Audit Risk and Assurance Committee - Final Accounts

Tue 09 July 2024, 09:30 - 12:00

Microsoft Teams

Agenda

1. Preliminary Matters

Verbal *Chair*

1.0 Audit Risk and Assurance Committee Agenda.pdf (3 pages)

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Draft Minutes of the last meeting held 21 May 2024

Attached *Chair*

1.4 21_05_2024 Draft Audit Risk and Assurance Minutes Chair Approved.pdf (10 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 21_05_2024 Audit Risk Assurance Committee Action Log. Chair Approved.pdf (3 pages)

1.5.1. Job Planning Assurance Note

Attached *Director of Workforce & OD*

To provide assurance for deferment of Action Reference ARAC 2811/3.4

1.5.1 Job Planning Assurance Note July 2024 JMC.pdf (3 pages)

2. Items for Approval/Ratification/Decision

2.1. To Approve the Closing Position of Quarter 1 2024/25 Audit Recommendations

Attached *Director of Corporate Governance*

2.1 Internal_External Audit Recommendations Q1 24_ 25 Cover Report ARAC.pdf (7 pages)
2.1 Appendix 1 Dashboard.pdf (1 pages)
2.1 Appendix 2 Pre updates Pre22 Overdue Recommendations.pdf (4 pages)
2.1 Appendix 3 Pre Updates Post22 Overdue Recommednations.pdf (10 pages)
2.1 Appendix 4 Post Update Overdue Recommendations.pdf (2 pages)
2.1 Appendix 5 Revised Timescale Requests.pdf (6 pages)
2.1 Appendix 6 Completed Recommenations.pdf (7 pages)
2.1 Appendix 7 Not Yet Due.pdf (6 pages)

2.2. To Approve the Audit Recommendations Tracking Procedure

Attached *Director of Corporate Governance*

2.2 Internal and External Audit Recommendations Management Cover Report.pdf (4 pages)
2.2 Appendix A_IA and EA Audit Recommendation Tracking Procedure_Updated June 2024.pdf (10 pages)

2.3. To Approve Changes to the Capital Assets and Charges Financial Control Procedure (FCP)

Attached *Director of Finance and Procurement*

2.3 Financial Control Procedure Cover Report.pdf (4 pages)
2.3 Appendix 1 ABUHB_Finance_0242 Capital Assets and Charges_Final.pdf (18 pages)

3. Items for Discussion

3.1. To Agree the Counter Fraud Functional Standard Return Declaration

Attached *Director of Finance and Procurement*

3.1 ARAC Counter Fraud Functional Standard Returns 23-24.pdf (3 pages)
3.1 Appendix 1 Counter Fraud Functional Return ABUHB 23-24.pdf (23 pages)

3.2. To Receive the Post Payment Verification Annual Report 2023-24

Attached *Post Payment Verification Manager*

3.2 PPV End of Year 23-24 Board and Committee Report.pdf (5 pages)
3.2 Appendix 1 PPV Aneurin Bevan End of Year 2023-2024.pdf (1 pages)

3.3. To Review the Health Boards Annual Report - Draft Final Overview & Performance section (Part 1)

Attached *Director of Corporate Governance / Director of Strategy, Planning and Partnerships*

3.3 Annual Report ARAC Final Accounts Cover Report.pdf (10 pages)
3.3 Final DRAFT Performance Report 2024 v6.1 finance update.pdf (41 pages)

3.4. To Review the Draft Final Accountability Report, Including Annual Governance Statement (Part 2)

Attached *Director of Corporate Governance*

3.4 Final Draft Accountability Report 23.24 v2 post draft submission Audited.pdf (102 pages)

3.5. To Review the Draft Final Accounts and Financial Statements (Part 3)

Attached *Director of Finance and Procurement*

The supporting appendices 3.5.1 - 3.13 are contained within the Technical Appendices Boardbook

3.5 Final 2023-24 Annual Accounts Cover Report.pdf (4 pages)
3.5 Appendix 1 - Adjustments from Draft Accounts Actioned.pdf (2 pages)
3.5 ABUHB 2023-24 Final Annual Accounts with SOAA activated.pdf (76 pages)

3.6. To Receive Audit Wales Audit of Accounts (ISA 260) including Letter of Representation

Attached *Audit Wales*

3.6 4335A2024_Audit of Accounts Report_AB_23-24_final.pdf (26 pages)
3.6.1 ABUHB Letter of Representation 2023-24.pdf (3 pages)

3.7. To Agree a Recommendation to the Board in respect of the Audited Annual Report and Accounts

Verbal *Chair*

3.8. To Receive External Audit Progress Report 2024/25

Attached *Audit Wales*

3.8 Audit Risk and Assurance Committee Update - July 2024.pdf (12 pages)

3.9. To Receive the Audit Wales Community Pharmacy Data Matching Report

Attached *Audit Wales*

3.9 Community_Pharmacy_Data_Matching_Pilot_English.pdf (24 pages)

3.10. To Receive the Head of Internal Audit Opinion

Attached *Head of Internal Audit*

3.10 ABUHB FINAL Opinion Annual Report 23-24 for Committee.pdf (36 pages)

3.10.1. To Receive the Internal Audit Progress Report

Attached *Head of Internal Audit*

3.10.1 ABUHB July 2024 Audit Committee Progress Report.pdf (8 pages)

3.10.2. To Receive the Final Internal Audit Work Plan 2024/25

Attached *Head of Internal Audit*

3.10.2 ABUHB_2024-25_FINAL Internal Audit Plan.pdf (30 pages)

3.11. To Receive Internal Audit Reports

Attached *Head of Internal Audit*

3.11.1. Bevan Health and Wellbeing Centre - Limited Assurance

Attached *Head of Internal Audit*

Supporting - Director of Public Health & Director of Strategy, Planning and Partnerships

3.11.1 ABU Bevan HWBC reissued Final Audit Report.pdf (28 pages)
3.11.1 Appendix 1 Status of Recommendations linked to the Tredegar Health and Wellbeing Centre IA 2022 v2.docx (4 pages)

3.11.2. Regional Partnership Board Financial Controls - Limited Assurance

Attached *Head of Internal Audit*

Supporting - Director of Finance & Procurement

3.11.2 ABUHB 2023-24 ABUHB Financial Controls - RPB - FINAL Internal Audit Report.pdf (22 pages)

3.11.3. Decarbonisation - Limited Assurance

Attached *Head of Internal Audit*

Supporting - Director of Finance & Procurement

3.11.3 AB 23-24 Decarbonisation FINAL Internal Audit Report for Client.pdf (23 pages)

3.11.4. LINC Programme - Reasonable Assurance

Attached *Head of Internal Audit*

3.11.4 ABUHB-2324-26 LINC Programme Internal Audit Report (Final).pdf (12 pages)

3.11.5. Intra-Site Patient - Reasonable Assurance

Attached *Head of Internal Audit*

3.11.5 ABUHB 2023-24 FINAL Intra-site Patient Transfers Audit Report for Client.pdf (14 pages)

3.11.6. Theatres - Stock - Reasonable Assurance

Attached *Head of Internal Audit*

3.11.6 ABUHB 2324-13 Theatre Stocks FINAL Internal Audit Report for Client.pdf (15 pages)

3.11.7. Financial Control Procedures - Substantial Assurance

Attachment *Head of Internal Audit*

3.11.7 32324-02 Financial Controls Final Internal Audit Report for Client.pdf (9 pages)

3.11.8. Flexible Working - Advisory

Attached *Head of Internal Audit*

3.11.8 AB2324-22 Flexible Working Final Advisory Review Report.pdf (12 pages)

3.12. To Receive the Committee Risk and Assurance Report

Attached *Director of Corporate Governance*

3.12 Strategic Risk and Assurance Report Cover Report_July2024.pdf (7 pages)
3.12 Appendix A Strategic Risk Register.pdf (6 pages)
3.12 Appendix B Strategic Risk Dashboard and Risk Assessments.pdf (27 pages)

3.13. Review the Committee Programme of Business

Attached *Director of Corporate Governance*

3.13 ARAC FWP Cover Report.pdf (3 pages)
3.13 ARA_Committee Work Programme 2024-25 Final.pdf (6 pages)

4. Items for Information

Information *Chair*

No Items for Information

5. Other Matters

Verbal *Chair*

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

Verbal *Chair*

5.2. Any Other Urgent Business

Verbal *Chair*

5.3. Date of the Next Meeting

Verbal *Chair*

- Thursday 12 September 2024

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Tuesday 9th July at 09:30 – 12:00**
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 21 May 2024	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
1.5.1	Job Planning Assurance Report linked to Action Log (ARAC 2811/3.4)		
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Approve the Closing Position for Quarter 1 2024/25 Audit Recommendations	Attached	Director of Corporate Governance
2.2	To Approve the Audit Recommendation Tracking Procedure	Attached	Director of Corporate Governance
2.3	To Approve Changes to the Capital Assets and Charges FCP.	Attached	Director of Finance and Procurement
3	**ITEMS FOR DISCUSSION**		
3.1	To Agree the Counter Fraud Functional Standard Return Declaration	Attached	Head of Counter Fraud
3.2	To Receive the Post Payment Verification Annual Report 2023/24	Attached	Post Payment Verification Manager

3.3	To Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	Attached	Director of Strategy, Planning and Partnerships
3.4	To Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	Attached	Director of Corporate Governance
3.5	To Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	Attached	Director of Finance and Procurement
3.6	To Receive the Audit of Accounts (ISA 260) including Letter of Representation	Attached	Audit Wales
3.7	To Agree a Recommendation to the Board in respect of the audited annual report and accounts	Verbal	Chair
3.8	To Receive External Audit Progress Report	Attached	Audit Wales
3.9	To Receive the Audit Wales Community Pharmacy Data Matching Report	Attached	
3.10	To Receive the Annual Head of Internal Audit Opinion	Attached	Head of Internal Audit
3.10.1	To Receive the Internal Audit Progress Report		
3.10.2	To Receive the Final Internal Audit Work Plan 2024/25		
3.11	To Receive Internal Audit Reports	Attached	
3.11.1 – 3.11.3	**LIMITED** • Bevan Health and Wellbeing centre • Regional Partnership Board • Decarbonisation		
3.11.4 – 3.11.6	**REASONABLE** • LINC Programme • Intra-Site Patient • Theatres - Stock		
3.11.7	**SUBSTANTIAL** • Financial Controls		
3.11.8	**ADVISORY** • Flexible Working		
3.12	Receive the Committee Risk & Assurance Report	Attached	Director of Corporate Governance

3.13	Review of Committee Programme of Business	Attached	
4	**ITEMS FOR INFORMATION**		
No items for Information			
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**: • Thursday 12th September 2024 (Agenda setting Tuesday 6th August 2024)		

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

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

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

DATE OF MEETING	Tuesday 21st May 2024
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Independent Member, Committee Chair Richard Clark– Independent Member, Committee Vice Chair Dafydd Vaughan - Independent Member Neil Patrick – Independent Member
IN ATTENDANCE	Rani Dash- Director of Corporate Governance Lucy Windsor – Head of Corporate Risk and Assurance Rob Holcombe - Director of Finance and Procurement Stephen Chaney –Head of Internal Audit Sara Utley – Performance Audit Lead, Audit Wales Michelle Morris – Head of Counter Fraud Mark Ross – Assistant Finance Director Paul Stocker – Senior Auditor, Internal Audit Bryony Codd – Head of Corporate Governance Julie Rees – Finance Audit Manager, Audit Wales Hannah Evans – Director of Strategy, Planning and Partnerships Leanne Lewis – Assistant Director for Quality and Patient Safety *(left at 09:57am)* Danielle Jackson – Secretariat
Apologies	Tracy Daskiewicz – Director of Public Health James Calvert – Medical Director

ARAC 2105/1	**Preliminary Matters**
ARAC 2105/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 2105/1.2	**Apologies for Absence** Apologies were noted.
ARAC 2105/1.3	**Declarations of Interest** There were no declarations of interest raised to record.

