Welsh Government targets. The pessimistic scenario may never see a return to pre-pandemic waiting list levels.

Exhibit 6: Illustrative scenarios of waiting list numbers for orthopaedic services across Wales



Source: Audit Wales analysis of StatsWales data

12 **Appendix 1** sets out how we modelled the scenarios.

24 The key variables in our modelling cover the rate at which patients are added to the orthopaedic waiting list over time, the rate at which patients are removed from the list, the potential growth in demand, and the extent to which potentially 'missing' referrals or latent demand returns (discussed later in this report). Our optimistic modelling is also based on assumptions around increasing current activity through increased capacity by 25% by 2025 and reducing the referral demand through prevention and early treatment (such as increased use of CMATS). Our modelling does not consider possible new or more complex demand because of changes in population health.

Long waits for treatment are affecting many people's physical and mental health

25 While orthopaedic and musculoskeletal problems are not, in themselves, life threatening, they can be debilitating and can significantly affect people's quality of life. Many patients waiting for treatment will be experiencing discomfort and pain daily which can lead to a loss in mobility and independence, which in turn can cause wider deterioration in physical and mental health. For some patients this can impact on their ability to work and for many patients there will be an increased need for ongoing support from GPs to help manage their condition. Prolonged waits for joint related problems can also result in further deterioration which could make the required surgery more problematic and potentially less effective.

26 In its submission to the Senedd's Health and Social Care Committee inquiry into the impact of the waiting list backlogs on people in Wales, the Board of Community Health Council's (CHCs)[13] highlighted that orthopaedic services were one of the most common services that the local CHCs were hearing about. In a report by the Swansea Bay Community Health Council on the lived experiences of people waiting for elective orthopaedic surgery, 92% of patients reported a deterioration in their condition. Nearly three-quarters agreed the length of time they had been waiting for surgery had affected their mental health and wellbeing.

13 Inquiry into the impact of the waiting times backlog on people who are waiting for diagnosis or treatment in Wales: Board of Community Health Councils

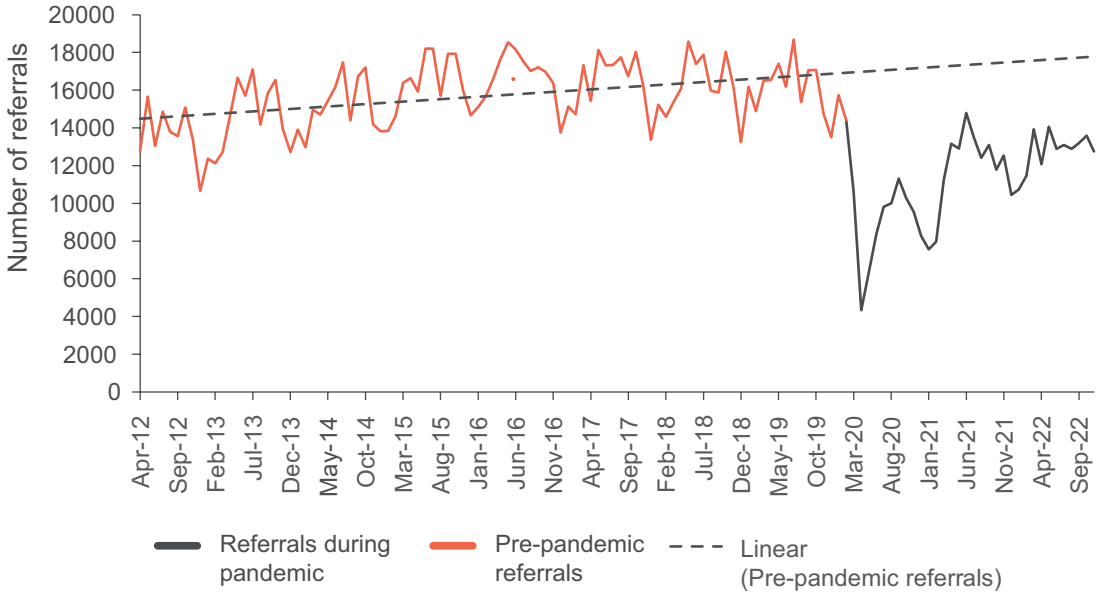
What is impacting the recovery of orthopaedic services?

02

Referral rates are not yet back to pre-pandemic levels

27 The change in the pattern of orthopaedic referrals during the pandemic is like that experienced across planned care services more generally, with a sharp decline in referrals at the onset of the pandemic[14] (**Exhibit 7**). Referrals have not yet returned to pre-pandemic levels. When comparing the level of referrals between March 2020 and March 2022, against 2019-20 referral levels, around 135,000 referrals are 'potentially missing'.

Exhibit 7: Number of orthopaedic referrals across Wales, April 2012 – November 2022



Source: Audit Wales analysis of StatsWales data

28 NHS Wales is currently benefitting from rates of orthopaedic referrals continuing to be lower than pre-pandemic levels. The waiting list position would otherwise be substantially worse. Some of the missing referrals or latent demand may never appear due to, for example, people choosing to seek private treatment, but it is expected that a proportion of the unmet demand will appear and further exacerbate the challenges being faced by orthopaedic services.

14 Note that referral patterns vary significantly by Health Board.

Although radiology and physiotherapy services are recovering, increased demand is adding to delays in orthopaedic pathways

29 Timeliness of orthopaedic treatment is dependent on the timeliness of each stage of the orthopaedic pathway[15] which will include other services such as radiology services and physiotherapy. Since the beginning of the pandemic, the total number of patients across Wales waiting for a consultant referred radiology test increased from 23,979 in March 2020 to 33,121 in November 2022. The total number of people across Wales waiting for a GP referred radiology test increased from 18,703 in March 2020 to 30,175 in November 2022.

30 Of particular interest to orthopaedic services are waits for diagnostic magnetic resonance imaging (MRI) and ultrasound scans. While the number of people waiting has increased, positively the number of people waiting less than the target wait of eight weeks is now at, or marginally better, than levels experienced pre-pandemic, suggesting good progress had been made to recover services. The number and proportion of people waiting over 14 weeks however has grown substantially across both diagnostic tests due to the increased demand (**Exhibit 8**).

15 A pathway is an agreed common approach for a course of care. For orthopaedic patients, this would typically include some or all the following: GP referral, first outpatient appointment, diagnostic test and/or therapy intervention, preoperative assessment, MRSA and COVID-19 screening, consenting, surgery and follow-up outpatient appointment.

Exhibit 8: Number and proportion of patients waiting over 14 weeks for diagnostic tests across Wales in March 2020 and November 2022

	March 2020		November 2022	
	Number	%	Number	%
MRI – Consultant referred	34	3.6%	1,344	10.4%
MRI – GP referred	1	0.04%	478	14.6%
Ultrasound Scan – Consultant referred	55	0.7%	2,361	19.5%
Ultrasound Scan – GP referred	18	0.1%	6,611	26.7%

Source: Audit Wales analysis of StatsWales data

31 Access to physiotherapy presents a similar but more concerning picture. The number of adults waiting for physiotherapy increased from 16,253 in March 2020 to over 32,269 in November 2022. Although more patients are now being seen by a physiotherapist within eight weeks compared to pre-pandemic levels, the number of patients waiting over 14 weeks for physiotherapy has increased 29-fold from 148 in March 2020 to 4,202 in November 2022. Numbers waiting however are gradually reducing. Long therapy waits will not only have an impact on the timeliness of orthopaedic pathways but can also undermine preventative efforts to reduce people's need for surgery.

Capacity and efficiency were already problematic prior to the pandemic, and a slow restart of orthopaedic services has exacerbated the backlog

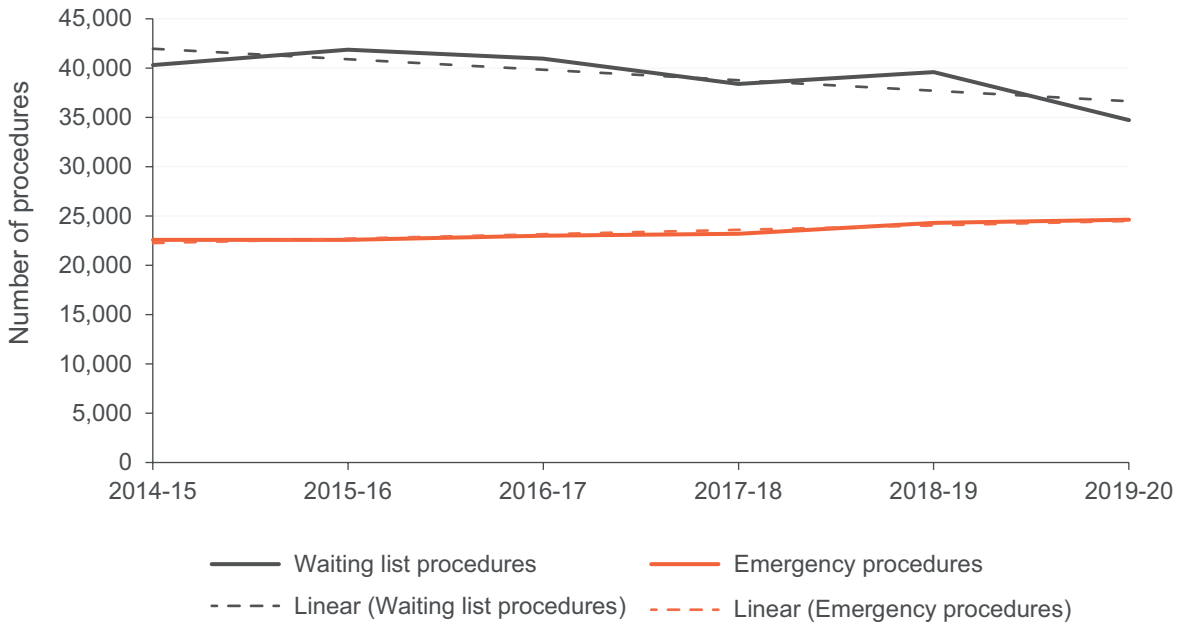
32 For several years there has been insufficient NHS orthopaedic capacity to meet demand. Prior to the pandemic, NHS Wales typically commissioned around 45,000 procedures for the Welsh population, with around 40,000 procedures provided though 'core' activity and waiting list initiatives[16]. The remainder was commissioned from other non-NHS Wales providers[17]. Outsourcing and waiting list initiatives have been short-term measures to improve waiting lists and provide capacity but had done nothing to ensure the sustainability of orthopaedic services.

16 Waiting list initiatives are used by NHS bodies to tackle waiting lists and meet national targets. They involve a short-term increase in capacity such as extra clinics at nights and at weekends, and the use of private healthcare provision.

17 Audit Wales analysis of Patient Episode Data Wales orthopaedic waiting list procedure data, NHS Wales provider versus total commissioned.

33 Over the six years leading up to the onset of the pandemic, the deployment of trauma and orthopaedic capacity changed. National data shows a 10% increase in emergency trauma activity between 2014-15 and 2019-20 which has placed pressure on capacity for planned care. For the same period, there was a 14% decrease in orthopaedic waiting list activity[18] (**Exhibit 9**). The shift between orthopaedic waiting list activity to trauma may not have been readily noticed over such a long period of time but will have had an impact on the capacity to tackle the already existing waiting list backlog. Changes to pension rules for NHS consultants have also impacted on waiting list activity due to a reduction in the willingness of consultants to take on waiting list initiatives.

Exhibit 9: Trend in emergency trauma and orthopaedic waiting list activity, based on the number of procedures, 2014-15 and 2019-20



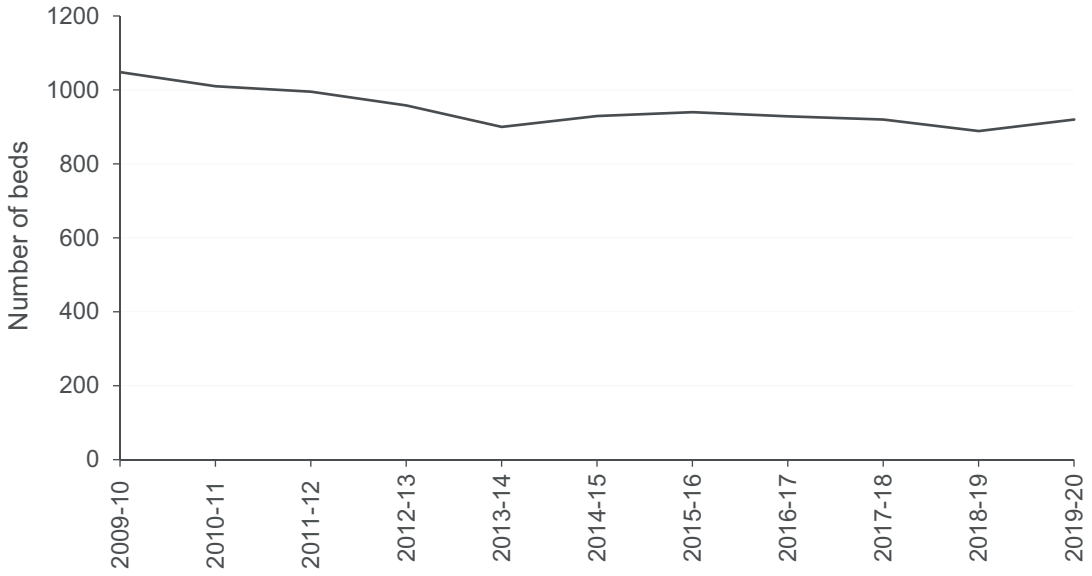
Source: Audit Wales analysis of Patient Episode Database for Wales

34 Capacity constraints also occurred because of a reduction of beds and wider urgent and emergency care pressures resulting in cancellations of orthopaedic activity. **Exhibit 10** shows the total number of orthopaedic beds declined by 12% from 1,048 in 2009-10 to 920 in 2019-20[19].

18 The numbers of waiting list procedures reduced disproportionately in 2019-20. We have assumed this is because of the onset of the pandemic.

19 2020-21 Bed data cannot be compared to previous years because it is based on a different source, definitions, and hospital types.

Exhibit 10: Trend in number of trauma and orthopaedic beds, 2009-10 to 2019-20



Source: Audit Wales analysis of StatsWales data

35 Bed capacity has also further reduced over the last two years with the continual need for health boards to respond to COVID-19 cases and retain infection control measures.

36 Orthopaedic services can operate models with fewer beds if the surgical element of the pathway is well planned, patients are prepared and educated, and processes enable effective and timely discharge. Enhanced recovery approaches also help to reduce length of stay. However, our data analysis indicates lengths of stay have not reduced for many years. Average combined trauma and orthopaedic lengths of stay have stayed at around seven days between 2014-15 and 2019-20[20], with substantial variability in lengths of stay by health board. Our data analysis also indicates around a 25% reduction in day case activity between 2014-15 and 2019-20.