ARAC 2105/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 16th of April 2024 were agreed as a true and accurate record.
ARAC 2105/1.5	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions that were not yet due. The Chair asked for a confirmed date for the Job Planning update (2811/3.4) to come back to the Committee and requested that the action log be updated once it was agreed.
ARAC 2105/2	**Items for Discussion**
ARAC 2105/2.1	**To formally approve the recommendations contained in the reports presented at meeting held on the 16th of April 2024.** In lieu of a quorum at the April 2024, meeting, a summary of the reports that had been previously submitted for formal approval were presented to the Committee. - Internal Audit Workplan 2024/25 - Audit, Risk and Assurance Committee Workplan 2024/25 - Three Financial Control Procedures (*Accounts Receivable, Counter Fraud Communication Strategy and Contract Management)* - Q4 Audit Recommendation tracking closing position The Committee **APPROVED** the Internal Audit Workplan 2024/25, the Audit, Risk and Assurance Committee Workplan 2024/25, and the three Financial Control Procedures. The Committee also **NOTED** the Q4 Audit Recommendation Closing Position and **ENDORSED** requested revised timescale requests.
ARAC 2105/2.2	**To Receive the Counter Fraud 2023/24 Annual Report and Approve the Counter Fraud Annual Work Plan 2024/25** Michelle Morris (MM), Head of Counter Fraud, provided the Committee with an overview of the Counter Fraud Annual Report 2023/24 and presented the Counter Fraud Annual Work Plan 2024/25. It was reported that the level of fund recovery had been higher in 2023/24 in comparison to previous years.

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	MM confirmed that the department was in the process of restructuring in order to generate additional resources to manage the increased referrals and concentrate on more proactive tasks, thereby reducing the need for administrative support. Rob Holcombe (RH), Director of Finance and Procurement, informed the Committee that the majority of the work completed was related to salary overpayments, which were often caused by administrative errors. A new process for dealing with salary overpayments and termination was under consideration. One of the benefits of the new process was the anticipated reduction in the counter-fraud team's involvement, allowing them to dedicate more time to addressing more significant fraud issues. The Committee **NOTED** the 2023/24 Annual Report and **APPROVED** the 2024/25 Counter Fraud Annual Workplan.
ARAC 2105/2.3	**To Receive the Clinical Audit Annual Report 2023/24 and Approve the Clinical Audit Plan 2024/25** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of its responsibilities in relation to clinical audit activity, stating that it was responsible for ensuring a robust clinical audit plan was in place, that audit activity was carried out effectively, and that the Patient Quality, Safety, and Outcomes Committee would monitor the outcomes of specific clinical audits and any associated risks. Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety, presented the Clinical Audit Annual Report 2023/24 and Clinical Audit Annual Plan 2024/25. LL informed the Committee that the second annual audit plan for national audits was now available, and that local audits were being recorded and tracked via the Audit Management and Tracking System (AMaT). When asked about the number of completed audits compared with the initial project number, it was confirmed that there was a 100% compliance rate for national clinical audits and approximately 80% compliance rate for national confidential inquiry into patient outcomes and death audits. Efforts to improve compliance were ongoing. Concerns were expressed regarding the limited audit rating for 30% of clinical audits. It was explained that work was underway to align ratings with the new risk management framework, provide appropriate advice, and adhere to the appropriate risk level. Risk training for auditors was also being offered.

	The Committee **NOTED** the 2023/24 Annual Report and **APPROVED** the 2024/25 Clinical Audit Annual Workplan.
ARAC 2105/3	**ITEMS FOR APPROVAL / RATIFICATION / DECISION**
ARAC 2105/3.1	**To Receive the Standards of Behaviour Policy** Rani Dash (RD), Director of Corporate Governance, provided a summary of the revised draft Standards of Behaviour Framework and Policy to the Committee. The revised policy aimed to provide a more robust policy and clearer expectations for reporting declarations of interest, gifts, and hospitality. The policy was scheduled to be presented to the Board for formal approval in July 2024. Neil Patrick (NP), Independent Member, inquired about the policy's scope and whether a set of behaviours could be used to address organisational behaviour issues. RD confirmed that it applied to all employees, including contractors, with specific sections addressing specific staff groups, and that the Health Board had a Values and Behaviours Framework in place. RD advised that the Values and Behaviours Framework would be reviewed and presented to the People and Culture Committee. The Committee **NOTED** the report.
ARAC 2105/3.2	**Review of the Health Boards Annual Report, Overview & Performance section (Part 1)** Rani Dash (RD), Director of Corporate Governance informed the Committee that the Health Board's Annual Accounts would be presented in three sections. The sections were required to be submitted to Welsh Government as a final consolidated document by 15th July 2024. All parts had been circulated to Audit Wales and Welsh Government for review. The final documents would be presented at the next scheduled committee meeting on the 9th of July 2024. Hannah Evans (HE), Executive Director of Strategy, Planning and Partnerships, provided the Committee with an overview of Part 1 of the Health Boards Annual Report, Overview and Performance which focused on the organisation's main objectives, strategies and principal risks for the organisation and linked closely to the Annual Governance Statement (AGS). The Committee expressed its approval of the draft report and raised no concerns regarding its contents. The Committee **NOTED** the report.

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ARAC 2105/3.3	**Review Draft/Final Accountability Report, Including Annual Governance Statement (Part 2)** Rani Dash (RD), Director of Corporate Governance presented the Committee with an overview of Part 2 of the Health Boards Annual Report, Accountability report and Annual Governance Statement, highlighting the report focused on corporate governance, the remuneration and staff report and the Welsh Parliament Accountability and Audit Report. The Committee expressed its approval of the draft report and raised no concerns regarding its contents. Iwan Jones (IJ), Chair, expressed concern about an increase in staff numbers, particularly non-frontline staff, that did not correspond to the current budgetary constraints, and suggested that the report include additional narrative to explain the increase. RD agreed to provide additional analysis and explanation about the changing workforce profile. **ACTION: Director of Corporate Governance.** Rob Holcombe (RH), Director of Finance and Procurement, suggested that the changes could be due to the Covid-19 pandemic, in which agency staff were converted to wholetime equivalents (WTEs), as well as new projects in which administrative staff were now supporting the operation of frontline services. The Committee **NOTED** the report.
ARAC 2105/3.4	**Review Draft/Final Accounts and Financial Statements (Part 3) – To include losses and special payments.** Mark Ross (MR), Assistant Finance Director, presented the Committee with an overview of Part 3 of the Health Board's Annual Report, draft accounts, and final statement noting it covered the draft accounts, final statements, losses, and special payments. The Committee was informed that the public sector payment policy target of 95% was met at 97.4%, as was the Welsh Government's cash target of £4.41 million at the end of the financial year. Details of clinical negligence losses were provided, indicating a steady increase to 1.8 million in 2023/24. It was unclear whether the increase in clinical negligence losses was a one-time occurrence or a continuing trend and that the increase may be

	due to post-COVID claims and would be monitored in the coming year. Iwan Jones (IJ), Committee Chair, inquired whether the recommendations contained in the Infected Blood Inquiry Report would have an impact on the health boards' accounts. Rani Dash (RD), Director of Corporate Governance, confirmed that spending was being monitored, but that no significant impact on the Health Board was anticipated at this time. Rob Holcombe (RH), Director of Finance and Procurement, agreed to work with Audit Wales to assess the potential impact of the Infected Blood Inquiry and ensure consistency in reporting. **ACTION: Director of Finance & Procurement, and Audit Wales.** The Committee expressed its approval of the draft report and raised no concerns regarding its contents. The Committee **NOTED** the report.
ARAC 2105/3.5	**To Review Audit Enquires to those charged with Governance and Management.** Mark Ross (MR), Assistant Finance Director, gave the Committee a summary of the report, stating that Audit Wales receives the annual return in order to provide auditors with information about the Health Board and its business activities, which aids in the examination of the financial statements. The committed **NOTED** the report.
ARAC 2105/3.6	**To Receive the Internal Audit Progress Report – To include Head of Internal Audit Opinion and Annual Report 2023/24** Stephen Chaney (SC), Head of Internal Audit, provided a summary of the Internal Audit Progress Report to the Committee. The Committee was informed that the Final Head of Internal Audit Opinion Annual Report 2023/24 is expected to receive a rating of reasonable assurance. The final document is expected to be received at the Committee's next scheduled meeting in July 2024. The Committee **NOTED** the Report
ARAC 2105/3.7	**To Receive Internal Audit Reports** Stephen Chaney (SC) - Head of Internal Audit, provided the Committee with an overview of the following four reports.

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Bevan Health and Wellbeing Centre – Limited Assurance
The Committee was informed that the audit sought to review the delivery and management arrangements in place to progress the Bevan Health and Wellbeing Centre. It was noted that this was the third review completed, with the first providing a reasonable assurance rating and the second and third resulting in a limited assurance rating.

Paul Stocker (PS), Auditor, Internal Audit summarised the main areas raised within the report. These included significant delays in project delivery and a forecasted budget that exceeded by 4.2%.

Hannah Evans (HE), Director of Strategy, planning and partnerships, reassured the Committee that the Health Board was aware of the issues identified and work was ongoing to resolve them. A Chairs Action meeting had been held to discuss and resolve outstanding disputes. The financial risks and their implications for the discretionary capital programme were being managed. Communication with Welsh Government remained ongoing, and a comprehensive bid would be submitted once outstanding disputes were resolved.

Iwan Jones (IJ), Chair raised concerns about the management responses to the recommendations raised as well as a lack of specific completion dates.

The Committee requested that the audit be reviewed, and management responses be updated to reflect progress made/planned and presented back to the committee at its next scheduled meeting in July 2024.
ACTION: Head of Internal Audit / Director of Public Health & Director of Strategy, Planning and Partnerships
ACTION: Secretariat

Rani Dash (RD), Director of Corporate Governance informed the Committee that work was underway to develop a clear process for the handling of management responses and audits to ensure quality assurance and robust sign off process. The process would be presented to the Committee for approval at its meeting in July 2024.
ACTION: Director of Corporate Governance
ACTION: Secretariat

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	Medical Equipment & Devices (Ultrasound) – Reasonable Assurance The audit sought to provide an opinion over the management and tracking of ultrasound devices throughout the Health Board. It was reported that asset management and the use of RFID tagging devices improved medical equipment management and tracking. A more detailed review of medical equipment and devices was scheduled in the 2024/25 Internal Audit Plan. **Maternity Services (Action Plan) – Reasonable Assurance** The audit sought to review the governance arrangements in place and examine the tracking and progress of maternity related actions from key external reviews; a more in-depth review of the Maternity Services Action plan was scheduled in the 2024/25 Internal Audit Plan. **Early Supported Discharge (Stroke) – Substantial Assurance** The audit sought to assess whether the arrangements in place for the early supported discharge of stoke patients are operating effectively. Iwan Jones (IJ), Chair, queried whether the management considerations outlined in the report would be implemented and monitored in line with the current process. SC advised that management considerations were suggested improvements, but they were not formal recommendations. IJ inquired about the practicalities of tracking management considerations for audit purposes and would discuss with the Director of Corporate Governance outside of the meeting. **ACTION: Committee Chair** The Committee **NOTED** the audit reports for assurance.
ARAC 2105/3.8	**To Receive the External Audit Work Plan 2024/25** Julie Rees (JR) and Sara Utley (SU), Audit Wales, presented the Committee with a summary of the 2024/25 External Audit work plan. It was reported that that following receipt of the draft account's materiality will increase to £19.4 million from £17.8 million and that there were six areas of focus of the Financial Statements Audit, listed below: - • Management Override, • Financial Duty,

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	• Losses and Special Payments Register, • Related Parties and Senior Officer Remuneration, • Asset verification, and; • Provisions and contingent liabilities JR advised that the review of Monnow Vale Hospital Pool Budget had not been confirmed but noted if this were to be included an extra fee would be charged for the work. SU informed the Committee that the performance audits for 2024 would encompass the following four areas: • Annual Structured Assessment • Structured Assessment – Deep dive of Digital systems • All Wales thematic review of urgent and emergency care • Review of the Health Boards Eye Care Services Dafydd Vaughn (DV), Independent Member, queried the plan to revisit the structured assessment of digital systems. Sara Utley (SU), Audit Wales, stated that the focus would be on the Health Board's digital systems, but the review into national programmes with DHCW was ongoing, and the completed report would be shared with the committee. Neil Patrick (NP), Independent member, questioned when the digital systems audit would be completed. SU confirmed that the audit was in the scoping stage and could not provide a specific timeline at this time but agreed to investigate the projected timeline and share findings with members. **ACTION: Performance Audit Lead, AUDIT WALES** Rob Holcombe (RH), Director of Finance and Procurement, inquired about the timeline for reporting on the efficiency review. SU confirmed that the report was in draft and would be available for presentation at the next audit committee meeting in July 2024. The committee **NOTED** the report
ARAC 2105/3.9	**To Receive External Audit Progress Report 2023/24** Sara Utley (SA), Audit Wales, Presented the committee with an overview of the 2024/25 External Audit progress report. The committee **NOTED** the report.
ARAC 2105/4	**Items for Information**
ARAC 2105/4.1	**To Receive Primary Care Follow-up Report - following amendments to recommendation status**

	The Committee was informed that the report had been reviewed and that the recommendation status and completion dates had been updated. However, it was noted that the changes to the completion date/management responses had not been incorporated into the main body of the report. The Committee requested that the report be reviewed and edited to ensure consistency throughout, and then republished. **ACTION: Performance Audit Lead, Audit Wales.**
ARAC 2811/5	**Other Matters**
ARAC 2811/5.1	**Items to be Brought to the Attention of the Board and Other Committees**
ARAC 2811/5.2	**Any Other Urgent Business** No items for any other business.
ARAC 2811/5.3	**Date of the next meeting;** • Tuesday 9th July 2024 (Final Accounts)

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
November 2023	**ARAC 2811/3.4** Job Planning Arrangements	Following full implementation of the job planning process an update report is to be received at a future meeting to provide assurance that all audit recommendations have been implemented.	Medical Director Secretariat	09 July 2024	**Outstanding.** The Medical Director has requested that the update report be postponed until the November meeting, following the submission of a comprehensive update report to the People & Culture Committee (delegated Committee) in October. In the interim, an Assurance Note (agenda item 1.5.1) has been issued to the Committee to provide assurance regarding progress.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
April 2024	**ARAC 1604/3.3** Review Internal and External Audit Recommendations Tracker	Explore ways to include data of requested timescale extension requests within future reports.	Head of Risk and Assurance	09 July 2024	**Completed.** The supporting appendices now show how many times a deadline has been requested and approved by the Committee.
May 2024	**ARAC 2105/ 3.3** Annual Report Part 2	Add further analysis and explanation into the remuneration and staff report in relation to the changing workforce profile.	Director of Corporate Governance	09 July 2024	**Completed.** Included in the final report
May 2024	**ARAC 2105/3.4** Annual Report Part 3, Final Accounts and Financial Statements	Look into potential financial impact for Health Boards in relation to the Infected Blood Inquiry.	Director of Finance and Procurement / Audit Wales	09 July 2024	**In progress.** Further exploration of this is required. A verbal update will be provided at the Committee Meeting.
May 2024	**ARAC 2105/3.7** Internal Audit Reports – Bevan Health and Wellbeing Centre	Review and update management responses to reflect progress/action plans and present final report back to the committee following amendments.	Head of Internal Audit / Secretariat	09 July 2024	**Completed.** The revised final report is on the agenda.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
May 2024	**ARAC 2105/3.7** Internal Audit Reports	Provide the Committee with the revised process for the handling of management responses and audits to ensure quality assurance and robust sign off process.	Director of Corporate Governance	09 July 2024	**Completed.** The process is on the agenda for approval.
May 2024	**ARAC 2105/3.8** External Audit Workplan 2024/25	Provide a briefing note to the Committee outlining the timeline for the planned digital systems audit.	Audit Wales	09 July 2024	**Completed.** This will form part of the 2025 work plan and will be undertaken toward the end of the year.
May 2024	**ARAC 2105/4.1** Primary Care Follow Up Report	Review, edit and republish the final Report.	Audit Wales	09 July 2024	**Completed.** The report has been amended and republished.

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.

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Deferred Item	Job Planning Progress Update
Date scheduled on Action Log	Quarter 2 – 09 July 2024
Proposed Date for deferment	Quarter 3 – 12 November 2024
Executive Lead	Dr James Calvert, Medical Director
Reporting to:	Audit, Risk & Assurance (ARA) Committee

Summary

This assurance note provides an interim update on the implementation of Consultant Job Planning in the following areas:

- Implementation of a new Health Board Job Planning Procedure
- Implementation and roll-out of an electronic job planning system.

At the ARA Committee meeting in November 2023 an update on Job Planning was received. A request was made to postpone a further update until the second quarter (Q2) of the financial year 2024/25, recognising that the systems would not be fully implemented until the end of June 2024. The Committee agreed to defer this on the basis that the update focus on the status of implementation and, if not on track, what the barriers to implementation were, with a more detailed report presented to the Committee in quarter three (Q3) 2024/25, accompanied by data to demonstrate improvement.

Implementation of a new Health Board Job Planning Procedure

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

Engagement

In order to develop the procedure, considerable engagement with the LNC and Medical Leaders was undertaken. Engagement with the BMA/LNC has been positive and helpful. Although there were some aspects which the BMA/LNC were still seeking clarification on the Heath Board launched the new procedure and associated documents on 18th August 2023 as it did not believe these areas were significant enough to delay implementation. Engagement with the LNC to work through these issues has continued. Any agreed amendments will be incorporated into the review

of the procedure scheduled to be undertaken at the end of August 2024 one year post the launch. Following this the procedure will be reviewed three yearly in line with other Health Board polices and procedures.

Job Planning Consistency Group

A Job Planning Consistency Group was established to allow issues with implementation to be resolved quickly. The Chair of this meeting which is held monthly is the Deputy Medical Director.

This group has recently commissioned a review of the definitions and expected outcomes for educational and clinical supervisors to provide further clarity for CDs and DDs as they undertake job planning. Any changes will be incorporated when the procedure is reviewed in August.

Job Planning Compliance

As of 31st May 2024 consultant job planning compliance is 21% across the Health Board.

In addition to those consultants with an in-date job plan there are 23 ie 4.4% within the system simply awaiting final sign off and 240 i.e. 45% job plans in progress within the system.

The delay in reaching significant improvement with compliance is in part due to some unexpected complexities in implementing the system and ensuring compliance with the Health Board's Job Planning procedure. These are highlighted below.

Electronic Job Planning system

The L2P job planning system has been configured to the Amendment to the Consultant Contract (Wales (2003)) and the Health Board's Job Planning Procedure. Training sessions on the system continue to be delivered.

Implementation and Rollout

The contract for the Health Board's E-job planning system was awarded to L2P on 4th September 2023 and implementation of the e-Job Planning system commenced on 22 January 2024. This "go live" date was amended due to Industrial Action by Junior Doctors and this has also contributed to a delay in the overall anticipated timeline for completion of the roll out. This has consequently also impacted on job planning compliance.

Issues contributing to low compliance and means of addressing:

- More time than originally anticipated has been required by both the Medical E-system team and the directorate teams to work through specialty specific requirements and ensure that these are accommodated within the system whilst still adhering to the agreed Job Planning procedure. For example, on call templates vary, such that L2P and the E-Systems team have needed to work with the directorates to build these into the system, as this will enable more efficient inputting and more accurate sessional calculations going forward.
- The initial plan was to role out e-job planning before e-rostering. Pilot work in Family &Therapies Division highlighted that simultaneous roll out of both systems permitted transparency in the job plan and measurement of delivery against the

agreed plan. It was therefore decided to implement job planning and e-rostering in each directorate. This lengthens implementation time but will ultimately benefit the organisation by providing the tools to ensure delivery of agreed job plans by the medical workforce.

- Divisional Directors are currently working with the e-system team to map out a trajectory for achieving 85% compliance with job planning based on experience so far with implementing the system. Once the revised trajectory has been agreed with operational divisions progress will be reviewed and reported on at the monthly E-system Programme Board meetings.
- Currently there are a number of complex job planning queries being worked through with specialist advice.
- Historically paper job plans provided less detail than required by the new system. This detail once captured will ensure granularity of reporting; support the implementation of the e-rostering system and assist in demand capacity planning. The e-systems team is working with the directorates to assist them in inputting this detail in the system. The identification of admin staff within the directorates nominated to assist in obtaining the required information is anticipated to improve the situation.
- The support from the central team is being prioritised to those areas first on the rostering implementation plan to reduce delays from a rostering implementation perspective.

Good Practice and positive feedback

- In rolling out the L2P system the inconsistencies in job planning across the Health Board have become apparent. These are being worked through in accordance with the Amendment to the Consultant Contract (Wales (2003)) and the Health Boards' Job Planning Procedure.
- In Divisions where job planning has been undertaken on the system there has been positive feedback on how the system has helped with capacity and demand planning. The data the divisions can access has been perceived as helpful to day-to-day service delivery.
- The functionality within the system which enables a variety of complex working patterns to be accommodated has been commended.
- Although significant time is required to input the initial job plan into the system the benefits for future job planning are evident within many departments. Once all job plans are on the system work required to maintain them will be significantly less.

Summary

Achievement of 85% compliance with Consultant job planning has been delayed for the reasons described above. However, the time spent in working through these issues will ensure that the job planning process and completion within the L2P system is robust and efficient, and there is consistency in job plans in line with the Health board's Job planning procedure. Once fully implemented future rounds of job planning will be easier; improving both compliance and quality of the resulting job plan.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk and Assurance Committee (the Committee) with an overview of all identified internal and external audit recommendations and current implementation status as at the end of Quarter 1 (Q1) 2024/25 (March – June) reporting period.

The paper also seeks to provide an update on recommendations that have progressed since the previous reporting period, where a revised deadline has been proposed, recommendations that remain outstanding, and an overview of management action plans that have now been completed in their entirety.

Cefndir / Background

Following the previous report to the Committee on 16 April 2024, which included an update on overdue recommendations up to the end of March 2024, the Audit Tracker has been updated with revised deadlines for the **61** approved recommendations, as well as the transfer of **50** completed recommendations from the Live Tracker.

In addition, all internal and external audit recommendations received at the last Committee meeting have been recorded in the database for tracking and reporting.

The Dashboard **(Appendix 1)** provides an overview of all live recommendations recorded in the Tracker.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking

Following the previous reporting period, which ended on 31 March 2024, **five** recommendations remained **overdue** (passed the original/revised implementation date).

In Q1 2024/25 (April – June), an additional **104** recommendations were triggered as **overdue**. As a result, **109** updates were requested.

Table 1 provides the Committee with a breakdown of the **109** recommendations that required an update by the Lead Director (abbreviations contained in Further Information).