20 Audit Wales analysis of Patient Episode Database for Wales

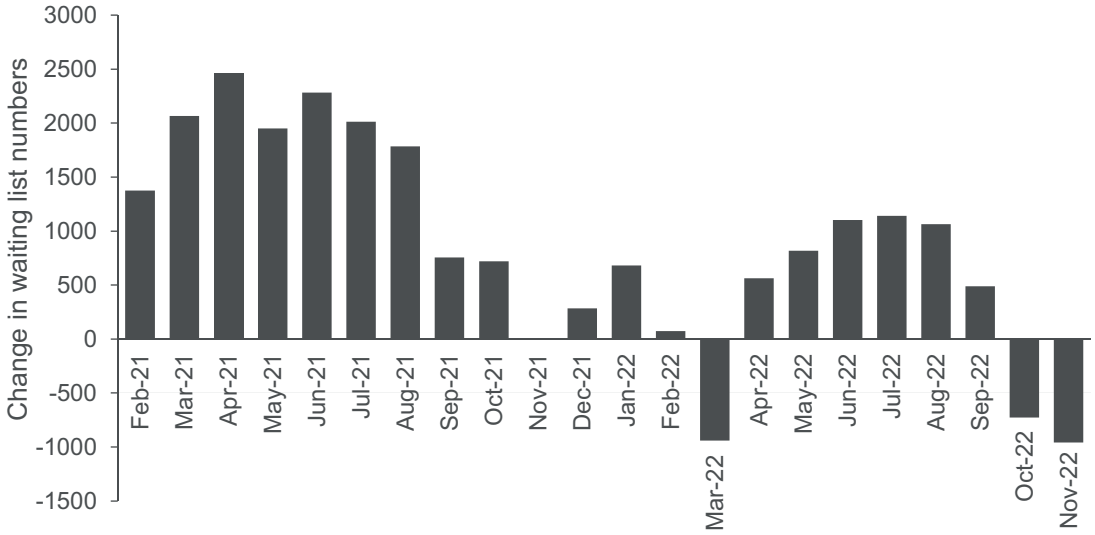
37 Orthopaedic services have been slow to restart since the lessening in the impact of the pandemic in 2021 and since the last major (omicron) COVID-19 wave in early 2022. Services are currently still far off the levels of activity seen prior to the pandemic. Current inpatient and day case orthopaedic activity across Wales is around 60% of pre-pandemic levels[21]. Most health boards are also only achieving around 20% to 30% of their orthopaedic procedures as day cases. NHS Wales is targeting around 60% in future. Day case (and very short stay) provides a significant opportunity for utilising existing capacity better.

38 Based on changes to waiting lists on a month-by-month basis, orthopaedic capacity is currently not meeting demand, resulting in monthly increases in the number of patients waiting (**Exhibit 11**). In 2021-22, the Welsh Government provided extra funding to health boards to buy additional short and medium-term capacity to support the recovery of planned care services, including orthopaedics. Historically NHS Wales would have looked to NHS England for additional capacity, but they too are struggling to recover their own waiting lists. Consequently, requests for additional capacity through private providers have been greater than the supply available and the ability of health boards to secure the additional capacity needed has been limited. This is particularly the case for orthopaedics. Some medium-term additional capacity has been secured using temporary expansions to health boards' existing clinical estate, such as using demountable units to create operating theatres.

39 Funding has also supported administrative and clinical validation of waiting lists to ensure that only those who need treatment are waiting. However, these have tended to be undertaken as one-off exercises to cleanse waiting lists at year end, resulting in a temporary reduction in waiting lists in March. Funding to support the ongoing recovery of planned care has continued and will be available to health bodies for a further three years.

21 Audit Wales analysis of Welsh Government, unvalidated orthopaedic statistics

Exhibit 11: Month-by-month change in waiting lists numbers across Wales, February 2021 – November 2022



Source: Audit Wales analysis of StatsWales data

Orthopaedic services have not kept up with demand and previous national funding initiatives have failed to secure sustainable service improvements

40 Basic analysis of trend data indicates that demand for orthopaedic services is growing. Furthermore, forecasts by the Office of National Statistics indicate a 27% growth of over 75-year-olds (from around 307,000 to 390,000) living in Wales between 2020 and 2032. While positive, this will likely drive further growth in demand for orthopaedic services as more people will be living with age-related orthopaedic and musculoskeletal conditions. This additional demand needs to be planned for and funded.

41 Given that orthopaedic waiting lists pre-COVID-19 were deteriorating, it is unrealistic to think that without significant changes, current capacity will ever result in sustainable service recovery. Indeed our 'optimistic' scenario modelling (**Exhibit 6**) is based on a gradual increase of commissioned orthopaedic capacity (whether provided by NHS Wales or externally commissioned) and/or productivity levels to 5% above pre-pandemic levels noting that services are currently only running at about 80% of pre-pandemic levels. Our model also assumes that services can curtail any growing demand.

42 There has been a history of short-term funded national initiatives for orthopaedic services in Wales. In June 2001, the then Minister for Health and Social Services announced a £12 million package to reduce orthopaedic waits to 36 weeks. Much of this was non-recurrent and consequently had limited ongoing impact. In 2005, the Welsh Government launched its orthopaedic plan for Wales. This initially brought down waits but again did not result in sustainable service improvements. In 2011, the national orthopaedic programme began its aim to eliminate over-36-week waits. At the same time, the then Minister for Health and Social Services announced £65 million over three years to make orthopaedics best in class. Our 2015 report[22] considered the £65 million investment. We reported that orthopaedic services have become more efficient in the past decade, but NHS Wales was not well placed to meet future demand. Whilst there had been a focus on securing immediate reductions in waiting times, less attention had been paid to developing more sustainable, long-term solutions to meet demand. Since then, NHS Wales has struggled to meet its orthopaedic waiting list targets.

43 Planning for elective orthopaedic services needs to have a clear focus on the short, medium, and longer term, and be supported by realistic assessments of capacity and demand. The short-term focus must be on speeding up recovery of services and addressing existing inefficiencies in the system, the medium-term on building sustainable service models which will start to tackle the backlog; whilst the longer- term view needs to take account of population demographics in forecasting future demand on services, and what is needed to meet that demand.

44 While NHS Wales needs to focus on getting services back up and running to meet the demands being placed on them, there is also a duty on health boards to be maintaining a focus on keeping people safe while they are waiting for treatment. Lack of communication from health boards whilst waiting was identified as an issue in the CHC reports. Very few health boards have put arrangements in place to monitor patients on waiting lists and provide the contact needed to reassure patients and provide advice and support as necessary.

22 Audit Wales Review of Orthopaedic Services, 2015

What action is being taken?

03

Community-based prevention and treatment are having a positive impact on reducing demand, but capacity is an issue

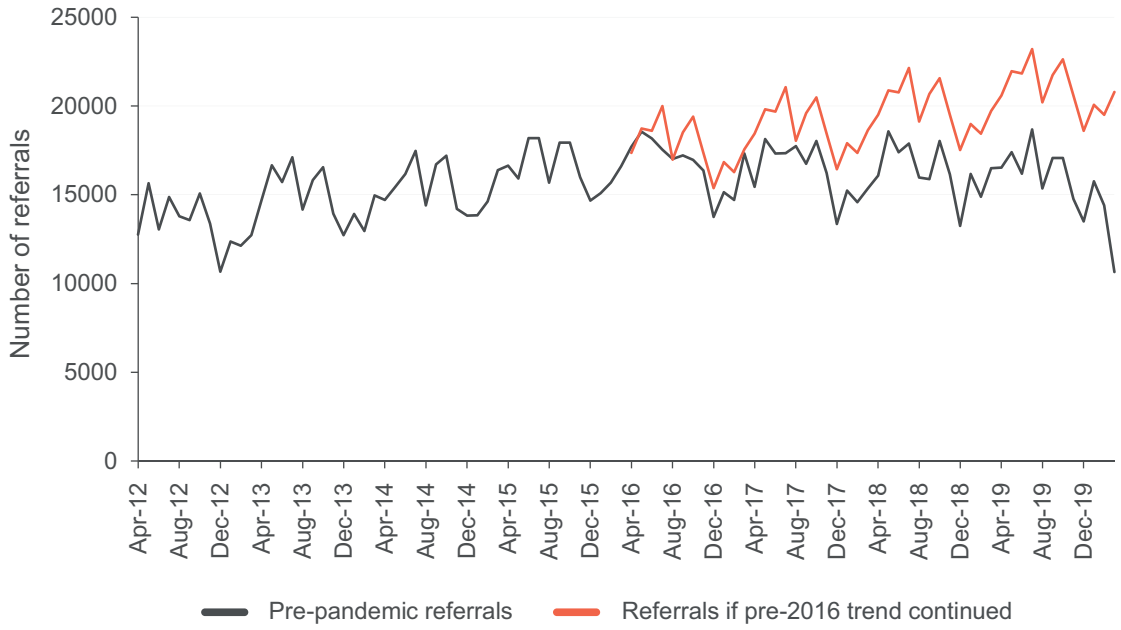
45 For several years, the Welsh Orthopaedic Board has helped to influence developments in orthopaedic services. The Board has overseen the rolling out of preventative approaches such as Community Musculoskeletal Assessment and Treatment Services (CMATS)[23], and more recently First Contact Practitioners (FCPs)[24]. While community-based musculoskeletal services began far earlier in some health boards, for most they started to be rolled out more comprehensively from 2016.

46 While it is difficult to attribute cause and effect directly to the achievements of the community-based prevention, national data suggests that efforts between 2016 and 2020 helped stem the growth in referrals. **Exhibit 12** shows referral trends, and a change in the referral trajectory had community-based prevention not been in place. We have applied a forecast trendline to highlight how the referrals may have increased if the pattern of demand seen between 2012-2016 continued into 2016-2020. With an aging population over this time, we would have expected to see a continued growth in referrals. But this has not been the case.

23 CMATS were developed to provide a community-based service for the assessment and treatment of musculoskeletal-related pain and conditions.

24 First contact practitioner is a new model evolving across the UK which involves placing physiotherapists directly into GP practices to see and treat patients who come into the practice with musculoskeletal problems.

Exhibit 12: Actual orthopaedic referrals compared with predicted referrals from 2016 onwards had community-based schemes not been in place, April 2012- December 2019



Source: Audit Wales analysis of StatsWales data

47 But capacity for CMATS has been an issue. Although waits for CMATS are not included as part of the standard waiting times, our recent work on orthopaedic services identified that CMATS waits could be up to four months. All referrals for orthopaedic services are made via CMATS, and only at the point in which is it considered that CMATS intervention is not appropriate, are referrals passed on to orthopaedic services. For many patients, this will be at the point the referral is triaged by the CMATS which can typically take up to a week. But for some, onward referral to orthopaedic services may not happen until they have waited and been seen by the CMATS.

48 Our recent work also identified inconsistencies in the CMATS model across Wales, with differences in the range of multidisciplinary professionals that make up the team, and differences in the ability for CMATS to refer directly for diagnostic tests. We also found potential duplication of effort between CMATS which include physiotherapists and FCPs and a risk that overall waits for treatment are elongated because of the need to access both FCPs and CMATS before onward referral to orthopaedic services.

49 One scheme to support people is the National Exercise Referral Scheme (NERS). Funded by the Welsh Government and run by the 22 local authorities, the scheme provides opportunities for people with long term conditions to make and maintain healthier lifestyle choices. This is provided through physical activity and behaviour change with the aim to improve health and wellbeing. One intervention is focused on low back pain[25], with another focused on weight management. Although numbers are small, the shift to virtual working in response to the pandemic has provided an opportunity to increase capacity and support people on waiting lists. In its latest report[26], over 25,000 participants attended one of the virtual, outdoor, or indoor activities put in place to support the wider NERS programme. However, due to the pandemic, the NERS was unable to take new referrals. This has now been changed, but services are heavily reliant on the short-term funding available from the Welsh Government and the support of local authority facilities such as leisure centres to run activities.

There is a clear commitment to improve and transform orthopaedic services nationally, although this may take time to achieve

50 Service efficiency, clinical productivity and effectiveness of hospital based orthopaedic services has been an aim in Wales for a long time. NHS Wales has developed clinical pathways based on best practice. But in the past, these clinical pathways have not always been well implemented and there continues to be variation in approaches across health boards.

25 NERS Low Back Pain Intervention

26 All Wales NERS Infographic Quarter Two, 2021-22

51 More recently NHS Wales has commissioned the Getting It Right First Time (GIRFT) team to review acute orthopaedic services. The reviews started in early 2022 and covered all seven health boards and 21 hospital sites that provide orthopaedic services in Wales, comparing clinical practice with England. Recommendations to health boards focussed on:

- strengthening leadership, through health board specific orthopaedic steering groups;
- reducing unwarranted and inappropriate variation in clinical practice, performance, and efficiency;
- engaging staff in change and improvements to orthopaedics and understanding the drivers that are affecting morale;
- implementing waiting list recovery at pace;
- better arrangements to support patients prior to admission, and better discharge planning;
- improving the consistency of collection and use of patient reported outcome measures;
- improving surgical site infection data recording and reducing deep infection rates to 0.5% or lower;
- creating short, medium, and long-term multi-disciplinary workforce plans; and
- building elective orthopaedic recovery plans, including capacity and demand planning on a health board and broader regional footing, multi-disciplinary workforce planning, ring-fencing elective capacity and boosting short-term theatre capacity.

52 The GIRFT team's national report to the Welsh Government includes 28 recommendations spanning but not limited to leadership, safety, workforce, efficiency and clinical practice. The recommendations from both the national and local reports need implementing swiftly and effectively.

53 At the same time as the GIRFT work, the Welsh Government, through the Welsh Orthopaedic Board, commissioned the Welsh Orthopaedic Society to prepare a clinical strategy for Wales. This strategy provides a thorough and honest appraisal of the current position of orthopaedic services. It sets out the need for new leadership through a Welsh Orthopaedic Network and a requirement for the development of orthopaedic hub sites to better protect waiting list activity from unscheduled care pressures, and to enable efficient high volume low complexity centres of excellence.

54 Regional treatment centre hubs offer a good solution to provide protected orthopaedic capacity and deliver best in class levels of efficiency in the medium and longer term. But these will take time, investment, and cooperation across health boards to implement. As an immediate action, some health boards are creating additional operating theatre capacity in the short term, as mentioned in **paragraph 38**.

What else needs to be done?