Table 1

Overview of Recommendations Requiring Updates for Q1 Reporting Period										
Lead Director	**COO**	**Dof CG**	**DofD**	**Dof F&P**	**DofN**	**Dof SP&P**	**Dof W&OD**	**MD**	**Dof T&HS**	**Total**
Total recommendations requiring an update	**35**	**18**	**24**	**3**	**13**	**8**	**5**	**1**	**2**	**109**

The position reported in Table 2 reflects the position following updates received from Lead Directors against their overdue recommendations for which the Committee is asked to approve **42** revised deadlines and **59** completed recommendations.

Table 2

Overview of Recommendations Following Updates for Q1 Reporting Period										
Lead Director	**COO**	**Dof CG**	**DofD**	**Dof F&P**	**DofN**	**Dof SP&P**	**Dof W&OD**	**MD**	**Dof T&HS**	**Total**
Revised Deadline	**4**	**8**	**16**	**2**	**6**	**2**	**2**	**-**	**2**	**42**
Completed	**26**	**10**	**8**	**1**	**5**	**5**	**3**	**1**	**-**	**59**
Residual Overdue against Deadline	**5**	**-**	**-**	**-**	**2**	**1**	**-**	**-**	**-**	**8**
Reconciliation with requested updates	**35**	**18**	**24**	**3**	**13**	**8**	**5**	**1**	**2**	**109**

To reassure the Committee that the longstanding (pre-2022) recommendations are being addressed, the **109** overdue recommendations have been separated into two tables: longstanding (pre-2022) and current (2022–present), as represented in Tables 3 and 4. This will enable the Committee to triangulate the data across the subsequent tables and note the progress being made to complete all long-standing recommendations. Further information is available in **Appendices 2 and 3**, respectively.

Table 3

All Longstanding (pre-2022) Overdue Recommendations as at 30 June					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	**-**	**-**	**2**	**-**	**2**
2019	**-**	**-**	**4**	**3**	**7**
2020	**-**	**-**	**-**	**4**	**4**
2021	**3**	**15**	**-**	**-**	**18**
Total	**3**	**15**	**6**	**7**	**31**

Table 4

All Overdue Recommendations from 2022 and 2023 Audit years as at 30 June					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2022	**6**	**21**	**8**	**1**	**36**
2023	**6**	**16**	**18**	**2**	**44**
Total	**12**	**37**	**26**	**3**	**78**

The information in Tables 5 – 6 provides a breakdown of the **109 overdue** recommendations following updates, of which, **42** have been assigned a revised timescale for implementation for approval by the Committee and **59** have been completed.

If the Committee approves the **42** revised deadlines the residual overdue position will be **eight** recommendations across the reports detailed below. **Appendix 4** contains further details for the remaining **eight** overdue recommendations.

Audit Year and Title	Overdue Recommendations
2021 - IT System Controls (WRIS)	**3**
2022 - Discharge Planning	**1**
2023 - Facilities (Stock Management & Bank Processes)	**1**
2023 – Estates Condition	**1** / **1**
2023 – Unified Breast Unit YYF	**1**

Table 5 provides a breakdown of the **42** recommendations that necessitate additional time to implement the actions outlined in the management response, by audit year and priority rating. **Appendix 5** contains further information, including the proposed revised implementation dates.

Table 5

Overview of Recommendations with Proposed New Implementation Dates					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	-	-	2	-	2
2020	-	-	-	4	4
2021	1	3	-	1	5
2022	5	9	2	1	17
2023	1	5	8	-	14
Total	7	17	12	6	42

Table 6 provides a breakdown of the **59 completed** recommendations by audit year and priority rating. Further detail can be found at **Appendix 6**

Table 6

COMPLETED Internal and External Audit Recommendations					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2019	-	-	4	-	4
2021	2	9	-	2	13
2022	1	12	5	-	18
2023	5	8	9	2	22
Total	8	29	18	4	59

Appendix 7 contains all 'Not Yet Due' recommendations as of the end of Q1 2024/25, as they are still within their initial or revised timeframes for implementation.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **NOTE** the position in respect of **8** overdue audit recommendations.
- **NOTE** the position in respect of **59** complete audit recommendations.
- **APPROVE** the revised timescales for the **42** Recommendations.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

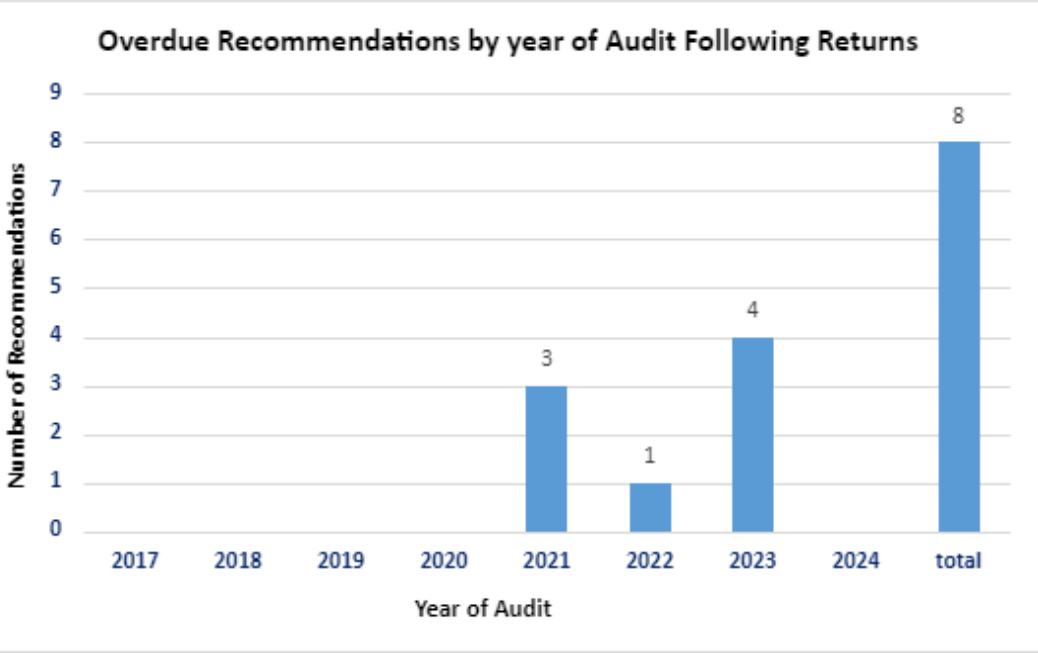
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

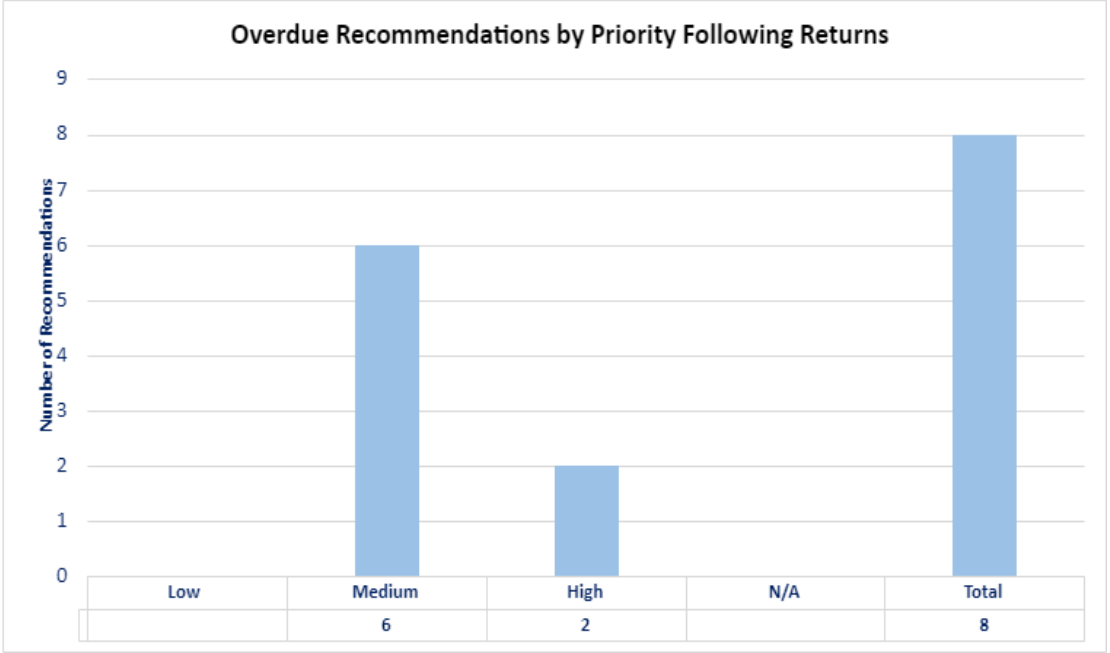
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	COO – Chief Operating Officer DofF&P – Director of Finance & Procurement DofCG – Director of Corporate Governance DofD – Director of Digital DofN – Director of Nursing DofSP&P – Director of Strategy, Planning & Partnerships DofW&OD - Director of Workforce & Organisational Development MD - Medical Director DofT&HS – Director of Therapies & Health Science
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

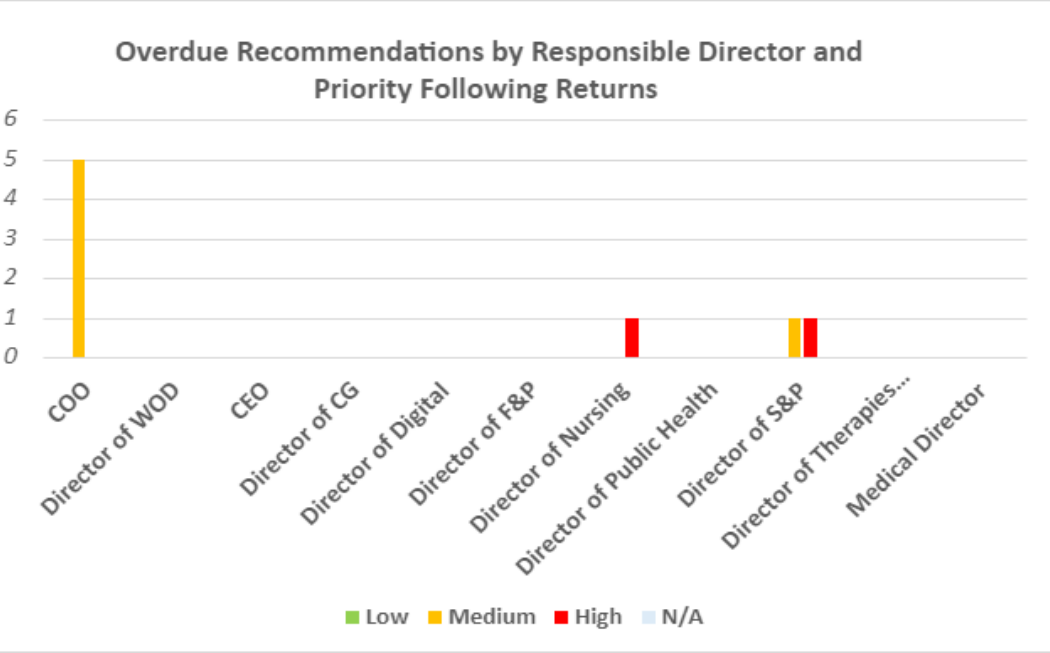
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper

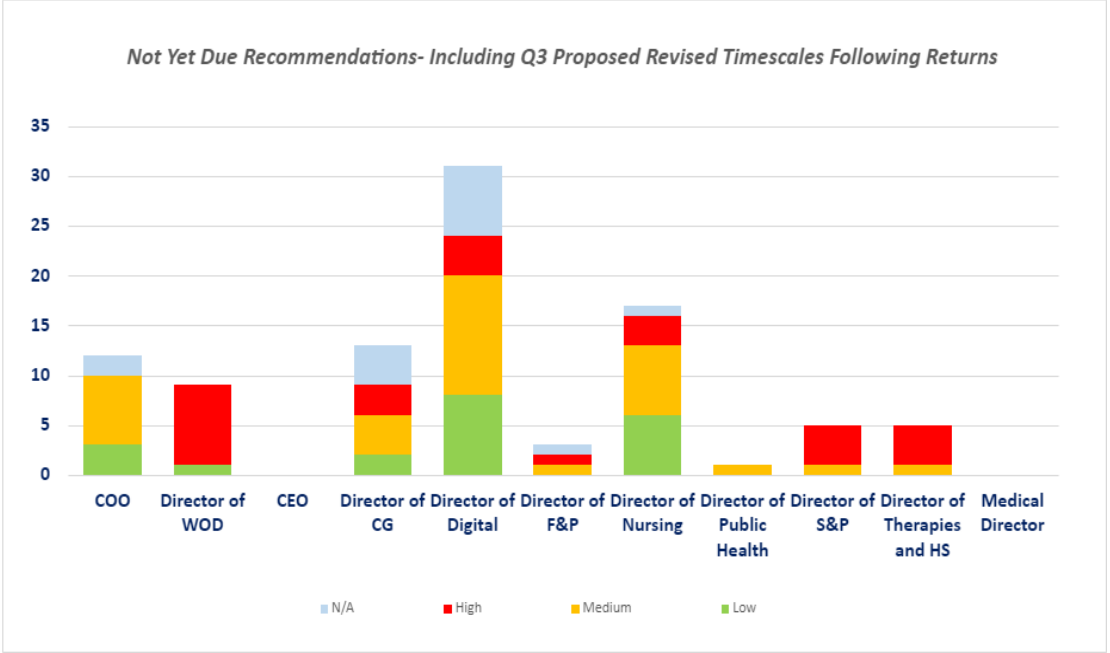
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice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

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









Overdue Recommednations by Priority	Low	Medium	High	N/A	Total
	0	5	2	0	8

Not Yet Due Recommendations by Priority	Low	Medium	High	N/A	Total
	20	34	27	15	96

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by AAAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	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	-74.85	30/04/2024	-2.00	16/04/2024	Overdue	Overdue	3		March 2024: The Health Board is compliant with the parts of the recommendation that, (a) registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details, (b) that the register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed, (d) discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded, and (e) going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues. The Health Board is currently partially compliant concerning the part of the recommendation that (c) each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. "A centrally managed industry standard pan-organisation medical equipment register (Softpro Medusa) is in place and operational. The database records medical equipment management information on each item of equipment, including the location where each item is deployed. Reports can be produced filtered by ward/ department though the on-line Customer Portal. Ward and departmental managers can access a list of equipment in the register that is allocated to their work area from the centralked register via an on-line Customer Portal. The database is overseen by the Health Board's Medical Electronics and Bio-medical Engineering (EMBE) service. There is a programme of periodic register accuracy reviews and of auditing the review processes. The register captures equipment lifecycle stage events and changes to the departments to which particular equipment is allocated. A rolling review programme applied during EBME's routine actions. This will be automated once the RF tracking system is fully implemented. • There is an identified need to create a user guide for using the Medusa Customer Portal. The EBME Service is compiling this information. • The QPS Risk Management team has an audit of non-medical equipment not already recorded in the database ready to deploy. January 2024: Please see assurance report for full details. Nov 2022: This recommendation is monitored regularly via the Medical Devices Committee. The deadline is proposed to be extended due to Health Board ability to get around all of the equipment. We would suggest that the system is in place to track the assets however, further work is required to physically tag the equipment and ensure compliance and traceability.	January 2024: The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle. EBME have not had the resources to create the Customer Portal instructions and disseminate them. The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	January 2024: The dominant risk factor related to this recommendation is of unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified: - Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate. Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment. - Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually. - Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH.	30/06/2024
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	-74.85	31/05/2024	-0.98		Overdue	Overdue	3		Nov 2022: An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised. • Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. • An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment. Aug 2023: • New infusion device service and training manager now in post. • New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard. • Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB. • Training sessions delivered and open to substantive and bank staff to book. • Strategic plan to incorporate cascade trainers into the training provision to increase compliance.	January 2024: Ward and departmental managers need appropriate resources to engage in the identification and the making available of staff for training Obtaining a match with an appropriate level of quality for the Health Board's needs from the training that can be provided by the manufacturer needs scrutiny Lack of manufacturer personnel limiting ability to respond with support to run training sessions on a large scale	January 2024: The dominant risk factor related to this recommendation is that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster, this is assessed as a having a current risk exposure level of 9 (high). The following mitigation actions are identified: - Follow up on seeking responses to the infusion training questionnaire originally sent out to ward and departmental managers in January 2023 and update consolidated infusion training database accordingly - this would give assurance the organisation is running at an appropriate infusion training compliance level by providing an accurate denominating figure - Increase capacity for provision of infusion device training, including using manufacturer's training resource for revalidation training using a cascade training model This risk is currently being partially mitigated by providing ad hoc training sessions in a seminar room in OSU to ensure new starter training for end users is being delivered as able. Fresenius reps helping with staff updates as able prior to finishing in post. Cascade sessions delivered to paediatric nurses as able, to enable them to support with delivery of paeds updates.Need for fixed infusion device training base escalated and venue	New QPS Infusion Device Service Training Manager now in post.Consolidation of the infusion device training records aim to be achieved by end of Sept 23, Development of a dashboard to indicate compliance levels aim to be achieved by December 2023.Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies.	30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	-35.93	31/03/2023	-14.98	16/04/2024	Overdue	Overdue	3		March 2024: The Information Governance, Health Records and Cyber Security governance groups are now meeting and the first Information Governance Sub-Committee is being held on the 26/03/2024. The Digital, Data & Technology Sub-Committee terms of reference are completed and will be taken to the Executive Committee on the 11th April pending agenda setting.January 2024: The directorates new governance arrangements have been consulted and agreed internally. The Information Governance structure has been approved by the executive committee which will build on the well-established Governance & Assurance groups where there is strong engagement between the Information Governance team and Divisional leadership.				30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	31/12/2022	-17.93	31/05/2024	-0.98	28.11.2023	Overdue	Overdue	2		January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments. Nov 23: The HIMSS maturity report has been excepted and it will be played into our Digital Strategy and IMTP planning. August 2023: The new Director of Digital is currently reviewing the TOF and will present findings and an action plan for the consideration by the Executive Committee in October 2023 November 2021 - This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for 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	-35.93	01/05/2024	-1.97	16/04/2024	Overdue	Overdue	3		Mar 24 - Divisonal engagement meeting dates for meetings are being established for Families & Therapies, Unscheduled car & MH&LD division and will be in place in April 24 subject to Divisional staff availability. January 2024: A new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requests are understood, are properly documented, and have sufficient detail to enable prioritisation. A key component of this will be strategic alignment with the core local and national digital strategies. The Digital, Data & Technology sub-committee of the Finance & Performance Committee will provide an additional governance space for assurance of the work of the directorate by its Health Board stakeholders as well as the Executive. Progress has been made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. Internal audit will shortly be undertaking an audit of our portfolio arrangements in line with best practice. Currently the new Data Strategy is currently under development and associated strategies for ICT and Cyber Security are planned for the first quarter this year. The Health Board has commissioned CGI to undertake consultancy of on the future of the Electronic Health & Care record across the organisation and we would expect a report for this in the summer. These strategies will be brought together as an overarching summary Digital Strategy following these developments. Nov 23: The new digital service request process is nearing completion and will shortly be launched across the Health Board. The Digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained on all projects. Aug-23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. May 2023 - Benefits audit carried out and substantial assurance awarded. Funding to fully establish the PMO not yet secured however a portfolio view of all digital service requests and trnasofmration programmes has been developed along with a prioritisation and optimisation framework. DDOB has been stood down temporarily so prioritisation is done on an ad hoc basis with members of the exec team. Mar 23: Funding required for Head of PMO however, digital Portfolio manager recruitment underway in Programmes and benefits audit completed with substantial assurance. January 2023 - Awaiting funding for Head of PMO. Benefits management audit underway in programmes.				30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	-29.90	30/06/2024	0.00	08/02/2024	Overdue	Overdue	3		January 2024: New Cyber Security Assurance Group will be meeting in January 2024 and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. In addition, the Cyber Resilience Unit will be visiting the Health Board in late January to discuss progress against the Network & Information System Regulations. In April 2024 work will commence on the Health Board's new security platform which will provide visibility of all assets connected to the network which will improve the visibility of critical assets which may not be managed by the directorate. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. Aug 2023: Awaiting next HBOTS meeting. May 2023 - work to commence shortly under SIRO March 2023 - Part of work programme that will be commencing from May under Rani January 2023 - Part of the HBOTS work programme to be established with SIAOs September 2022 - Paper is drafted and will be submitted October 22. August 2022 - Pending financial strategy andTOF implementation June 2022 - subject to financial strategy for TOF implementation November 2021 - This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system				30/06/2024
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements. b.The policy and process documents will be updated to reflect the amendments.	31/10/2021	-31.90	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: A revised Standards for Business Conduct Policy will be submitted to the Board for approval in May 2024. January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				30/06/2024
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Head of Corporate Governance	Medium	R2	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	-31.90	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: A revised method for the reciept and management of DoIs is incuded in the revised Standards for Business Conduct Policy. January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				30/06/2024

Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R1	R1 Clarity should be sought over the roles and responsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner. ABUHB Radiology internally request on service point if the department knows the server team need to undertake work. We will continue to do this.	01/03/2022	-27.93	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.		Targetted training is provided to teams in the meantime.		30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	RS.1	RS.1 The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS.	Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	30/06/2022	-23.97	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.		Targetted training is provided to teams in the meantime.		30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R4	R4 The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed.	There is a backup regimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	-26.95	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. A database that the alerts and notifications is on is not supported by RadIS.	RadIS will not support this with the alerts and notifications query on the server still.	The database has been backed up by the server team		30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	31/03/2022	-26.95	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and this is currently being looked at by informatics	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R6	R6 Password controls should be improved with an increased minimum length and the Board should reduce the default maximum attempts available.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have 5 attempts.	01/03/2022	-27.93	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Nov 2023: currently trialling in primary care which has been succesful and is with software developments and informatics bussiness analysist to scope out as this is the selected solution from RISP.	Would need to staple in WCP ETR into CWS once the project has been scoped and timlined.	We have got checks for clinicians with similar names for obvious booking errors.		30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	-25.97	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.				30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	-26.95	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.			30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however , since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	-25.97	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The BC plans in radiology are quite extensive and well practiced	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.			30/06/2024

Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	-14.98	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		**Update March 2024:** **Policy extended with review date 31st May 2024. Revised policy due to be provided to Clinical Policy & Standards Group 9th May 2024.** **Update Aug 2023:** **The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics).** **The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy.** **The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational procedures are being implemented prior to introduction of the new policy and are expected to be completed by the end August 2023.** **A revised Management of Controlled Drugs Policy has been drafted and is being reviewed across the Divisions and will provided to the Clinical Standards and Policy Group in November 2023 for approval.**	Delay due to HMRC licencing requirements		ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6	30/06/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-17.93	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Cyber continues to attend GAG (Governance and Assurance Groups) meetings when scheduled with divisions to highlight the need of Information Asset Owners (IAO) and Senior Information Asset Owners (SIAO). CSAG (Cyber Security Assurance Group) meeting has been postponed due to circumstances within the team, this will be rearranged when applicable. Attendees have been identified and agreed with the SIRO. Terms of Reference will be covered in the first scheduled meeting. January 2024: The Cyber Resilient Unit assessment is now scheduled for 22/01/2024. There was a pre assessment meeting arranged with the CRU before the new year to discuss scope and this included Information Asset Owners.There is strong engagement through our divisional assurance arrangements where regular meetings are held between the divisions and our cyber security team. This will be further strengthened with the Cyber Security Assurance Group which will be meeting for the first time this quarter. Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dev to discuss scope and Digital will ensure this includes Information Asset Owners. Aug-23: CRU have provisionally provided a date for the next NIS CAF assessment process Oct 2023. As part of the engagement CRU have suggested a hybrid approach with onsite visits and interviews with systems owners. This is being piloted currently but is a process change from the previous assesment process undertaken in 2021				30/06/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	-17.93	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: As part of the NIS CAF, CRU have supplied Cyber with a "Findings Update" Excel documentation, which allows Cyber to provide monthly updates against the outcome recommendations for the Principle(s). Currently, Cyber's responsibility is to gather updates for CRU from Remedial Action Owners until CSAG (Cyber Security Assurance Group) meetings are held; however, CRU require monthly updates and CSAG will be on a quarterly basis. We are reviewing the project management arrangements to ensure the reporting requirements can be met. January 2024: In our assessment with the Cyber Resilience Unit in January we are discussing the documentation requirements and how we can ensure this audit recommendation can be satisfied going forward. Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assesesmnt scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023 Aug-23:CRU are piloting process changes to their approach from their initial NIS assessment undertaken in 2021, Future NIS CAF assessments will include evidence gathering ,recording and reporting as part of the new format.				30/06/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS I mprovement 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	-20.95	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Due to unforeseen circumstances, Cyber has postponed the first meeting of the Cyber Security Assurance Group (CSAG) and is yet to set a rearranged date and time. Attendees have been agreed by the Cyber Security Manager and the SIRO and a Terms of Reference (TOR) paper has been created in readiness of this meeting. January 2024: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital I MTP planning process and will form the basis of associated capital plans and potential bids to Welsh Government. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital I MTP planning process. AUG 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Office of he SIRO has been established, implementation of supporting governance and structures are in progress allowing costs to be fully assessed and actions prioritised. Aug 22: The creation of the TOM and creation of the HBOTS is ongoing This will provide the risk management framework to allow costs associated to improvements to be managed and prioritised."				30/06/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security and the risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	-20.95	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: The first Information Governance Sub-Committee meeting has been postponed until March 26th; however, the Cyber Security Assurance Group (CSAG) are yet to have their first initial meeting. January 2024: The new Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024.Regularly report of cyber incidents, risk, awareness and training will be provided to the Finance and Performance Committee through reporting from the Information Governance Sub-Committee. Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established Sept 22. The reporting route is being established following the appointment of the new SIRO. Aug 22: Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that could be imposed."				30/06/2024
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Flow Centre Nurse	Low	R3	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre	30/09/2022	-20.95	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Mar 23•Some KPIs have been created, reviewed each week at SLR and will form the basis of the Flow Centre Review currently taking place	Mar 23 Review being undertaken currently			30/06/2024
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Medium	R4	R4. We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	-23.97	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •The BCP has been created/updated and is due for a further review in light of recent IT risks and the joining of the Urgent Care Division	Mar 23 recent Divisional changes have meant that the BCP now requires further refinement however, orginal recommendation was implemented.			30/06/2024
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Low	R4.1	R4.1 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	-19.97	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •This is on hold until we return to our call centre.				30/06/2024

External	2019.01 EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R1	The Health Board should develop a fully costed Estates Strategy as soon as possible as recommended in our Structured Assessment 2017 (December 2017).	Draft Estate Strategy produced. Report to ABLHB Executive Team on Monday 19 November, with following recommendation:'The Executive Team is asked to consider the draft Strategy and advise of any material changes that need to be made prior to its consideration by the Health Board Development session on 19th December'	31/03/2019					Overdue	0						30/06/2024
External	2019.01 EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R2	The Health Board should finalise the 'Six-Facet' survey report to inform the Estates Strategy.	6 Facet Survey information now available. Migration to Health Board preferred database ongoing. Survey data being utilised to inform Estate Strategy. Please see attachment in R1 above	30/11/2018					Overdue	0						30/06/2024
External	2019.01 EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R3	The Division should include a range of Key Performance Indicators in its Performance Dashboard. These should include user satisfaction and completion targets.	Overarching Divisional KPI Dashboard is currently being developed which will incorporate performance data for each service discipline within the Division. Example of Estates Maintenance performance data attached, this datasheet will be revised to include user satisfaction and completion targets	31/01/2019					Overdue	0						30/06/2024
External	2019.01 EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R4	The Health Board should ensure that it completes post inspections for apercentage of repairs as part of a systematic quality control process. It should include the results in its local performance management dashboard.	Quality assessments to be undertaken for every 10 requests received, along with customer satisfaction form for completion. Feedback to be collated and reported into the Divisional KPI performance dashboard.	31/01/2019					Overdue	0						30/06/2024
External	2021 9EA	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R3b	Review the frequency with which Board and committees receive performance reports regarding primary care.	Monthly reports are submitted via the assurance meetings. The Division also reports for both mid and full year reviews.	31/04/2024					Overdue	0						30/06/2024
External	2021 9EA	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R4b	Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs.	The Division has a dashboard which captures activity and performance which is shared with the NCNs.	31/04/2024					Overdue	0						30/06/2024
External	2021 9EA	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R4c	Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	Work has already begun and services such as Wet AMD for ophthalmology and extended skin are now funded as a core service which was initially established through pace setters	31/04/2024					Overdue	0						30/06/2024

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2022.1	Digital Benefits Realisation	Substantial	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the Informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to programmes or Service Delivery. This will provide internal assurance of the process and ensures that options are presented to Digital Delivery Oversight Board (DDOB) with a clear assessment of priority and recommendations. DDOB is the body that will make informed decisions on the prioritisation of Informatics programmes and projects. New national programmes will be tracked through the same process allowing the Health Board to locally prioritise and feedback these priorities back to national. This draft process needs to be signed off and fully implemented.	01/06/2023	-12.95	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: The new digital service request has been drafted and will be completed by end of March 2024 for dissemination and implementation and will be presented to Exec Board in April 2024. Jan 24: A new digital service request process will be implemented by March 2024 to funnel all new service requests using a request form in our Seren ICT portal through the DDaT senior leadership team with additional appraisal of requests undertaken by the business analysis team with requestors to ensure requests are understood, properly documented and managed and have sufficient detail to enable prioritisation and scaling to enable prioritisation and progression in alignment with Health Board priorities. Nov 23: The new digital service request process is nearing completion and will be launched shortly across the Health Board. The digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained in all projects. Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls				30/06/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents. November 2023: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues	November 2023: Any new policies are checked for embedded documents prior to publication		30/06/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: This will be included as part of the revised framework November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed. November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this, escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval. November 2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework. November 2023: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status. November 2023: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status.	November 2023: capacity to review policies given current operational and financial pressures.			30/06/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-14.98	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database) November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024

Internal	2022.1	Records Managment	Limited	Director of Digital	Head of Workforce and OD	Medium	R4	R4 The management of ward clerks should be centralised, and consideration should be given to manage shortages through "bank arrangements".	a.) Local ward clerk shortages will be escalated to the Assistant Directors of Nursingand subsequently escalated to the Executive Director of Nursing. Action plan will be agreed how to solve them. b.) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing hierarchy to the ward staff.	31/07/2023	-10.98	30/06/2024	0.00	08/02/2024	Overdue	Overdue	1		Jan-24: First level of organisational process is underway and will commence in February. Nov 23: Will be discussed at Executive Committee and considered as part of the Digital Organisational Change Process				30/06/2024
Internal	2022.1	Records Managment	Limited	Director of Digital	DPO & Head of IG	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023	-5.97		-1490.92		Overdue		0		Mar 24- Closure of another library of records achieved at Llangennech and move of some mental health, children service records to vacated Antenatal Basement Library to relieve pressures. - Unable to provide a revised timescale at this stage.				30/06/2024
Internal	2022.1	Records Managment	Limited	Director of Digital	CNIO	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.	31/03/2023	-14.98	30/06/2024	0.00	08/02/2024	Overdue	Overdue	1		Jan-24: Ward visits undertaken by records management staff to ensure loose notes colelcted from sites. As a part of the Digital Strategy, a review will be undertaken for a review of digitisation of the remaining health records, with a key requirement being eForms. With reference to R4, we can pick up any further improvements to be made to loose patient record filing. Nov 23: The promotion of good practice continues and the roll out of WNCR at NHH has commenced. Aug-23: Health Records have found significant amounts of loose filing on wards in RGH & St Woolos. This has been collected and scanned but has a negative impact as each sheet needs to be individually checked, barcoded and scanned rather than as a complete record. The rollout of WNCR has reduced paper generation on wards and the CNIO has been promoting good practice on wards as the system rolls out across RGH. Further implementations at YYF and NHH will further reduce the loose records situation.	Further rollout of WNCR in YYF, YAB, NHH will reduce the loose records and guidance will be provided to the staff on the wards in these areas.	Training of ward clerks where there are issues identified is ongoing and datix reports submitted where substantial breaches are identified.		30/06/2024
Internal	2022.1	Records Managment	Limited	Director of Digital	DPO & Head of IG Interim ADI – Governance & Assurance	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	-5.97	30/06/2024	0.00	16/04/2024	Overdue	Overdue	1		Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.				30/06/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Assistant Director for Strategy, Planning & Design	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transisition to service delivery	01/06/2023	-12.95	30/06/2024	0.00	08/02/2024	Overdue	Overdue	2		Jan-24: RPA posts are in the Trac process for readvert and interview. A draft operational model has been developed. Completion remains dependent on successful team recruitment Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services				30/06/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	-12.07	30/06/2024	0.00	16/04/2024	Overdue	Overdue	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The interim product specialist is implementing a benefits register. This work will be ongoing during April and May 2024. Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/06/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	-14.98	30/06/2024	0.00	16/04/2024	Overdue	Overdue	2		Mar 24 - a benefits management framework is being implemented in RPA. Benefits are captured duing the RPA opportunity assessment process (see above line 15). Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				30/06/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	-15.97	30/06/2024	0.00	16/04/2024	Overdue	Overdue	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being interviewed in April 2024. Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.				30/06/2024

Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-15.97	30/06/2024	0.00	16/04/2024	Overdue	Overdue	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being intrviewed in April 2024. Handover needs to be completed from the RPA contractor and the product specilist recruited to enable the work to be undertaken to complete this recommendation Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023				30/06/2024
Internal	2022.2	Monitoring Action Plans	Reasonable	Director of Nursing	Assistant Director of Nursing (PT Safety)	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-13.97	30/04/2024	-2.00	08/02/2024	Overdue	Overdue	2		Januray 2024: In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."This will be implemented across the HB in April 2024. August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."				30/06/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.	01/04/2024	-2.95		-1490.92		Overdue		0						30/06/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024	-2.95		-1490.92		Overdue		0						30/06/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.	01/04/2024	-2.95		-1490.92		Overdue		0						30/06/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024	-2.95		-1490.92		Overdue		0						30/06/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024	-2.95		-1490.92		Overdue		0						30/06/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	-2.95		-1490.92		Overdue		0						30/06/2024

Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC	01/04/2024	-2.95		-1490.92		Overdue		0						30/06/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Planning Director / Head of Performance	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	01/10/2023	-8.95	31/03/2024	-2.98	08/02/2024	Overdue	Overdue	1		March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review				30/06/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	-12.95	30/06/2024	0.00	16/04/2024	Overdue	Overdue	2		March 2024: Tredegar Medical Practice (TMP) have recently has become an Independent Practice. Legal & Risk are in connection with TMP solicitors to sign off the Lease. Glan-Y-Afon (GYA), have changed solicitors, Legal & Risk are corresponding with GYA solicitors. GYA had queries which have been responded to. Jan 2024: Still being progressed by Shared Services Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	None	N/A	Aug 2023: Agreed leases	30/06/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	High	R3	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.	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.	01/06/2023					Overdue	Overdue								30/06/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	High	R10	Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions	Agreed. Non-compliance to be advised to the Programme Board via submission of this audit report and the Director of Finance.	01/06/2023					Overdue	Overdue								30/06/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	-12.95	31/01/2024	-4.95	12/09/2023	Overdue	Overdue	1		March 2024: "OAMH dementia wards complete the Kings Fund audits on the three dementia wards. They are piloting the ABUHB Accreditation audits on Cedar Park which will be rolled out on at OAMH wards which include environmental audits. Ligature risk assessment audits are part of the ward OAMH yearly review. General hospital wards do not routinely use the Kings fund audits on wards, but the tool has been used to support individual ward improvement plans as part of the VIPS hospital dementia Friendly Hospital Charter implementation programme. UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards.				30/06/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-9.93	30/06/2024	0.00	16/04/2024	Overdue	Overdue	1		This is an ongoing action, monthly team meetings facilitate an opportunity to share feedback and consider how we use this feedback to influence practice and services. Patient feedback is used as a basis of QPS, Internal and external reporting. A 1 year reporting of VIPS will take place in April 2024.				30/06/2024
Internal	2022.3	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support and Complex Needs Senior Programme Managers	Medium	R1	The control and oversight of each individual mental health transformation project is formally allocated, documented and communicated to all interested parties to the project. This should include any third-party bodies engaged and ensure that any duplication or omission of effort is identified and addressed. There is a need to ensure that assurance mechanisms, including those provided by third-parties can be relied upon. b. Any such document should ensure that key aspects of a project's development and implementation are considered including time, cost, benefits, linkage of projects to strategic objectives, management of risk and ongoing monitoring of targets etc.	A review of the control and oversight of each of the individual mental health transformation projects will be undertaken to ensure it is appropriately allocated, documented and communicated to relevant stakeholders. The document will cover the areas outlined in recommendation 1.1b	01/10/2023	-8.95	30/04/2024	-2.00	08/02/2024	Overdue	Overdue	1		Januray 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.				30/06/2024

Internal	2022.3	Mental Health Transformation	Reasonable	Chief Operating Officer	Divisional Director and Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board and the Mental Health Transformation Board established to provide oversight have Chairs appointed who are independent of divisional management to demonstrate and deliver the independence required of such bodies.	A review will be undertaken regarding the Chairs of both the WPWS Crisis Support Programme Board and Mental Health and Learning Disability Transformation Board.	01/09/2023	-9.93	30/04/2024	-2.00	08/02/2024	Overdue	Overdue	1		**January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. Nov 2023.** Dr Kathryn Walters (Joint Head of Psychology, Counselling and Arts Therapies) has replaced the Divisional Director as the Chair of the Whole Person Whole System Crisis Support Programme Board. A more detailed update on progress will be provided in the next reporting cycle.				30/06/2024
Internal	2022.3	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	The Whole Person Whole System Crisis Support Programme Board performs deep dives into projects to further scrutinise the information received in the Project Flash Reports.	Within the current structure of the Whole Person Whole System Crisis Support Programme Board there is currently the ability to focus on details regarding specific projects. However, a more formal approach to "deep dives" for individual projects will be introduced (12 monthly minimum) that will include comprehensive performance and benefits reporting.	01/09/2023	-9.93	30/04/2024	-2.00	08/02/2024	Overdue	Overdue	1		January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. November 2023: The Board has agreed to carry out annual Board Planning and Development sessions where 'deep dives' will inform the onward planning for content. Dates in consideration for Jan/Feb 2024 being agreed at Nov 2023 Board	• Funding & locations of physical space to carry out sessions • Access to information with BAU teams for Operational Workstreams such as MH111p2 • Developments in systems to support in outcomes evidencing; eg Alt to inpatients theme. o Electronic PREMS/PREMS Programme have set up and manage collection of information, That information evidences qualitative & quantitative content for the services in the theme. The baseline comparators for BAU traditional services are not implemented electronically(EG Ward PROMS/PREMS) o The performance team priority has a request for virtual wards outstanding (2021) their focus has been with wider WCCIS issues.	• Funding - Looking at availbility rooms in wider HB estate & in discussion with partner stakeholders to ID any cost effective/neutral space in they may be able to offer as co hosts • Access to information from BAU leads (MH111p2) – SRO to meet with GM & AGM to discuss information requirements for Programme for benefits realization & whole system impact for all stakeholders. • Systems – o Programme Manager is able to support wards in 'spread & scale' to support them(on request from servcie leads) in implementing electronic PROMS/PREMS issue and reporting. o Performance team recognise the priority requirement for virtual wards set up, and requesting it is reprioritised.	Ongoing anticpating closure evidence Feb 2024	30/06/2024
Internal	2022.3	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	Consideration be given to the Whole Person Whole System Crisis Support Programme Board only receiving the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports	The Mental Health and Learning Disability Transformation Programmes (Whole Person Whole System Crisis Support Programme and Complex Needs Programme) will receive the Project Flash reports for all workstreams and those Boards will then report by exception to the Mental Health and Learning Disabilities Transformation Board.	01/09/2023	-9.93	30/04/2024	-2.00	08/02/2024	Overdue	Overdue	1		January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.				30/06/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	High	R4	Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	31/12/2023	-5.97	30/06/2024	0.00	16/04/2024	Overdue	Overdue	1		March 2024: The QPS resource centralised on 15th February 2024. We are in the process of reviewing and remapping the entire concerns pathway which will identify and address the barriers that are leading to poor complaince. The PALS service are now managing all grade 1 and 2 concens.				30/06/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R5	Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require following OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability frameowrk between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023	-5.97		-1490.92		Overdue		0		March 2024: The orgaisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divsional leads to be trained by ABCi team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Working with datix team to ensure that actions are assigned on the datix system.				30/06/2024
Internal	2023	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Chief Information Officer	High	R4.1	we reccommend that the Health Board devise a plan to address the longstanding underperformance in the monthly coding of episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	The Executive Committee approved the restructing of the Clinical Coding department in August 2023, the agreed restructure when comlete wil deliver on the monthly coding of episodes target.	30/06/2024	0.00		-1490.92		Overdue		0		Jan 2024: The Executive Committee approved the restructuring of the Clinical Coding Department in August 2023, the agreed restructure when complete will deliver on the monthly coding of episodes target.All posts have been approved by the vacancy scrutiny panel, they have been advertised on NHS Jobs and shortlisting / interview processes are completed. Some of the posts are being readvertised due to a lack of suitability of candidates.				30/06/2024
Internal	2023	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Chief Information Officer	High	R4.2	We reccommend that the Health Board devise a plan to address the longstanding underperformance in claering the backlog of uncoded episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	Backlog of episodes will be systematically coded when the new Clincial Coding Structure in implemented. The new structure provides the workforce with he capability to deliver on the monthly coded episodes target and address backlog.	30/06/2024	0.00		-1490.92		Overdue		0		Jan 2024: Backlog of episodes will be systematically coded when the new Clinical Coding Structure is implemented. The new structure provides the workforce with the capability to deliver on the monthly coded episodes target and address backlog.Requires recruitment to new structure as above				30/06/2024
Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	N/A	Medium	R1.1	Business continuity plans and associated documentation should be completed for all service areas within the Health Board. The Health Board may wish to incorpoarte this process with the wider opeartional risk management processes. There needs to be an accountability and escalation routes if such plans/actions cards not completed.	Recommendation accepted - the requirement for business continuity plans is within the Policy and BG planing guidance. The emergency planning team have plans in place to further engage with specific service areas. The new intranet repository will provide further information and will provide further information and will be established to monitor the progress of plans. The newly established EPRR group will be well suited to be the forum for escalation.	31/01/2024	-4.95	30/06/2024	0.00	16/04/2024	Overdue	Overdue	1		March 2024: All Divisions have been reminded of ther need to have their BC plans in place, each have a nominated lead. Guidance, templates and training/workshops are accessible to all areas to support developing plans. The repository in available on line and starting to be populated with plans produced. The first meeting of the EPRR Group has taken place with representation from all Divisions, the ToR identfy this as being a forum to review progress and escalate issues.		March 2024: Processes are in place but some Divisions are early in there development of plans - these will be monitored through the EP team and to the EPRR group		30/06/2024

Internal	2023.1	Facilities - Jan 2024	Limited	Chief Operating Officer	Catering Servce Improvement Manager	High	R1.1	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Standard Operating Procedures will be developed to detail each step of the new process. These processes will be shared with staff and be made accessible	29/02/2024	-4.00	30/04/2024	-2.00	16/04/2024	Overdue	Overdue	1		March 2024: Processes have been developed however upon reviewing it has been decided to enhance further. Final documents scheduled to be completed and signed off w/c 8th April (due to annual leave of key people)				30/06/2024
Internal	2023.1	Facilities - Jan 2024	Limited	Chief Operating Officer	Head of facilities	High	R1.7	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: The Head of Facilities will consider the potential benefit of software to improve the efficiency, effectiveness and accuracy of stock management processes. Options to be presented to the Divisional Director for decision	31/03/2024	-2.98	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: Following completion of the actions above and the assessment of benefits of any additional software any proposal will be presented by the Head of Facilities to the Divisional Director by mid May				30/06/2024
Internal	2023.1	Facilities - Jan 2024	Limited	Chief Operating Officer	Head of facilities	High	R2	Management should implement a consistent approach to stock ordering. This process should be based on current footfall and patient numbers, provisions already in stock and the quantities required per portion from the All-Wales recipes. Management should then complete monthly spot checks to ensure the process is being adhered to. Stock ordering should then be reported at the monthly Facilities meetings to ensure senior management have view of any issues.	ACCEPTED. The following steps will be taken to address the issue:Actions set out in agreed management action for matter arising R1.1-1.7	31/03/2024	-2.98	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: R2-6 completed. Anticipated that remaining two recommendations will be completed by May 2024.				30/06/2024
Internal	2023.1	Facilities - Jan 2024	Limited	Chief Operating Officer	Senior Facilities Manager	Medium	R5.2	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.	1 Review processes for staff access. To ensure that processes are in place to ensure all goods are secured and accessed in a controlled environment.	29/02/2024	-4.00	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	1		March 2024: Completed but but consideration of additional steps on specific sites including additional CCTV is now being scoped up and costed				30/06/2024
Internal	2023.1	Facilities - Jan 2024	Limited	Chief Operating Officer	Catering Service Improvement Manager	High	R6.1	Management should review how they measure and monitor waste and ensure a consistent approach across all sites. There should also be consideration of the use of extended functionality within Synbiotix and / or the recording of food waste for management information.	Develop a process, in flow chart form, to effectively monitor food waste	29/02/2024	-4.00	06/04/2024	-2.79	16/04/2024	Overdue	Overdue	1		March 2024: This action has been completed locally. We have taken the decision to hold off implementing this new process whilst we assess it against the new waste regulations due to be implemented on 6/4/24				30/06/2024
Internal	2023.1	Facilities - Jan 2024	Limited	Chief Operating Officer	Buisness Support Manager	Medium	R7.4	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Explore the use of safe care or alternative system to monitor staffs start and finish time this is part of the pre-enabling plan for the roll out Health Roster payroll drop down.	29/02/2024	-4.00		-1490.92		Overdue		0		March 2024: This has been explored. Unfortunately this is not possible at this stage. Other options are being explored				30/06/2024
Internal	2023.1	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Director of Strategy, Planning and Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	31/03/2024	-2.98	30/06/2024	0.00	16/04/2024	Overdue	Overdue	1		March 2024: mCapital priorisiation complete. Estate Strategy will follow org. strat.				30/06/2024
Internal	2023.1	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Divisioal Director of Estates and Facilities	High	R5	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) and to inform a financial model for required revenuesupport.	Agreed - the Divisional Director will review the operational workforce required to manage the current level of reactive work and also to ensure compliance with the appropriate level of Planned and Preventative Maintenance (PPM).	31/05/2024	-0.98		-1490.92		Overdue		0						30/06/2024