04

Several challenges need to be addressed if services are not just going to tackle the orthopaedic backlog, but be sustainable for the future

55 This report sets out the huge scale of challenge that is faced in Wales. The extent of the numbers of patients waiting, limited capacity available and potential for further growth in demand provide a concerning landscape not just in the short term but also the medium term. All that can be done must be done within the current operating environment, but there remain several risks to longer-term improvement.

56 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.

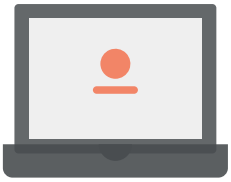
57 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively. New technology and improved estate need to be prioritised and regional solutions need to be much more at the core of delivery plans.

58 In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.

59 These key actions are explored further in the exhibit below.

Exhibit 13: Key actions for NHS Wales to tackle the challenges in orthopaedic services

Lessons must be learnt from previous initiatives which have failed to secure service transformation	Together the new clinical strategy and the GIRFT reports provide the most comprehensive assessment on the position of orthopaedic services in Wales. It is positive that the Welsh Government and NHS Wales are recognising the scale of the challenge. But the response to these cannot be the same as we have seen in response to previous orthopaedics plans; fundamental embedded change is needed.
National plans must be accompanied by buy-in from local clinical teams	Our recent work in orthopaedics, whilst recognising good intent from the Welsh Orthopaedics Board to improve and transform services, highlighted the variability in which that intent translated into practice across health boards. Where national directives to implement service changes have been set in the past, implementation has often been slow, inconsistent, and without the 'buy-in' of local clinical teams. The strategy needs to be underpinned by clear and defined programmes of activity and bold leadership will be needed at all levels to ensure that the new clinical strategy delivers a consistent service across Wales.

A renewed focus on efficiencies is needed	The GIRFT reports have a clear focus on improving efficiency and productivity in orthopaedics, and ultimately delivering better outcomes for the people of Wales. But this focus is not new. NHS Wales has been focusing on reducing length of stay, improving theatre productivity, reducing follow-up rates, and minimising cancellations for some time, but inefficiencies still exist. There needs to be a significant and constant focus in this area. Regular benchmarking reporting needs to be in place to enable challenge and scrutiny to happen locally and nationally, supported by clear action plans to address the things that get in the way of improvement.
A whole system and wider patient pathway focus is needed	The GIRFT reports and clinical strategy quite rightly focus on orthopaedic services, but effective delivery is reliant on wider services across the NHS. Capacity of enabling clinical services such as diagnostics and therapies to support timely diagnosis, prevention and treatment in the community and effective discharge needs to be available.
Investment in new technologies and improved estate needs to be prioritised 	Digital solutions offer further opportunities for efficiencies but need to be effectively piloted and evaluated to ensure wider investment delivers value. Capital and revenue investment needs to be carefully prioritised to get most impact, considering where opportunities exist to make better use of digital initiatives and estate development.

Regional solutions to meet current and future demand need to be pursued with much more rigour	Developing regional service models has been notoriously difficult in the past but regional working provides opportunity to maximise available capacity and provide centres of excellence that deliver better outcomes. Some health boards are starting to work together to look at regional solutions, but these are limited and often as a reactive response to short-term capacity issues. Regional models need to be at the core of orthopaedic delivery plans, and not around the margins with small scale low impact initiatives, which has been the case previously.
Information on patient experience and outcomes must be used extensively to shape clinical decisions and advice to patients	A greater focus needs to be given to patient experience and outcomes. The roll out of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) for orthopaedic services is still variable across Wales. These have been an ambition for a long time but are not well used to inform future investment and more importantly dis-investment and value-based decisions. At a patient level, outcomes should inform choice and 'what matters' discussions. More also needs to be done to support consistent clinical decision making. For example, establishing a common list of procedures not normally undertaken and setting criteria such as BMI thresholds, if surgery for some patient groups would not result in positive outcomes. Our earlier audit work found health boards were working to different lists of procedures considered ineffective.

Appendices

1 Our approach

Our approach

The evidence base for our work comes from reviews of documents on orthopaedic and musculoskeletal services, data analysis, observation of the Welsh Orthopaedic Board and more recently the Orthopaedic Summit in August 2022, and interviews with Welsh Government and NHS officials. We also build on evidence captured prior to the pandemic from health boards.

Our data analysis is based on Welsh Government data on StatsWales, Health Maps Wales, Patient Episode Dataset Wales, and bespoke data requests to NHS officials.

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

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

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 6**). We accounted for the possible pent-up demand (see **paragraph 26**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario, with the optimistic scenario assuming that no pent-up demand returns. **Exhibit 14** sets out our modelling assumptions.

Exhibit 14: Waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90.0%	85.0%
Annual increase in additions 2025 onwards	-0.1%	0.0%	-0.2%
Latent 'missing' referral demand presenting	5.0%	10.0%	0.0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80.0%	80.0%	80.0%
2023-24	90.0%	85.0%	95.0%
2024-25	100.0%	95.0%	105.0%
2025 onwards	102.5%	100.0%	105.0%

Source: Audit Wales

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

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Orthopaedic Services in Wales – Tackling the Waiting List Backlog

A comparative picture for Aneurin Bevan University Health Board

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Summary

Introduction

1 This report supplements our national report on orthopaedics services and provides additional analysis of the orthopaedic waiting list position at Aneurin Bevan University Health Board (the Health Board). The report presents a range of data to inform discussion and oversight of the current challenges associated with the recovery of orthopaedic services at the Health Board. It includes several prompts and questions for board members to inform debate and obtain assurance that improvement actions are having the desired effect.

2 **A note on the data**: In some instances, the most up to date data available is prior to the pandemic. In others, the data available since the onset of the pandemic is not comparable because of service changes over this period. Therefore, we have:

- selected data and indicators to help stimulate board member and senior manager discussion and scrutiny on specific aspects of orthopaedic service delivery.
- used long-term trends and calculations to help present a perspective on orthopaedic services both in relation to the current position and taking a more strategic longer-term outlook.

3 In May 2022, the Getting It Right First-Time (GIRFT) team[1] issued its national report on orthopaedic services in Wales and provided additional local feedback to each health board. The local report for the Health Board was finalised in May 2022. The findings presented here seek to complement rather than duplicate the GIRFT reviews. We have recommended that relevant health board committees receive a progress update against the GIRFT recommendations alongside the Audit Wales national report and the locally tailored data briefing.

4 We have presented the findings in this report under the following headings:

- The scale of the waiting list
- Referrals and demand
- Resources and capacity
- Outpatient models

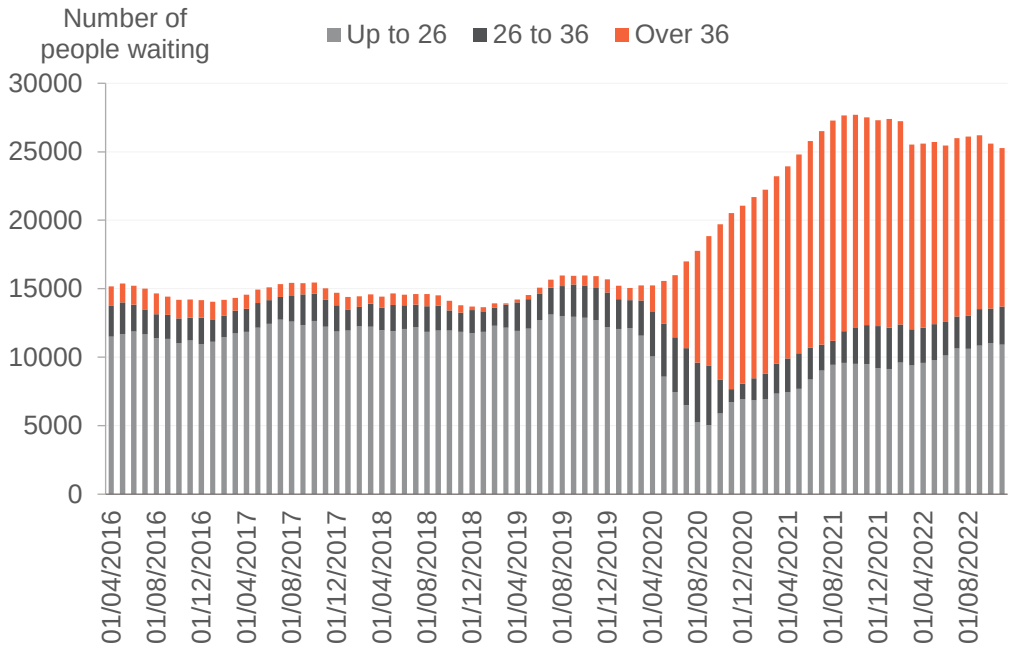
[1] Getting It Right First-Time is a national programme designed to improve the treatment and care of patients through review and benchmarking.

Detailed report

The scale of the waiting list

5 **Exhibit 1** shows the overall trend in orthopaedic waits at the Health Board since 2016. It shows a picture common to most health boards with a sharp increase in the numbers waiting since the start of the pandemic and within those figures, a significant increase in the numbers facing longer waits.

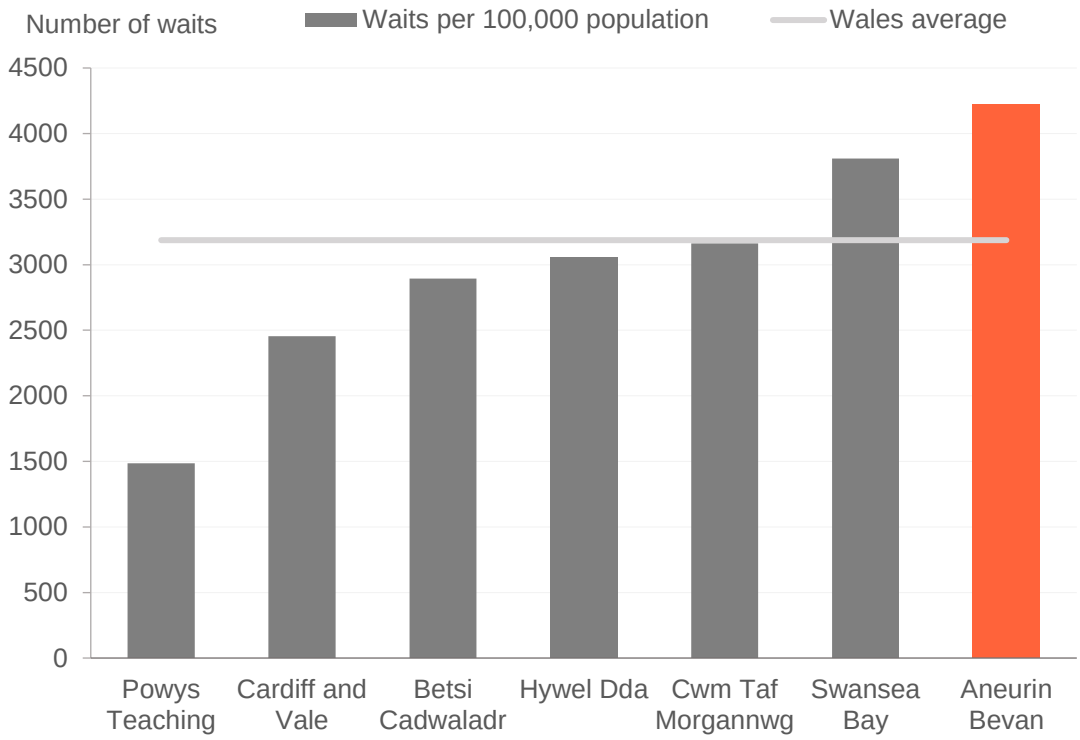
Exhibit 1: total orthopaedic waits, by weeks waiting - Aneurin Bevan University Health Board (April 2016 – November 2022)



Source: Audit Wales analysis of Stats Wales

6 Comparatively the number of patients on orthopaedic waiting lists relative to population varies across Wales. **Exhibit 2** shows the number of orthopaedic open pathways (waits) per 100,000 population as of November 2022, with the Health Board having the highest figure in Wales. This variance may occur because of demographic differences, such as age and deprivation, different primary care referral approaches, different community-based approaches for prevention, treatment, and onward referral. But it is also likely to show that some health boards have been able to a secure a better match between capacity and demand than others.

Exhibit 2: total number of orthopaedic waits per 100,000 population, November 2022



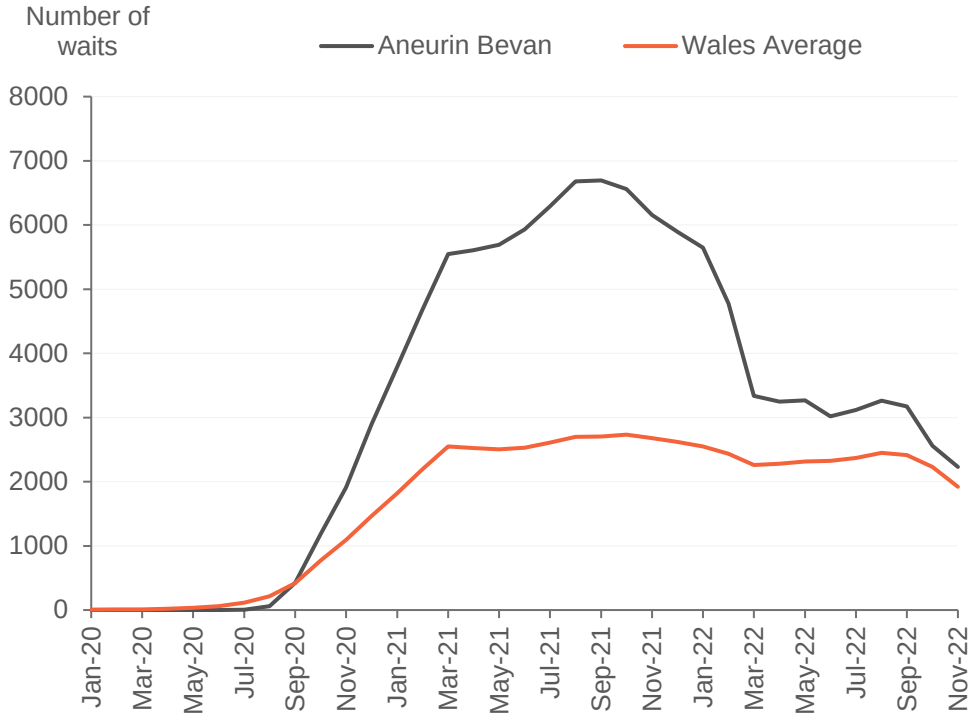
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- What factors are contributing to the Health Board's comparative performance on overall orthopaedic waits relative to population?

7 In April 2022, Welsh Government published its programme for transforming and modernising planned care and reducing waiting lists in Wales. This sets out five ambitions to reduce waiting times in Wales. The first one being 'No one should be waiting longer than a year for their first outpatient appointment by the end of 2022'. **Exhibit 3** shows the number of orthopaedic waits for first outpatient appointment longer than a year. As of November 2022, there were 2,232 patient pathways in the Health Board which were waiting longer than a year.

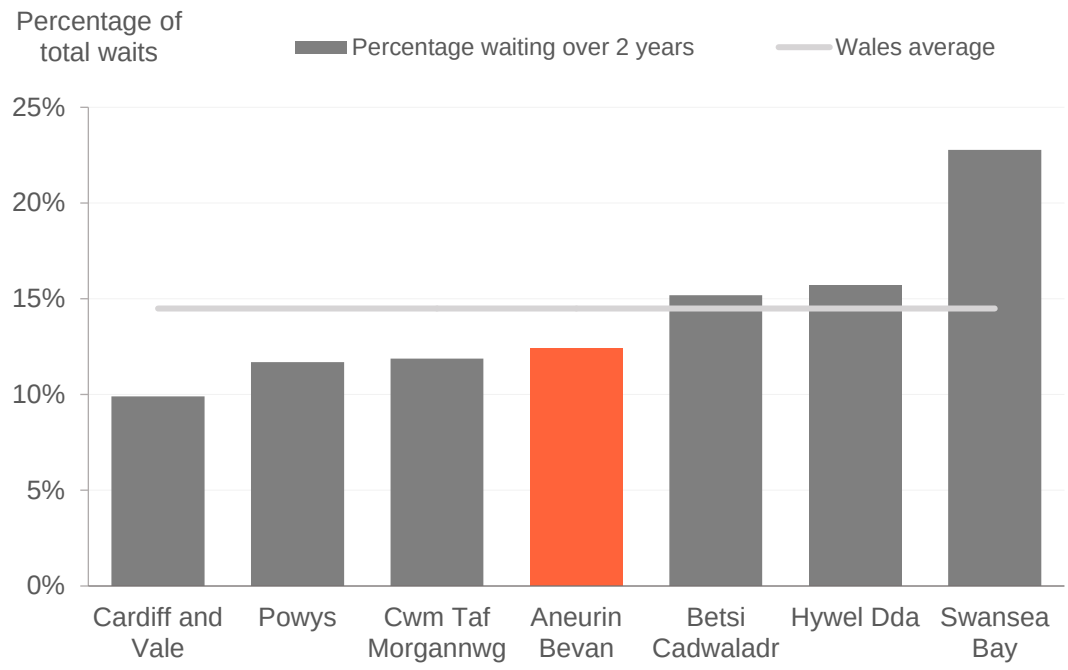
Exhibit 3: total number of orthopaedic waits over a year, waiting for a first outpatient appointment – Aneurin Bevan University Health Board



Source: Audit Wales analysis of Stats Wales

8 The second key ambition set out in the Welsh Government's planned care programme is to eliminate the number of people waiting longer than two years in most specialities by March 2023. As at the end of November 2022, there were around 3,140 patient pathways waiting over two years for orthopaedic services in the Health Board. This number is the second highest in Wales. From our wider analysis, the trends across Wales indicate that health boards are now starting to focus on the growth in extremely long waits. But there is clearly more to do and a finite capacity. **Exhibit 4** shows a comparative picture of long waits. As a proportion of total waits, the proportion waiting over two years in the Health Board is below the Wales average. Exhibit 4 indicates that there is inequality for long waits depending on where people live.

Exhibit 4: percentage of orthopaedic waits over 2 years, by residence, November 2022



Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- Is the Health Board likely to meet the targets set out in the Welsh Government's national recovery plan for planned care? If not, when does it anticipate achieving the key milestones set out in the plan?
- How is the Health Board communicating with patients to tell them how long their wait is likely to be and what to do if their condition deteriorates?
- What is the Health Board doing to prioritise those most at risk of coming to harm because of a delay?
- Does the Health Board have information to indicate whether orthopaedic patients are coming to harm because of delays in their diagnosis and treatment? If so, what does this show and what action is being done to minimise the harm?

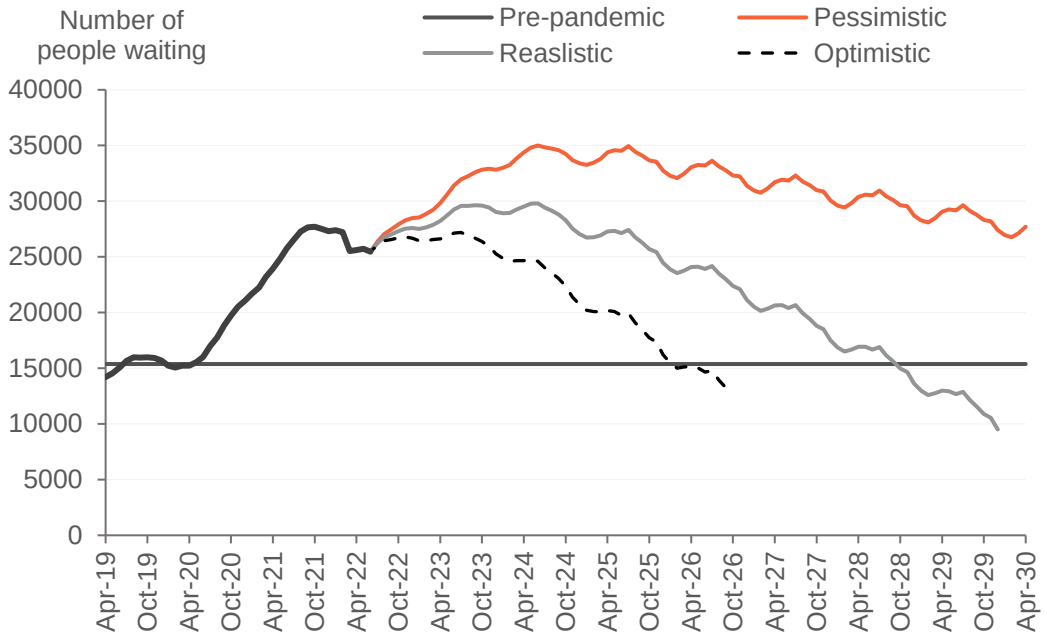
9 **Exhibit 5** provides an illustrative scenario (optimistic, realistic, and pessimistic) for the possible length of time that it could take to return orthopaedic waits to pre-

pandemic levels[2]. Our scenario model is based on pre-pandemic levels of capacity, new demand (additions) and activity (removals), future growth in referral demand, and future growth in capacity and/or activity levels.

10 The scenario model also assumes the levels of pent-up demand hitting the system. Pent-up demand being caused by lower-than-expected referrals since the onset of the pandemic. The model does not assume growth in referral demand due to population changes. The scenarios we have presented are based on assumptions which may alter over the coming years.

11 Even in the most optimistic model scenario, the Health Board's orthopaedic waits would not return to pre-pandemic levels until early 2026. This is based on a move towards a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels. Clearly the timeframe for recovery will reduce if the pent-up demand does not materialise, demand does not grow year-on-year, the Health Board increases internal capacity or productivity, or if there are opportunities for outsourcing. The realistic and more pessimistic modelling scenarios would not see waiting list number return to pre-pandemic for many years, if at all.

Exhibit 5: illustrative scenarios of orthopaedic waiting list numbers – Aneurin Bevan University Health Board



Source: Audit Wales analysis of Stats Wales data

[2] **Appendix 1** sets out how we modelled the scenarios.

12 **Exhibit 6** shows the extent of the variation in waits for hip and knee replacement surgery across Wales prior to the pandemic when this data was last available in 2020. At that time, waits for knee and hip replacements in the Health Board were some of the shortest in Wales. Variation shows differences between service capacity and waiting list management. As health boards across Wales try to reduce waiting lists through outsourcing, there is potential for further widening of inequalities of access to care.

Exhibit 6: mean waiting times (in days) for knee and hip replacement and revision surgery, 2019-20[3]

Health Board	County	Knee	Hip
Betsi Cadwaladr	Isle of Anglesey	609.5	363.9
	Gwynedd	604.4	568.9
	Conwy	409.3	344.3
	Denbighshire	266	212.7
	Flintshire	232.4	221
	Wrexham	236.1	226.6
Hywel Dda	Ceredigion	252.4	213.1
	Pembrokeshire	246.4	238
	Carmarthenshire	221.1	180.9
Swansea Bay	Swansea	362.7	373.2
	Neath Port Talbot	323.1	331.8
Cardiff and Vale	Vale of Glamorgan	229	216.3
	Cardiff	241.9	210.1
Powys	Powys	154.2	147.9
Aneurin Bevan	Caerphilly	185.8	165.2
	Blaenau Gwent	200.2	157.1
	Torfaen	182.1	164.7
	Monmouthshire	180.2	160.2
	Newport	196.6	164.1
Cwm Taf Morgannwg	Rhondda Cynon Taf	177.8	150.8
	Bridgend	317.6	294.9
	Merthyr Tydfil	175.3	161.1

Source: Audit Wales analysis of Health Maps Wales

[3] Table Key: Under 36 weeks 26-36 weeks Over 36 weeks

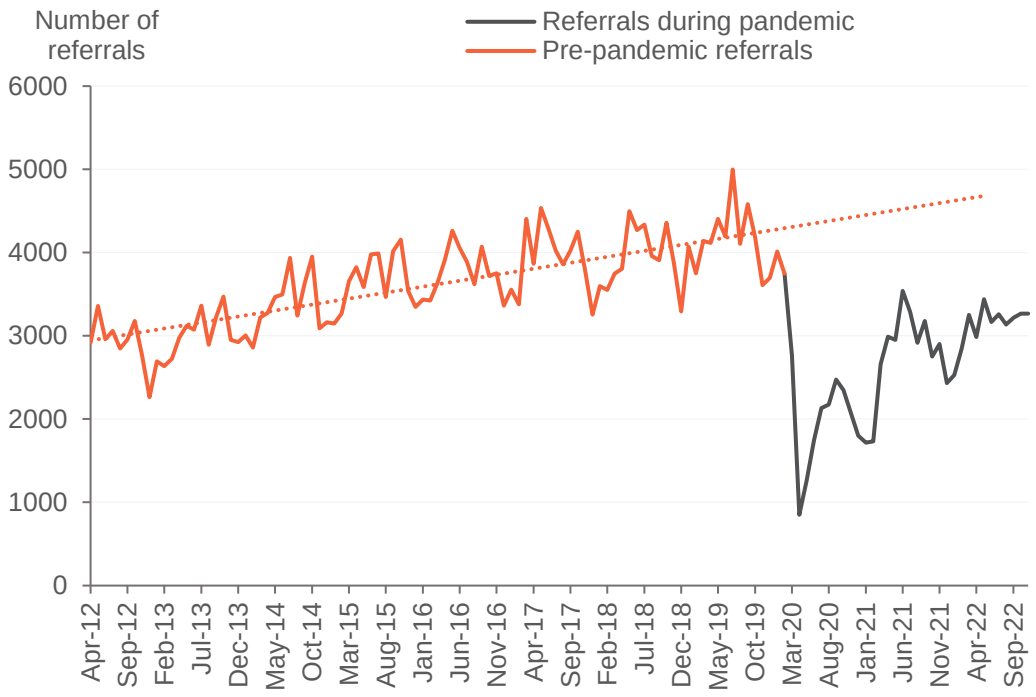
Suggested board member questions

- Has the Health Board undertaken any recent analysis of variation in waiting times by type of surgery and hospital site? If so, what does the analysis show?
- What action is the Health Board taking to reduce variations in lengths of wait for the same treatment across different hospital sites?

Referrals and demand

13 **Exhibit 7** shows the trend in the Health Board's orthopaedic referrals over time and the significant reduction in referrals during the pandemic. The volume of the Health Board's orthopaedic referrals continues to remain below pre-pandemic average referral levels[4].

Exhibit 7: trend in referrals to the orthopaedic waiting list, April 2012 to November 2022 - Aneurin Bevan University Health Board



Source: Audit Wales analysis of Stats Wales data

[4] Based on average referral rates for 2019-20

14 The extent of the lower levels of referrals during the last couple of years suggests that patients who would have normally been referred potentially still have a need for treatment. Our calculations suggest around 135,000 orthopaedics latent or 'lost' referrals across Wales. The numbers vary quite significantly by health board with Aneurin Bevan University Health Board having the highest proportion (**Exhibit 8**). The effect of this latent demand returning to the system and referral demand returning to pre-pandemic levels more generally, will be to make an already challenging waiting list recovery position even more daunting.

Exhibit 8: number of potentially latent 'lost patients' between March 2020 and March 2022

Health Board	Latent 'lost' referrals	Percentage of all-Wales total
Aneurin Bevan	42,438	32%
Hywel Dda	22,860	17%
Cwm Taf Morgannwg	18,294	14%
Cardiff and Vale	17,576	13%
Betsi Cadwaladr	15,987	12%
Swansea Bay	13,046	10%
Powys	4,204	3%
Total	**134,406**	

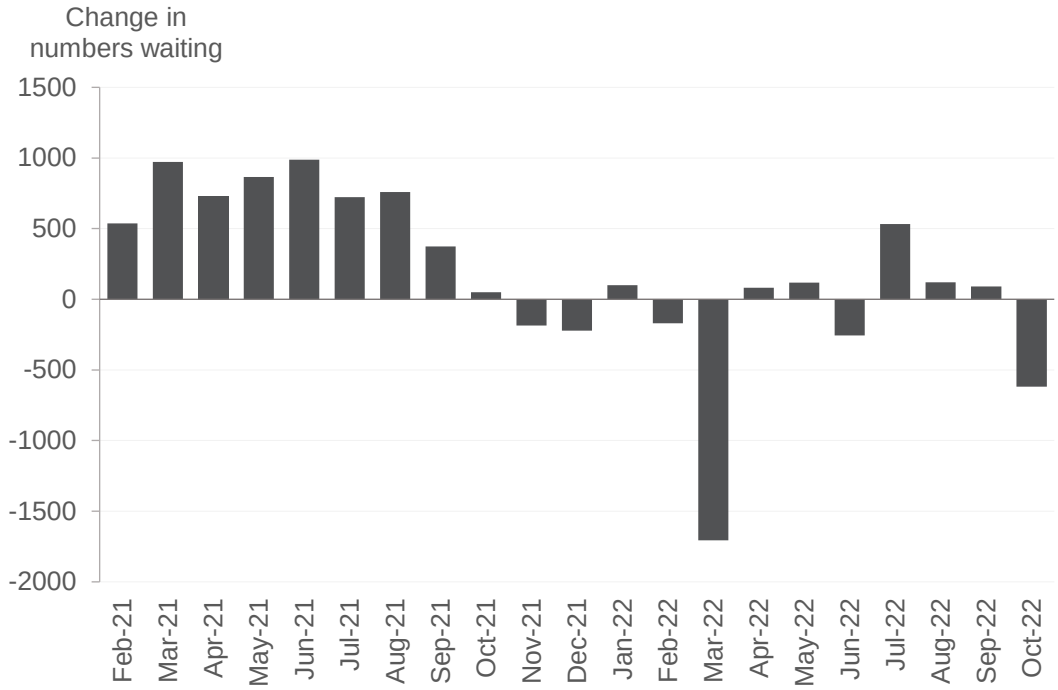
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- To what extent is the Health Board seeing, or expecting to see, the latent demand return? If not expected to return, does the Health Board know where the demand has gone?
- Does the Health Board have a good understanding of the current and future demand for orthopaedic services?
- How is the Health Board ensuring that only appropriate referrals are made into secondary care services?
- Are community-based prevention and treatment approaches such as Clinical Musculoskeletal Assessment and Treatment Services operating effectively, and are there opportunities to exploit community-based services further?

15 **Exhibit 9** shows a month-on-month trend of orthopaedic waits, i.e., whether and by how much each month the waiting list has increased or decreased. Across Wales, some health boards have recently managed to stem the growth in waits in some months, either using short-term additional capacity to meet demand or through validation exercises to cleanse waiting lists. But these reductions have not been sustained. With referrals starting to return to pre-pandemic levels, it illustrates the difficulty health boards are having balancing capacity to meet levels of demand.

Exhibit 9: month-on-month change in numbers of orthopaedic waits - Aneurin Bevan University Health Board



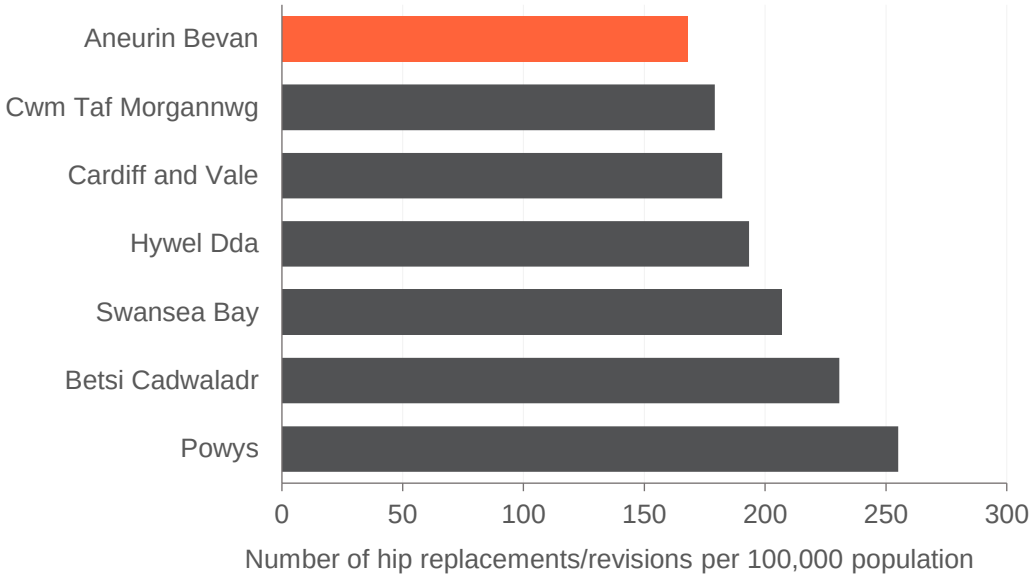
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- What is the Health Board doing to stem the growth in the numbers of people waiting?
- To what extent has list validation been the main factor in reducing waiting lists? To what extent are removals because of validation due to administrative issues? If so, what lessons are being learnt?
- How is the Health Board ensuring the elective orthopaedic capacity is protected from unscheduled care and wider pressures?

16 **Exhibit 10** provides a comparative historical average trend in the rate of hip revisions or replacements over three years from 2017 to 2020 per 100,000 population. While there are demographic differences in each health board, the exhibit shows quite wide variation which is unlikely due to demographics alone.

Exhibit 10: admission rates for hip replacements/revisions per 100,000 population based on a three-year average, 2017-18 to 2019-20



Source: Audit Wales analysis of Health Maps Wales

Board member questions

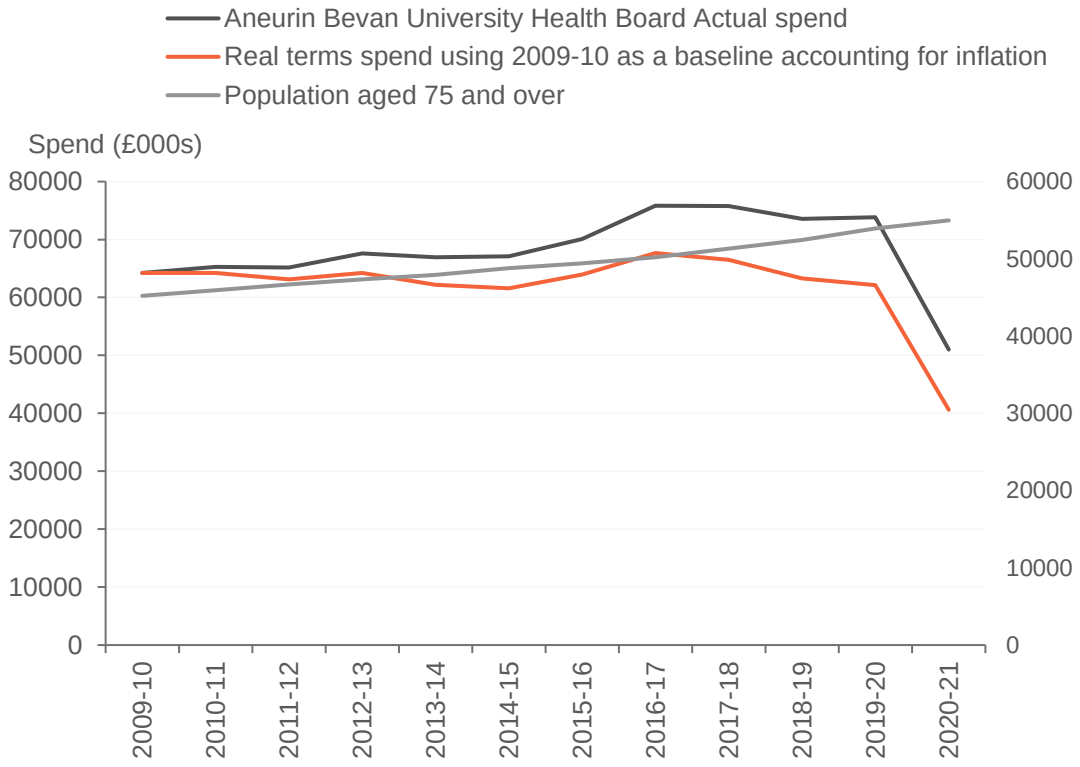
- Has the Health Board undertaken any analysis to understand whether there is a higher or lower rate of procedures, such as hip and knee replacements, than would be expected for the local population? If so, what does it show and are there opportunities for improving productivity and efficiency?
- Does the Health Board understand whether the procedures are delivering positive outcomes for patients?

Resources and capacity

17 **Exhibit 11** provides a long-term perspective on actual spend[5] on orthopaedic services in the Health Board, and the spend adjusted for inflation (i.e., real terms). In general, and across Wales, the pre-pandemic 'real terms' spend on orthopaedics has remained largely static up until the impact of the pandemic.

18 Service demand is linked to an aging population, with the number of people aged 75 and over increasing by around 19% between 2009 and 2020. This trend is expected to continue. Between 2020 and 2032 across Wales the number of people aged 75 and over is forecast to grow by a further 27%, which could create additional strain on orthopaedic services already struggling to recover.

Exhibit 11: actual spend and real terms spend on orthopaedics vs aging population profile - Aneurin Bevan University Health Board



Source: Audit Wales analysis of Stats Wales - Health programme budget and population mid-year estimates

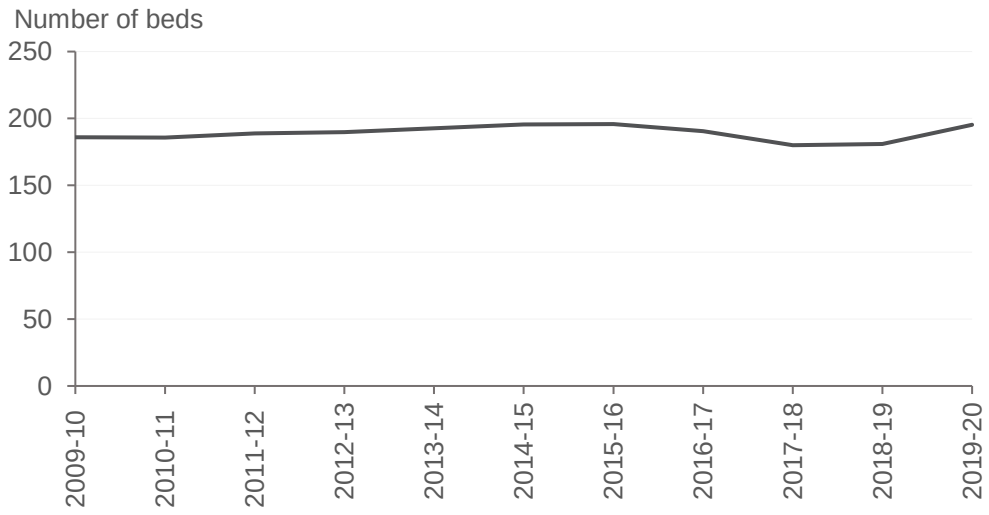
[5] Based on NHS Programme Budget spend for musculoskeletal system problems (excluding trauma)

Suggested board member questions

- If the older population continues to grow, but real terms spend on orthopaedics does not keep pace, can the Health Board ensure that future service models will be sustainable?

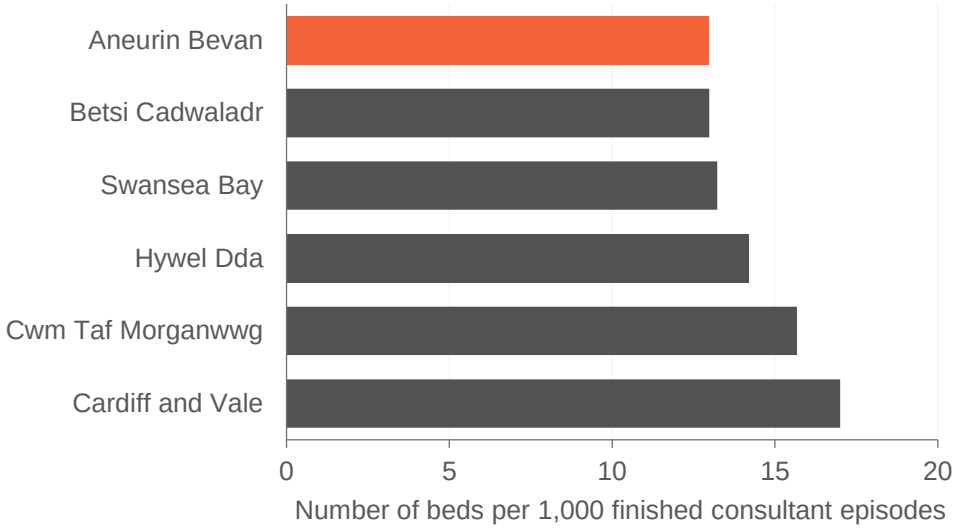
19 **Exhibit 12** and **Exhibit 13** provide trend and comparative data on the number of available orthopaedic beds. The Health Board has the lowest level of beds per 1,000 finished consultant episodes. Given the potential increase in orthopaedic demand due to a growing elderly population, health boards will need to assess whether they can meet demand within existing bed capacity. The extent that efficiencies in bed utilisation can be made and the extent that elective orthopaedic beds can be protected from wider unscheduled care pressures will determine whether current and future demand can be met with the current bed capacity.

Exhibit 12: trauma and orthopaedic bed availability - Aneurin Bevan University Health Board



Source: Audit Wales analysis of Stats Wales

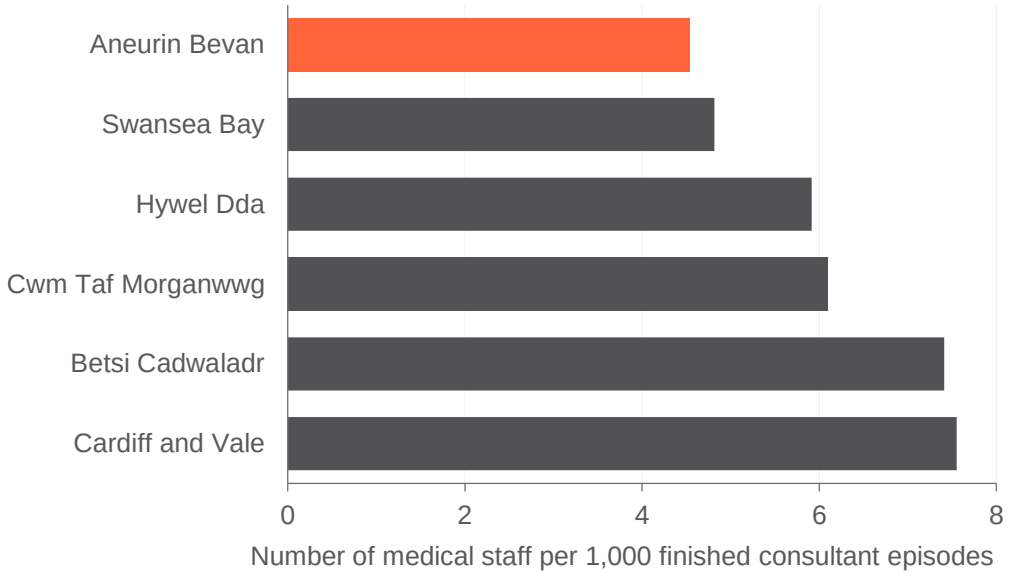
Exhibit 13: comparison of trauma and orthopaedic beds per 1,000 finished consultant episodes 2019-20



Source: Audit Wales analysis of Stats Wales and PEDW data

20 **Exhibit 14** provides a comparative perspective of the medical workforce. The Health Board has the lowest level of medical staff per 1,000 finished consultant episodes. The variation visible across Wales may be due to operational differences in ways of working. However, there is a need to consider optimal staffing levels, efficiencies, productivity, and different pathway models that maximise prudent healthcare principles. As part of this we would expect to see health boards planning on a regional footing to develop high-volume low complexity regional capacity to improve productivity and reviewing consultant job plans as part of pathway redesign.

Exhibit 14: comparison of trauma and orthopaedic medical workforce (WTE) per 1,000 finished consultant episodes 2019-20



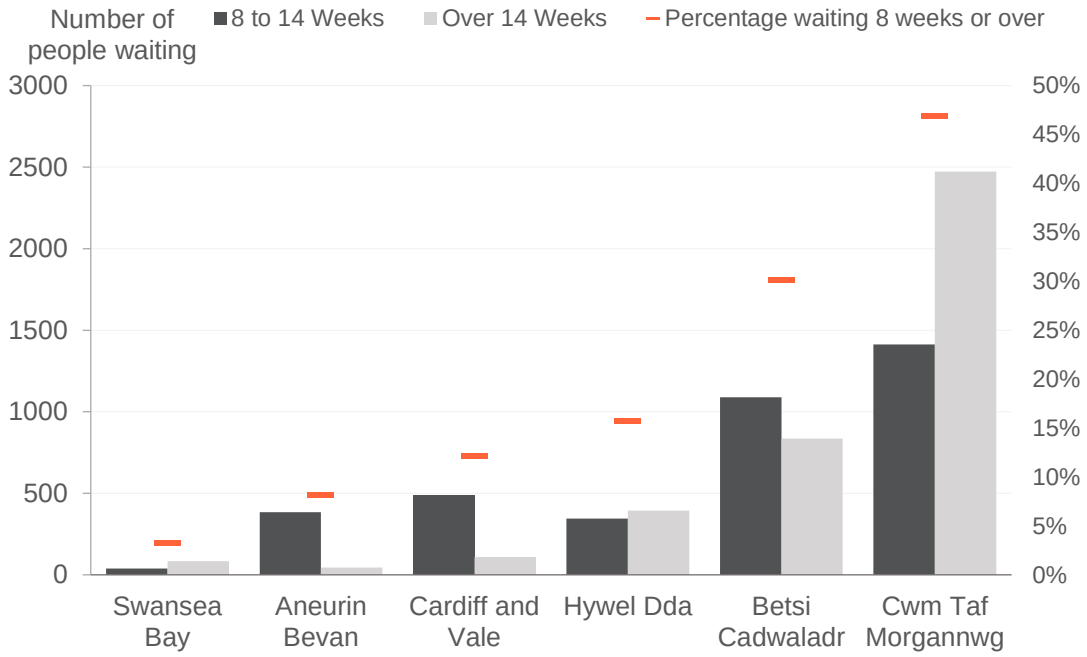
Source: Audit Wales analysis of Stats Wales and PEDW data

Board member questions

- To what extent does the Health Board currently have the capacity to meet orthopaedic service demand? Where are there capacity gaps?
- What are the workforce risks and challenges?
- How is the Health Board working regionally to create high volume low complexity capacity?
- What is the Health Board doing to create greater levels of efficiency in orthopaedic pathways?

21 People with musculoskeletal conditions often need diagnostic tests to provide clarity on the cause and extent of their problems. The Welsh Government targets say that patients should wait no longer than eight weeks for diagnostic tests. The Health Board has comparative low waits for diagnostic tests. Delays in diagnostic tests are likely to impact on the overall timeliness of orthopaedic treatment. At present there is wide variation in the number and proportion of delays in access to radiology services across Wales (**Exhibits 15 and 16**).

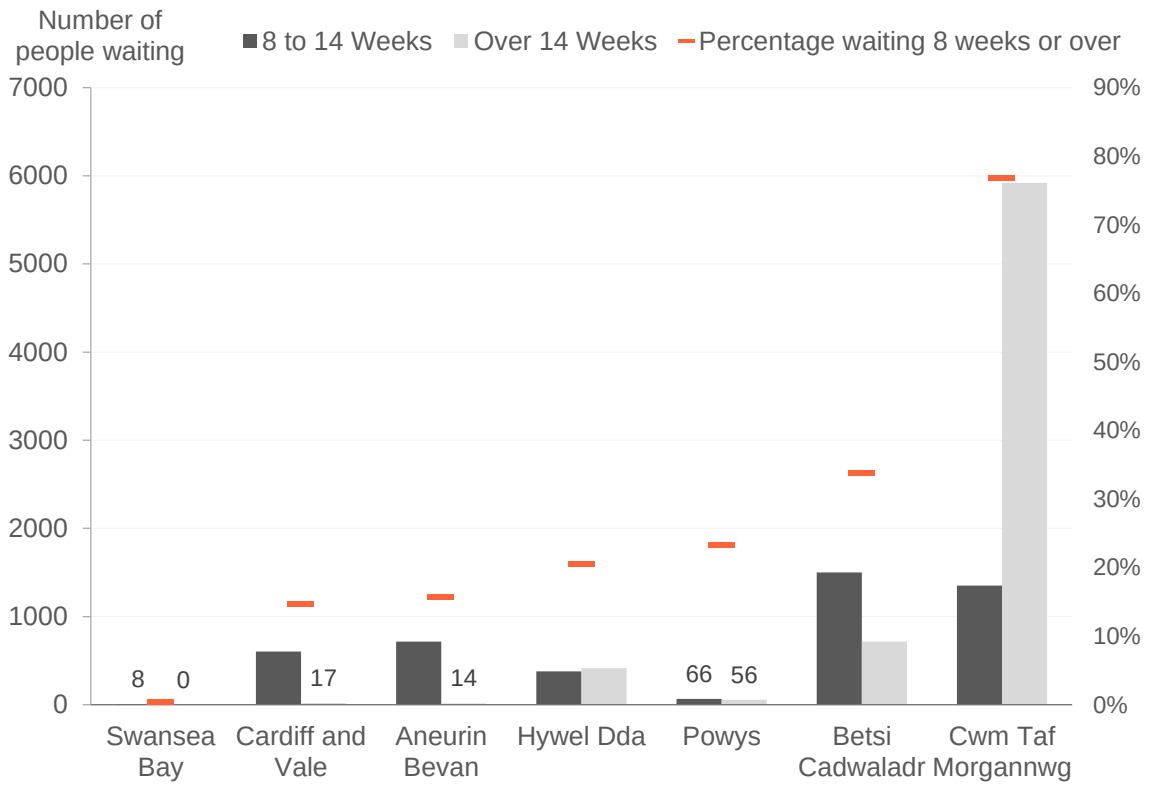
Exhibit 15: number and percentage of waits for consultant referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

Note: Powys consultant referred radiology requests are too low to be visible in the chart.

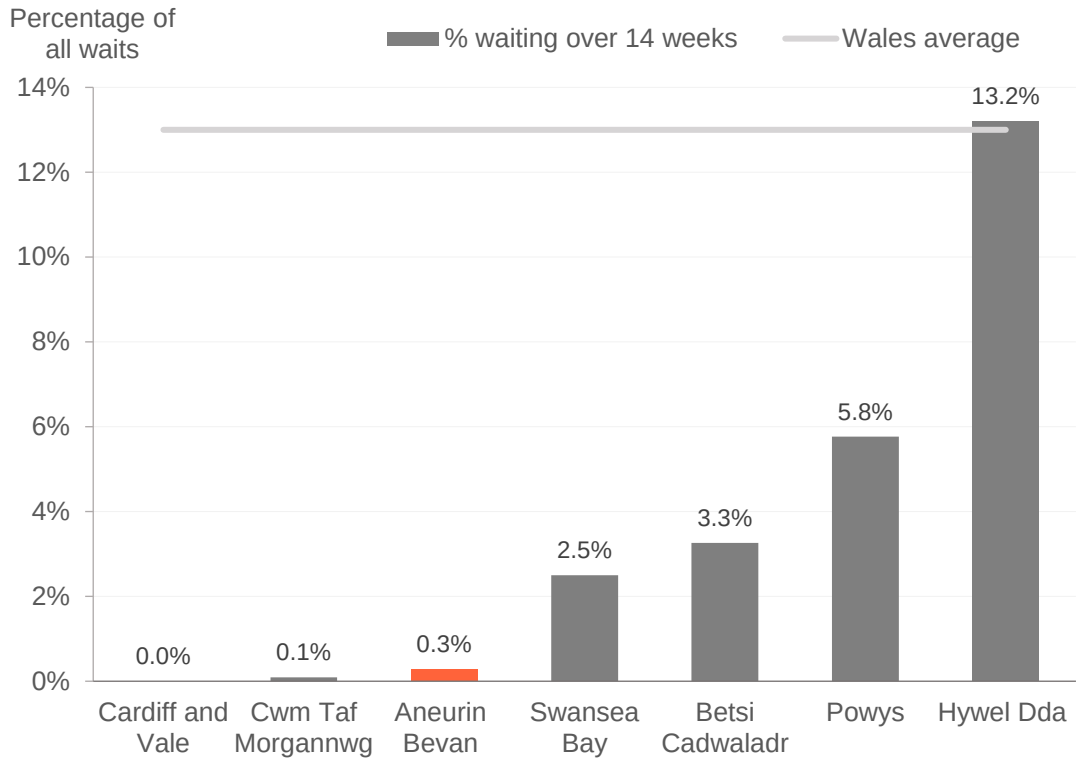
Exhibit 16: number and percentage of waits for GP referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

22 People with musculoskeletal conditions also often require physiotherapy. **Exhibit 17** shows the proportion of people waiting for physiotherapy who are waiting over the Welsh Government target of 14 weeks. The Health Board has very few patients waiting over 14 weeks.

Exhibit 17: percentage of waits over 14 weeks for physiotherapy, November 2022



Source: Audit Wales analysis of Stats Wales

Board member questions

- To what extent is radiology or physiotherapy capacity having an impact on the timeliness of the overall orthopaedic pathway?
- Are there costed plans to match demand and capacity in those areas if required?

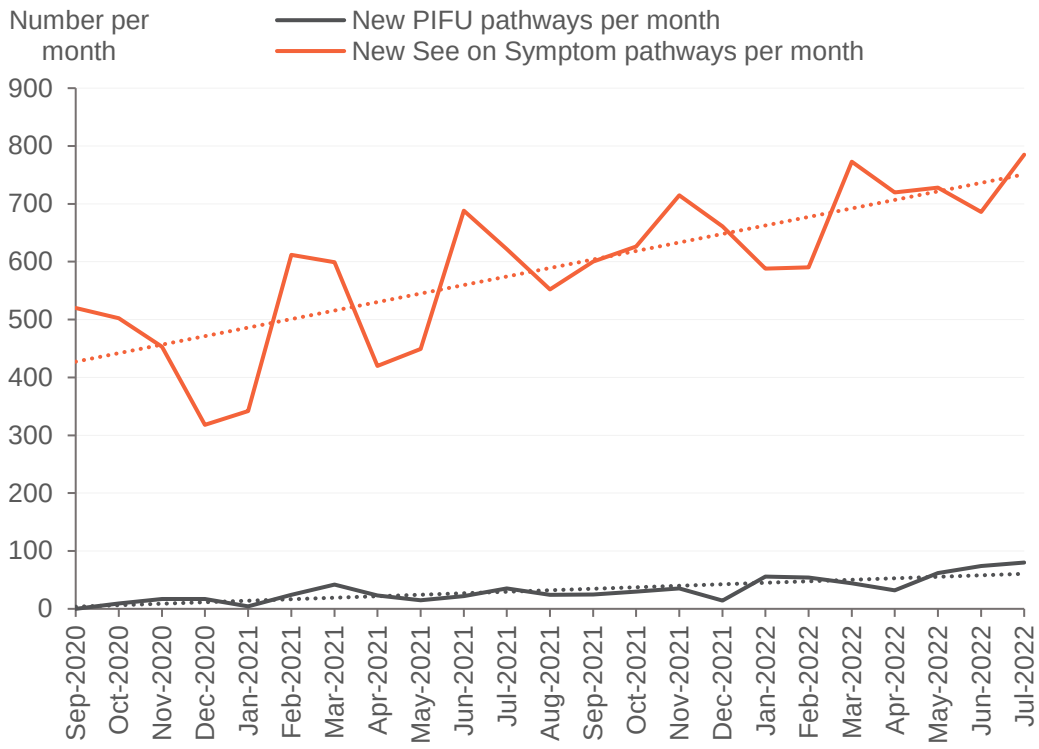
Outpatient models

23 Health boards are implementing new ways of working. The pandemic resulted in a greater extent of 'digitally enabled' working. This helped enable continuation of some services at times where face-to-face appointments were not available. Health boards are also on a journey of implementing new outpatient pathways known as 'see on symptom (SOS)' and 'patient initiated follow up (PIFU).' These approaches are designed to reduce unnecessary follow up outpatient appointments. The aim is

to improve efficiency, reduce unnecessary patient journeys, empower patients to manage their own condition and provide access when they need it.

24 **Exhibit 18 and 19** show the trend in the uptake of new 'see on symptom' and 'patient initiated follow up' pathways. In most health boards in Wales, we are seeing growth in the use of these new pathways but compared to overall numbers of follow up outpatient appointments, these new approaches remain in the minority. For the Health Board, much more progress has been made with implementing SOS pathways when compared with PIFU pathways.

Exhibit 18: trend in adoption of new Patient Initiated Follow Up and See on Symptom pathways per month - Aneurin Bevan University Health Board (September 2020 - July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 19: average number of Patient Initiated Follow Up and See on Symptom pathways per month compared to average number of follow up outpatient appointments (based on 2018-19 activity levels)[6]

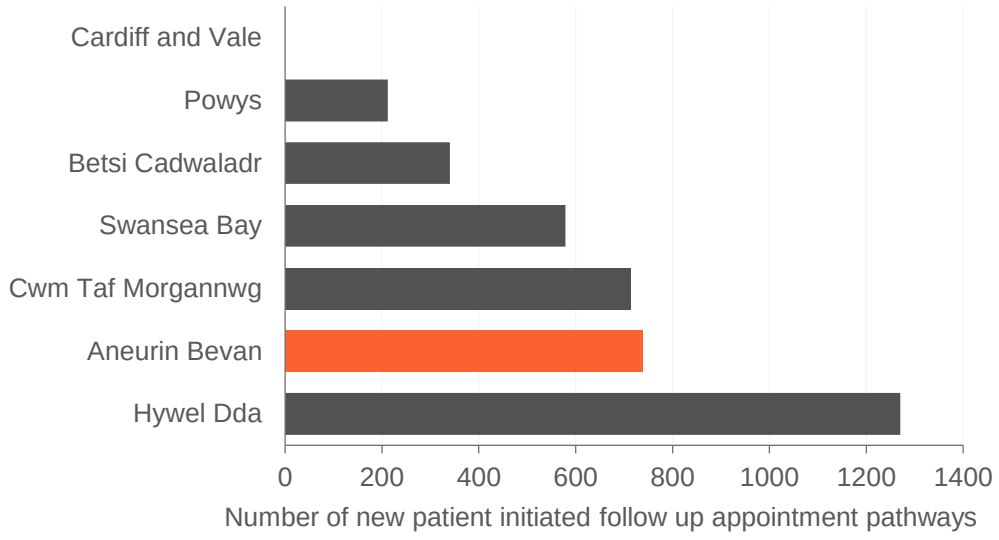
Health Board	Follow up outpatient appointments per month (18/19) average	'Patient Initiated Follow up' pathways per month (21/22)	'See on symptoms' pathways per month (21/22 average)
Abertawe Bro Morgannwg	5283	N/A	N/A
Aneurin Bevan	5840	31	607
Betsi Cadwaladr	4352	15	128
Cardiff and Vale	4317	0	1275
Cwm Taf	2529	N/A	N/A
Cwm Taf Morgannwg	N/A	3	15
Hywel Dda	3428	53	336
Powys	98	11	259
Swansea Bay	N/A	38	507

Source: Audit Wales analysis of Welsh Government provided data

25 **Exhibits 20 and 21** provide a comparison of the numbers of new 'see on symptom' and 'patient initiated follow up' pathways. These are actual numbers and have not been adjusted or weighted for organisational size.

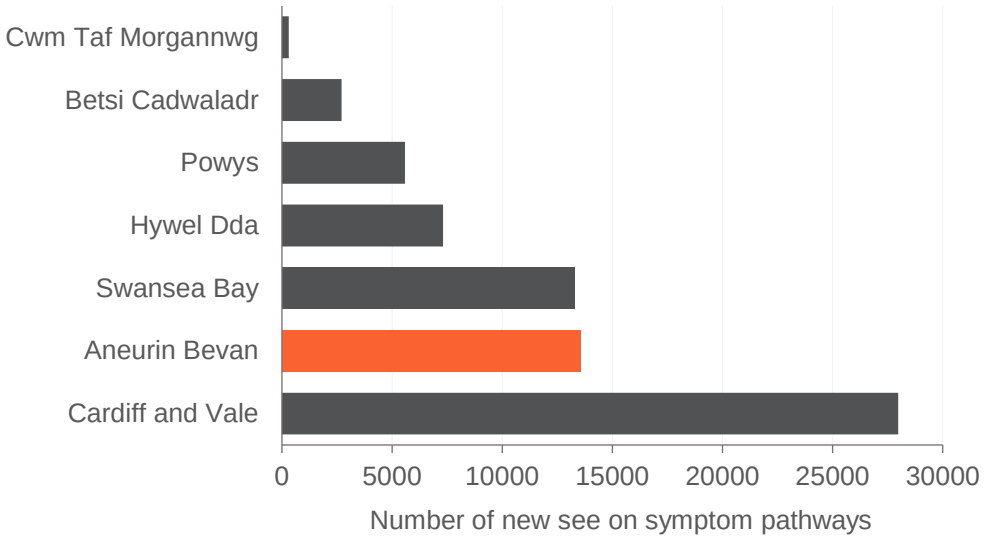
[6] Total follow up outpatient activity levels have not been publicly reported on StatsWales since 2018-19

Exhibit 20: comparison of total new Trauma and Orthopaedic patient initiated follow up appointment pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 21: Comparison of total new Trauma and Orthopaedic See on Symptom Pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Board member questions

- Is the Health Board adopting Patient Initiated Follow Ups and See on Symptoms pathways at sufficient pace? If not, what are the barriers?
- Are consultant job plans being reviewed to adapt to new outpatient models and maximise use of their time?
- To what extent are digital/virtual outpatient appointments being used? Is this delivering a better and more efficient service?

Appendix 1

Scenario modelling

Our scenario modelling in **Exhibit 5** draws on some initial modelling work conducted by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit, was:

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

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 5**). We accounted for the possible pent-up demand (**see Exhibit 8**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario. **Exhibit 22** sets out our modelling assumptions.

Exhibit 22: waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90%	85%
Annual increase in additions 2025 onwards	99%	100%	98%
Latent 'missing' referral demand presenting	5%	10%	0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80%	80%	80%
2023-24	90%	85%	95%
2024-25	100%	95%	105%
2025 onwards	102.5%	100%	105%

Source: Audit Wales

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

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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

Organisational response

Report title: Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Completion date: [21/03/2023]

Document reference: National Report and 3289A2022

Ref[1]	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)
R3	The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and	ABUHB Trauma and Orthopaedic Directorate have been fully supportive of the GIRFT programme since February 2022, receiving commendation for the level of engagement. Following the GIRFT recommendations, the Health Board established the Orthopaedic Steering Group, chaired by the Director or Operations, to oversee progress against an Action and Delivery Plan.	Trauma Review programme completed Q4 23/4 under the ELGH reconfiguration Group Patient Reportable Outcome Measure data collection in place: phased roll out during Q1-Q2 23/24	Assistant Director of Service Redesign Directorate Manager for Trauma and Orthopaedics

Recommendations 1 and 2 relate specifically to the Welsh Government

	ensure that clear action plans are in place to address the things that get in the way of improvement.	78% of actions that are within the Health Boards direct influence have been addressed. In terms of current improvement priorities, the present focus includes sustainable trauma capacity, further improving theatre utilisation and a flagship pilot to establish a short stay hip and knee arthroplasty unit, the first unit in Wales. The Health Board are also fully engaged in regional working, including the Regional Orthopaedic Programme Board.		
R4	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	All orthopaedic sub specialties run Consultant lead multidisciplinary triage with physiotherapy support. The triage process is effective in optimising surgical candidacy and identifying patients more suitable for conservative management, including therapies pathways. The MDT approach reduces risks of patients having delayed access to consultant led care and ensures only patients suitable for surgery progress to the waiting list, supporting appropriate use of outpatient capacity. Historically across Gwent there is evidence of significant variation in the management of MSK on a borough, cluster and even individual practice level. This is indicated via prescribing rates and referral rates for diagnostics and secondary care specialties. The Family & Therapies division will be implementing the community MSK Hub, creating a single point of access for ABUHB MSK services, to improve access to high quality MSK advice & self-management information, reduce unnecessary	Complete	Directorate Manager for Trauma and Orthopaedics

		variation in access and enable self-referral to MSK specialist therapy services		
R5	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	The extent of the recovery challenge, in terms of extended waiting time for patients and the size of the orthopaedic waiting lists, necessitates the use of clinical resources to maximise our capacity to deliver services, particularly to enable access to new outpatient appointments. Concerns from patients about changes to their condition whilst waiting are reported to the Directorate via the Concerns/ Putting Things Right First Time team and addressed accordingly. Or raised via GPs in expedite requests. From 1 May 2023, the Trauma and Orthopaedic Directorate will have access to an on-line app that will support collection of PROMS and PREMS. The app will have a phased roll out by sub specialty. This will be supported by an alternative means of data collection to address digital deprivation. Consultant level reviews of Interventions Not Normally Undertaken data are actioned on a regular basis. From 1 April 2023 the Health Board will be bound to adhere to the Duty of Candour to support reporting of harm where delayed access to treatment has led to added complexity or avoidable harm.	Q2 23/24	Clinical Director for Trauma and Orthopaedics

Page	Board member question	Organisational response

		Please set out here relevant commentary on the planned actions in response to the recommendations
9	Is the Health Board likely to meet the targets set out in the Welsh Government's national recovery plan for planned care? If not, when does it anticipate achieving the key milestones set out in the plan? Does the Health Board have information to indicate whether orthopaedic patients are coming to harm because of delays in their diagnosis and treatment? If so, what does this show and what action is being done to minimise the harm?	Exhibit 5 in the report shows illustrative scenarios of the number of patients on the orthopaedic waiting list in Aneurin Bevan. Currently, recovery of the waiting list is out-performing the 'Optimistic trajectory' presented. Funding to enable additional activity and a focus on supporting new out patients capacity has significantly reduced patient waiting times since September 2022. There are zero patients waiting longer than 52 weeks for their first outpatient appointment for all orthopaedic sub-specialties with the exception of spines. To secure improvements in waiting times for spinal patients, Welsh Government funding has supported additional clinical posts for spinal Specialty Doctors which will lift outpatient capacity by 250%. A detailed programme of work is underway to review the spinal service to ensure the service is sustainable and delivering timely access to care for patients. Achievement of the target for zero two year treatment waits is challenging, particularly for hip and knee and spinal procedures. Success in tackling treatment waiting times is predicated on additional funding to uplift capacity. Without additional funding the waiting list will grows as core capacity for some sub specialities does not match demand. The Duty of Candour will provide the framework to identify and report on patients that have come to harm due to extended waits on the waiting list. Actions to reduce harm are currently focused on maximising capacity to reduce waits for patients.
P11	Has the Health Board undertaken any recent analysis of variation in waiting times by type of surgery and hospital site? If so, what does the analysis show?	Centralised theatre scheduling within Orthopaedics means variation in waiting times by hospital site is primarily driven by the size of the waiting list, and therefore length of wait, for individual consultants; for which there is significant variation. Consultants are planned into specific theatres in particular hospital sites, so the size of their waiting list has a bearing on the length of wait by site. This will be reviewed through 23/24. Patients are prioritised for treatment by urgency then length of wait. Patients awaiting complex inpatient procedures have a longer wait due to higher resource implications compared to day case procedures which typically have higher throughput. To identify inequity and inequality within the Orthopaedic waiting list the Directorate is reviewing referral rates and length of waits by areas of deprivation.

	What action is the Health Board taking to reduce variations in lengths of wait for the same treatment across different hospital sites?	
P12	To what extent is the Health Board seeing, or expecting to see, the latent demand return? If not expected to return, does the Health Board know where the demand has gone? Does the Health Board have a good understanding of the current and future demand for orthopaedic services? Are community-based prevention and treatment approaches such as Clinical Musculoskeletal Assessment and Treatment Services operating effectively, and are there opportunities to exploit community-based services further	The referral rates for orthopaedics have returned to pre-pandemic levels. In addition, referral rates for spinal services have increased by 66% to approx. 500 referral per month. Demand management is a key programme of work, with a review programme coordinated by the Planning Team. The workstream will include reviewing equitable access to fall services across local authority areas and falls prevention initiatives. As well as a review of trauma demand in the short, medium and longer term considering the aging population profile. Health Pathways will be used to drive this forward. The Health Board are launching a community MSK Therapy Hub where patients can self-refer MSK specialist therapy services. . The service will receive patients self-referring for with an MSK concern, having the functionality for onward referral of patients to investigations or other subspecialties as required.
P13	What is the Health Board doing to stem the growth in the numbers of people waiting? To what extent has list validation been the main factor in reducing waiting lists? To what extent are removals because of validation due to administrative issues? If so, what lessons are being learnt?	There are multiple processes in place to help ensure clinical capacity is focused on patients who need it. The Orthopaedic team have a dedicated validation team reviewing waiting lists to remove inappropriate referrals, and identify patients who no longer require treatment. On average they remove 27% (of 3000) pathways they review per month. On breaching 52 weeks for treatment waits patients are automatically sent a validation letter asking them to confirm they wish to remain in the waiting list. Validation helps reduce waste, however, the primary reduction in the outpatient waiting list, that has enabled the service to achieve zero 52 week wait, was due to funding enabling additional capacity targeted at providing new outpatient appointment slots. Further tools to support efficient running of the service include: • a text service to remind patients of their forthcoming appointments; • the use of ‘partial booking’, booking appointments nearer to when they are due reduces the likelihood of short notice cancellations.

	How is the Health Board ensuring the elective orthopaedic capacity is protected from unscheduled care and wider pressures?	The cancellation rate for patients not attending a new outpatient appointment (DNA rate) is 4.5%, far below the average for best in Wales. The booking teams are also responsive, being able to fill short notice cancellations for outpatients and other clinics. Patient Initiated Follow Up (PIFU) and See on Symptom (SOS) pathways have been rolled out across all subspecialties, supporting a reduction in follow up waiting lists. Combined, the effect is a removal for other than treatment rate from the Orthopaedic waiting list of 28%. Executive support and diverse hospital estate ensures ringfenced orthopaedic capacity away from urgent care capacity. The Directorate is relatively richly resourced with dedicated outpatient clinic facilities, dedicated theatre access in five community hospital sites and ring-fenced inpatient beds supporting both high and low complexity patients. Capacity for outpatients and treatments has also been expanded by introducing a wider range of clinical expertise, such as Surgical Care Practitioners (SCP), independent working for Advanced Nurse Practitioner and Extended Scope Practitioners and advanced physiotherapists.
14	Has the Health Board undertaken any analysis to understand whether there is a higher or lower rate of procedures, such as hip and knee replacements, than would be expected for the local population? If so, what does it show and are there opportunities for improving productivity and efficiency? Does the Health Board understand whether the procedures are delivering positive outcomes for patients?	The GIRFT review in February 2022 identified an underreporting of hip and knee replacements. The Directorate has a deep dive session to review the National Joint Registry data following annual publication in November 2023. In relation to productivity and efficiency, the orthopaedic theatres run at 91%, surgeon productivity is reviewed on an individual basis to support minimum number of joints per list. The department also has a dedicated high volume low complexity site which runs 3 theatres sessions per day. All orthopaedic patients will soon have access to an online app. As well as enabling the collection of outcome data the app will support patients with post operative care advice and relevant recovery programmes such as physiotherapy.
18	To what extent does the Health Board currently have the capacity to meet orthopaedic service demand? Where are there capacity gaps? What are the workforce risks and challenges?	Recently completed Demand and Capacity modelling for 2023/24 demonstrates an in-year capacity gap of 4.5k for new outpatient appointments and a gap of 5.7k for treatments. Plans are being costed against achieving the Welsh Government targets. The Health Board primarily focuses HVLC activity in a single site to maximise efficiency. The Directorate are fully engaged in national and regional orthopaedic programmes, which includes considering regional HVLC programmes.

	How is the Health Board working regionally to create high volume low complexity capacity? What is the Health Board doing to create greater levels of efficiency in orthopaedic pathways?	Responses in this report have evidenced efficiency in the orthopaedic pathways including: • maximising day case first opportunists • detailed outpatient modernisation activities (virtual/ PIFU/ SoS/ validation/ partial booking/ low patient cancellation rates) • 91% theatre utilisation • wider variety of clinical roles supporting outpatients and treatments.
	Does the Health Board understand whether the procedures are delivering positive outcomes for patients?	The collection of Patient Reported Outcome Measures will be supported by the roll out of a digital app which will be accessible to all orthopaedic patients. Phased roll our commences May 2023. Non-digital collection process will also be available to account for digital deprivation.
	Is the Health Board adopting Patient Initiated Follow Ups and See on Symptoms pathways at sufficient pace? If not, what are the barriers? Are consultant job plans being reviewed to adapt to new outpatient models and maximise use of their time? To what extent are digital/virtual outpatient appointments being used? Is this delivering a better and more efficient service?	Within Orthopaedics, PIFU and SoS pathways were rolled out by sub speciality, now in place in all orthopaedic pathways. The consultant job plans are efficient with 12 sessions. The majority of orthopaedic activity requires face to face appointments. Due to the size of the clinical body, activity needs to be delivered across multiple sites due to estate constraints. This also supports placed based care. The geographical spread of estate results in a degree of inherent inefficiencies in the model. Utilisation of virtual appointments has been low whilst the focus has been on first out patient appointments, which require face to face appointments.

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To:
NHS Audit Committee Chairs
NHS Directors of Finance
NHS Board Secretaries
The Chair of the NHS Technical Accounting Group
Steve Elliot – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Reference: AC350/3415A2023

Date issued: 1 March 2023

Dear colleague

NHS – Audit of Accounts 2022-23

We are about to commence our accounts audit work for all NHS bodies in Wales and I am conscious that the closure of the 2022-23 NHS financial statements will be challenging to both Audit Wales and the NHS.

In the attached letter, my Executive Director of Audit Services provides some important information on the introduction of a new auditing standard. The new standard fundamentally impacts how we will undertake the 2022-23 audit and has implications for you and your teams. The letter gives more detail on the standard itself and its impact on fees and the 2022-23 audit certification deadline.

I am acutely conscious that the message is a difficult one, with our fee rates increasing and deadlines moving later, at a time when colleagues everywhere in the public service are under great pressure. It is for that reason that I wanted to write to you directly, to explain the drivers behind the changes and to give my assurance that Audit Wales will be doing all it can, in the coming years, to continue to provide high quality audit, delivered efficiently, and that we have a plan to bring deadlines forward. I would like to thank you for your continued communication and engagement, which are so vital if we are to deliver those things.

In respect of the certification deadlines, the introduction of the revised Standard, and a radically different audit approach, has implications for audit timetables and it is inevitable that the new approach will require additional time to implement. I am also conscious that there will be additional challenges for finance teams preparing accounts this year, including the introduction of IFRS 16 – Accounting for Leases and accounting adjustments resulting from the quinquennial valuation of the NHS estate. It is important that finance teams have sufficient time to reflect these changes accurately in draft accounts submitted for audit to ensure a smooth audit process.

Given the circumstances set out above, I feel I have no option but to extend the audit certification deadline to 31 July 2023 to ensure I build in sufficient time to deliver an audit that meets my high standard in terms of audit quality.

That said, it is essential I recover this position in future years. In terms of my proposed certification deadlines in 2023-24 and 2024-25, I have signalled to my colleagues at Audit Wales the importance of recovering the position and a continual and collaborative dialogue with NHS colleagues is crucial.

To help us achieve the proposed certification deadlines set out in the attached letter, my Engagement Director and audit teams will continue to liaise closely with you and your colleagues. Notwithstanding the ongoing dialogue taking place at a local level, I have asked my Executive Director of Audit Services to arrange discussions with key stakeholder groups across the NHS. I hope that this is a helpful update and I wish you all the very best for the forthcoming audit of accounts.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

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[by-email]

Reference: 3415A2023

Date issued: 1 March 2023

To: NHS Directors of Finance
NHS Audit Committee Chairs
NHS Board Secretaries
The Chair of the NHS Technical Accounting Group
Steve Elliot – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Dear colleague

NHS – Audit of Accounts 2022-23

1 We are about to commence our accounts audit work for all NHS bodies. We are therefore taking the opportunity to write to you with some important information on the introduction of a revised auditing standard which fundamentally impacts on how we will undertake your 2022-23 audit.

2 Within this letter we consider:

- the impact of the revised standard;
- the resultant impact on audit fees; and
- the timetable for the Audit of Accounts 2022-23 and for future years.

The impact of ISA 315

3 Our audits of NHS accounts for the year ended 31 March 2023 will be carried out under a revised auditing standard (ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020)).

4 This revised standard is effective for audits of accounts for periods beginning on or after 15 December 2021 and applies to the audit of all private and public sector entities across the UK, regardless of their nature, size or complexity.

5 The revised standard will have significant and far-reaching impacts on how auditors undertake audit risk assessments and our overall audit approach.

6 In planning our audit, we will be required to undertake more detailed and extensive risk assessment procedures to identify risks of material misstatement. The subsequent design and performance of our audit approaches will be responsive to each assessed risk.

7 **Appendix 1** outlines the key changes and the potential impact on your organisation in terms of information requests from our audit teams.

8 The standard has been amended to drive better quality, more effective risk assessments, as well as to promote greater exercise of professional scepticism. It also requires us to obtain a much more robust understanding of an organisation's IT systems. Financial reporting frameworks and governance structures are becoming increasingly complex, while technology continues to play a more advanced role in the control environment of entities. These changes require risk identification and assessment to be enhanced and rigorous audit processes.

9 The previous standard did not address automated tools and techniques, which are increasingly being used by auditors to inform risk assessment. All audits of 2021-22 NHS accounts incorporated elements of our Analytics Assisted Audit. The revised standard introduces specific considerations relating to the auditors' use of automated tools and techniques.

Impact on audit fees

10 As a result of the changes outlined above, we expect 2022-23 audits to take longer to complete. We will also be required to use more experienced CCAB qualified staff on audits to deal with the higher level of judgement necessitated by the standard.

11 In our August 2022 Consultation on Fee Scales, we indicated that our initial assessment of the impact of this richer skill mix on fees was a potential average increase in fee scales for our financial audit work of between 12% and 18%. This is consistent with expectations in other UK public audit bodies and the private sector audit firms.

12 We have now started more detailed risk assessment under the new audit approach and will be able to provide you with an updated assessment of the audit fee once we have completed that initial risk planning. Our initial estimate is

that audit fees will increase by 10.2% for ISA 315, in addition to the 4.8% inflationary increase set out in our Audit Wales 2023-24 Fee Scheme . Your Engagement Director will discuss the proposed fee for your audit once that risk assessment has been completed.

Timetable for the Audit of Accounts 2022-23

13 The introduction of the revised Standard and a radically different audit approach has implications for audit timetables. We have worked closely with the other UK Public Audit Bodies to develop an audit methodology which, we believe, will add value to Audited Bodies whilst continuing to maintain the high-quality audit which we know you expect from us. However, it is inevitable that the new approach will require additional time to implement.

14 We are also conscious that there will be additional challenges for finance teams preparing accounts this year, including the introduction of IFRS 16 – Accounting for Leases and accounting adjustments resulting from the quinquennial valuation of the NHS estate. It is important that finance teams have sufficient time to reflect these changes accurately in draft accounts submitted for audit to ensure a smooth audit process.

15 We will be working closely with NHS finance teams over the next few weeks to agree the precise timings for submission of NHS draft accounts. There will also be logistical matters to consider, such as managing staff annual leave and potentially securing revised Audit Committee, Board and Annual General Meeting (AGM) dates. We are aware that Health Boards and Trusts must hold an AGM no later than 31 July each year as per Standing Orders.

16 From our discussions with Health Bodies, we are aware that a number of you are struggling to recruit experienced finance staff and that this may also impact audit timetables. We are facing similar challenges and know that this position is consistent with the National Audit Office (NAO), Audit Scotland and the Northern Ireland Audit Office. The NAO's recovery plan article is a useful reference in this context[1]. In addition, a more recent report by the National Audit

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[1] The NAO: getting government accounts back on track | ICAEW

[2] Timeliness of local auditor reporting on local government in England

Office (January 2023) highlights how the delays to local government audit opinions are impacting elsewhere in the public sector, including the NHS, and describes plans to get back on track with the timetable for published audit opinions[2].

17 For information, reporting deadlines in England are slightly more complicated, with providers and commissioners having different dates and different requirements around annual reports. The NAO have just published in their opinion for the Department of Health and Social Care Annual Report and Accounts 2021-22 (page 264) that 25% of providers in NHS England and 20% of commissioners failed to meet the Department of Health and Social Care audited accounts deadline in 2021-22.

18 As the auditors of Local Government Bodies in Wales, we have been experiencing similar delays to those seen in England in completing our audit of the 21-22 accounts. These delays result mainly from a technical issue regarding the valuation of Local Government infrastructure assets, which resulted in the Welsh Government deferring the audit certification deadline to 31 January 2023 and have impacted our ability to commence our 2022-23 audits in line with previous year timetables.

19 Taking all of this into account and having discussed with colleagues in Welsh Government responsible for preparing the NHS Consolidated accounts, we are therefore proposing an audit certification deadline of **31 July 2023** for NHS Bodies in Wales.

20 We recognise that this is later than many bodies would like but we believe it is important to set realistic timescales we can all work to. Over the next three years our plan would be to revert to a 15 June deadline as follows:

- Audit of Accounts 2022-23 – certification by 31 July 2023;
- Audit of Accounts 2023-24 – certification by 30 June 2024; and
- Audit of Accounts 2024-25 – certification by 15 June 2025.

21 You will note that by 2024-25, we are not intending to revert to the pre-covid 31 May deadline but will aim to certify accounts by 15 June. This will ensure that the time required for Health Boards and Trusts to circulate the requisite accounts and audit reports to the Audit Committee and the Board, does not compress the audit window to less than a month.

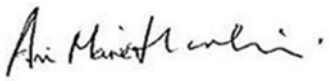
22 In respect of the Charitable Funds audit or the independent examination, we intend to complete these by the deadline set by the Charities Commission.

23 We value the constructive working relationship we have with your finance teams and will continue to work closely with you to bring forward the deadlines for future years.

24 We remain committed to working collaboratively with you to successfully navigate this challenge, building on our shared experiences. We will ensure we attend all the relevant NHS fora to discuss the content of this letter with you and will be arranging meetings with all NHS Directors of Finance and Audit Committee Chairs to provide you with an opportunity to meet with us all.

Thank you to you and your teams for working so well with us.

Yours sincerely



Ann-Marie Harkin
Executive Director Audit Services

Appendix 1 – the key changes to the standard and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.

Key change	Potential impact on your organisation
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

Follow-up of High Priority Recommendations

Final Internal Review Report

March 2023

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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

Acknowledgement

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Disclaimer notice - please note

This review has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The review sought to determine if a sample of high priority recommendations had been implemented or recognised as still outstanding on the Audit Recommendation Tracking Tool.

As each audit was previously assigned an assurance rating, we have not provided an overall assurance rating for this review.

Overview

We reviewed whether any 2021/22 internal audit recommendations scheduled to be completed after October 2021 and any 2022/23 recommendations due for completion before October 2022 had been implemented / recorded onto the Health Board's Audit Recommendation Tracking Tool (the 'Tracker').

The process for updating the Tracker and extending recommendation deadlines is clear.

We have made some suggestions to ensure the Tracker is fully accurate.

Report Classification

		Trend
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.	N/A

1. Introduction

1.1 The review of the high priority recommendations was completed in line with the 2022/23 Internal Audit Plan. The review sought to determine if a sample of high priority recommendations had been implemented appropriately and in a timely manner by Aneurin Bevan University Health Board (the 'Health Board').

1.2 The key risks considered in this review were:

- failure to implement agreed high priority audit recommendations in a timely manner;
- increased financial, clinical, statutory and reputational risk for the Health Board; and
- inaccurate reporting of the Tracker within the Health Board.

1.3 The following limitations of scope are included within this review:

- the scope of this follow-up review will not provide assurance against the full scope and objectives of the original audits. The 'follow-up review opinion' provides a summary status against the level of implementation of the identified actions and outstanding recommendations.

1.4 We assessed the progress of any 2021/22 recommendations due for completion after October 2021 and 2022/23 recommendations scheduled to be completed by October 2022. We did not assess the Tracker itself, but rather whether the sample of high priority recommendations had been implemented.

2. Detailed Review Findings

Objective 1: The level of implementation of the high priority recommendations raised during the 2021/2022 and 2022/2023 financial year that were due to be completed before October 2022

2.1 We reviewed the current position of the seven recommendations due for completion after October 2021 and before October 2022. From the seven high priority recommendations raised previously, we agreed with the current position / tracking of the recommendations, with no further adjustment required.

Conclusion:

2.2 No further action is required.

Objective 2: The completeness and accuracy of the updates provided to the Audit, Risk and Assurance Committee via the Audit Action Tracker (the 'Tracker')

2.3 We tested the completeness of the Tracker and found the Tracker is regularly updated for each Audit, Risk and Assurance Committee. There is evidence that the Head of Corporate Services, Risk and Assurance discusses the position of

each outstanding high action with the relevant Director before each Audit, Risk and Assurance committee, where a status update is provided.

2.4 We did note that there are recommendations within the audit that are noted as outstanding, which is accurate, but have subsequently been superseded through more recent internal audit reports. One example is that of Clinical Audit, which was completed during this audit year (2022/23) and previously as a follow-up review (2018/19).

2.5 We recommend that as part of the periodic review and update that the Health Board considers the removal of superseded recommendations within the Tracker.

Conclusion:

2.6 The Tracker is well maintained; however, there may be further opportunity for the Health Board to remove superseded recommendations.

Objective 3: Where necessary the appropriateness of requested extensions to deadlines for implementation

2.7 The Health Board's Tracker includes a column for a deadline extension. The original recommendation deadline is noted and where an extension is requested and a new deadline is set. Only the Audit, Risk and Assurance committee can approve extension deadlines.

2.8 Where the recommendations sampled required an extension, it was clear when the Health Board should be expecting the action to be completed. We also found that the Tracker is updated regularly and the process regarding the sample is managed well. However, we did identify an exception within our sample, where the high recommendation action raised as part of the Falls Management internal audit was overdue. A status update on the action was provided during November 2022 stating the action was still ongoing, but the due date for the action had not been amended from October 2022. We suspect this requires a simple administrative update to resolve.

2.9 Whilst we focussed on our sample of recommendations from between a specific time period, we did identify 60 (12 high) recommendations on the Tracker that are marked as overdue. It may be that some of these are legacy overlaps with more recent audit recommendations and / or have been superseded. Likewise, the implementation timeframes may need updating to incorporate the impact of the last few years.

Conclusion:

2.10 The extension deadline process for recommendations is clear. However, there may be further scope to refine the Tracker in collaboration with the respective service areas and together with the appropriate approval.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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