Internal	2023.1	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Director of Corporate Governance	High	R6	The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	At its meeting in January 2024, the Board approved its Revised Risk Management Framework which set out the revised hierarchy for risk management within the organisation, alongside an agreed Risk Appetite Statement. In-line with this Framework, the Head of Risk and Assurance will work with the Divisional Director of Estates & Facilities to review the risk management arrangements in place, ensureing appropriate escalation reporting from service to Board level.	31/01/2024	-4.95	31/05/2024	-0.98		Overdue	Overdue	1		"March 2024 - The Head of Corporate Risk and Assurance will work with Estates to ensure that their divisional risk register is robust and up to date, underpinned by operational risk reporting, and that it feeds the hierarchy process to CRR and SRR (in accordance with the framework). Furthermore, the Finance & Performance Committee is responsible for seeking assurance on estates compliance matters, which has been included in the committee workplan 2024/25 to ensure sufficient assurance is built in. "				30/06/2024
Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Medium	R1.1	Minutes will be sufficiently detailed to record discussions, decisions, and actions.	Accepted. Will ensure this is undertaken for relevant project meetings and is carried forward onto other capital projects.	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Medium	2.1	Welsh Government Project Progress Reports should be fully populated at each return.	Accepted. Will ensure detail is included in the next return and for future Capital Projects	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	2.2	Progress reporting within the PPR should reflect the current status/ progress, rather than only reporting when a target has been achieved.	Accepted. Will ensure detail is included in the next return and for future Capital Projects	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	3.1	The Welsh Government funded element should be presented as a subtotal on the cost report –i.e., prior to the inclusion of fundraising.	Noted – will apply to other projects where this is relevant	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	3.2	Include the breakdown of the cost to an item basis where large equipment or single items are contributing to a significant financial variance from FBC costings	Noted – will apply to other projects where possible	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Medium	4.1	Change control documents should be signed/ authorised using a recognised document control programme.	Noted – however the HB does not currently have access to such document control programmes. Will be considered for future projects including any cost implications. If it is not possible to progress with this, we will continue with email and ensure the email trail/ discussion is available for review as per this project.	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	4.2	Change Request Forms should be completed to include 'Change Log Number' field.	ccepted – will ensure this is included in future project change control.	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024

Internal	2023.1	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	4.3	All Project Manager Instructions (including zero value and omissions) should be completed in a timely manner as required by the contract.	Noted – will endeavour to complete as recommended, however there will be some situations where it will not be possible to achieve the contractual timeline due to the complexity of the instruction/ change.	30/11/2023	-6.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance & General Managers.	Medium	R1.1	We recommend that additions forms are obtained from asset owners promptly following equipment purchase and that forms with missing data are returned to owners for completion.	The Capital Finance Team include the new asset form on the Capital Scheme approval email that is sent out to the responsible budget holder when a new equipment purchase is approved. The email requests the form be completed when the new equipment asset is received and returned to the Capital Finance Team. New assets are added to the Fixed Asset Register each quarter. Any missing forms are subsequently chased with the owning department. This process has significantly increased the number of forms received over the past two years.In addition to the above, the Capital Finance team will include a list of missing forms as an agenda item for each monthly divisional meeting and will return forms where information is incomplete. General Managers to ensure that forms are completed and returned to Capital Finance.	30/04/2024	-2.00		-1490.92		Overdue		0						30/06/2024
Internal	2023.10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance & General Managers.	Medium	R2.1	We recommend where assets are disposed of and are not being sold, or where disposal forms are completed retrospectively after an asset has not been found in a physical verification test, that asset owners are required to obtain the countersignature of their manager on the disposal form.	To ensure all asset disposals are approved appropriately prior to disposal, a counter signature from the General Manager for the Division will be added to the disposal form and the Financial Control Procedure will be amended accordingly. The policy change will need to be reported to and approved by the Audit Committee.	30/04/2024	-2.00		-1490.92		Overdue		0						30/06/2024
Internal	2023.10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance	High	R3.1	We recommend that the Health Board examine each exception individually and take appropriate action to rectifythe matter when the reason for the anomaly is determined.All items that were not found in the register during a physical asset test should be accounted for. Asset owners that did not submit a disposal form at the time of the disposal should be required to provide documentation to evidence the disposal method and to corroborate what took place.	Agree. These issues will be resolved in readiness for the end of year accounts and disposal forms requested for those assets that cannot be located.	31/03/2024	-2.98		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Long Term Sickness Absence Management	Reasonable	Director of Workforce & OD	Director of Workforce and OD	Low	R1.1	The Health Board should review the Pack to ensure it is up to date and in line with the Health Board's processes and remains fully aligned to the NHS Wales Managing Attendance at Work Policy.	To update the pack, to include the enhanced OH referral process and any other appropriate updates, whilst recognising that the pack predicates on the policy, which requires national approval and update.	30/06/2024	0.00		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Long Term Sickness Absence Management	Reasonable	Director of Workforce & OD	Director of Workforce and OD	Medium	R2.1a	The Health Board should encourage staff to ensure manager details are correct on ESR for all employees.	Periodic reminders to update details including manager details will be published on ESR portal. In additional, annual report to be run for review by division on manager allocation in ESR	30/04/2024	-2.00		-1490.92		Overdue		0						30/06/2024
Internal	2023.1	Long Term Sickness Absence Management	Reasonable	Director of Workforce & OD	Director of Workforce and OD	Medium	R2.1b	There should be regular communications with divisions and prompts to ensure long-term sickness is managed effectively and all steps of the process are completed fully and correctly.	Review training material to ensure that all issues above are included. Long term sickness process to be updated in "the pack" plus internal sickness absence group to produce regular comms/tips on effectively managing and supporting staff who are absent.	30/06/2024	0.00		-1490.92		Overdue		0						30/06/2024
External	2022.03 EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	Head of Board Business	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023	-9.93	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2		March 2024 -A review of Board Business processes and products has been undertaken and the outcome of this work is included in an Improving Board Business action plan and report that will be submitted to a future Board meeting. In terms of practical application there is greater focus taken at agenda setting meetings to ensure that sufficient time is allocated to support the meeting agenda. November 2023: The HOBB is undertaking a review of all board processes and procedures to secure greater consistency of approach and to ensure that all regulatory and statutory requirements are addressed though an action plan to improve board buisness. This will include the timeliness of meetings and scope of papers for consideration.				30/06/2024

External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	Medium	R1	The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could public unconfirmed committee meeting minutes shortly after the meeting	The Health Board remains fully committrf to operating with openness and transparency. Greater transparency of the Boards committee buisness will be implemented, building on existing practicies.	30/04/2024					Overdue		0						30/06/2024
External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R3	The Health Board should establish a robust wuality assurance mechanism to review the quality of reports for its Board and Committees.	The Health Board is currently reviewing its Board and Committee administation processes, including key performance measures. This will include a focus on the quality assurance process with clarity on expected standards. This will also be supported by work in resepct of report writing develipment in recommendation 2.	30/04/2024					Overdue		0						30/06/2024
External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R4	The Health Board needs to rapidly complete remaining work to identify and address assurance gaps on its Strategic Risk and Assurance Report and ensure it is actively owned by the Board and infomr committee agenda setting.	The Health Board is actively progressing work to strenghen its strategic risk and assurance reporting, alligning risks to the board and Committee buisness cycles. This work will be processed alongside work to embed strenthened risk management and assurance arrangements at all levels of teh organisation R5	30/04/2024					Overdue		0						30/06/2024
External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R5	The Health Boards need to complete the remaining work on its risk management strategy and effectively embed arrangements accross the organisation to help to manage the significany finance, performance and quality risk faced.	The Health Board will consider its received Risk Management Framework and underpinning Policy at its meeting in January 2024. The audit, risk and assurance committee will receive these in draft form for comment in november 2023. Implementation of these throughout the organisation as the organisations approach to risk managemnet matures.	31/01/2024					Overdue		0						30/06/2024
External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Strategy, Planning and Partnerships	High	R6	In the Intergarted Performance Dashboard, the Health board should provide more information on the actions required to address underperformance, the impact of past actions taken and where apropriate include benchmarking with other health bodies	As part of the IMTP progress report specific attention has been given to address underperformance including assurance mechanisms. Thsi can be seen in the Quater 2 report and will continue to be strenthensed in future reports. Where avaliable the data for the current quater is presented and dates provided for data availability. Benchmarking data will be included in the dashboard where avaliable. Not all performance measures have benchmarking data avlaible, an asssessment of benchmarking data can be included in the dashboard.	31/12/2023					Overdue		0						30/06/2024
External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Strategy, Planning and Partnerships	High	R7	The Health Board should strengthen the IMPT progress report to ensure that it can be used as an effective tool for monitoring progress against the delivery of its strategic objectives. By including up to date data, and clear narrative on the impact of past and ongoing improvement actions.	s part of the IMTP progress report specific attention has been given to address underperformance including assurance mechanisms. Thsi can be seen in the Quater 2 report and will continue to be strenthensed in future reports. Where avaliable the data for the current quater is presented and dates provided for data availability. It remains important for the Health Board to maintain a mix of definitive progress measures and measures of longer term population outcome. for population outcome measures the Health Board may be the sole influencing factor and measurement may be reported over a long term timescale, however as a population health organisation it is important the Board is sighnted on these measures.	31/12/2023					Overdue		0						30/06/2024
External	2023.05 EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R2	The Health Board does not have an agreed funded establishment that covers all its services. The Health Board should determine its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually.	an All-Wales group has been established to support the implementation of setting funded establishments.The Health Board has commenced work in relation to establishing agreed funded establishments supported by the assistant Finance Director and Workforce Information teams. A targeted approach is being undertaken to support completion e.g., by staff groups. The implementation of the medical E-Systems programme will also support this from a medical workforce perspective.	29/02/2024					Overdue		0						30/06/2024
External	2023.05 EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R4	We found that the Health Board had workforce planning training and support, particularly in relation to the opening of Grange University Hospital, however this was paused during the pandemic, and it now needs to recommence. The Health Board should develop and implement a programme of workforce planning training and once in place create an evaluation framework to measure the success of its training programme. (	Plans are in place in provide formal training and education in line with the newly revised HEIW workforce planning competency frameworks. The Health Board will also be introducing workforce planning awareness into existing training management and leadership programmes	31/03/2024					Overdue		0						30/06/2024

External	2023.06 EA	Primary Care Follow Up	Not Rated	Director of Corporate Governance	Director of Corporate Governance	N/A	R2	The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care and publishing an annual report on primary care.	The Health Board's Integrated Medium-Term Plan is based on the life course approach and consequently includes key priorities for primary care to integrate across the whole health care system. Monitoring of the Primary Care related elements of the IMTP follow the same format as other areas, including Executive chaired monthly assurance meetings, mid-year reviews, end of year reviews and issue led discussion at Executive Team, Health Board and other committees.The Division has been invited to lead a number of Board development sessions over the past 12 months, notably the presentation of the Primary Care Sustainability plan, which includes the expansion of the primary care academy and is key in ensuring the workforce of the future.The weekly Executive Team meeting provides a forum to discuss any issues across the operational divisions, and primary care features regularly on the agenda. This will include updates from the primary care contracting team reporting on GP and other independent contractor changes. A potential risk that Primary Care could lose profile at Board level due to re-structure and cessation of the Executive Director for Primary Care post. However, stability has been brought to the Primary Care &Community Services Division through substantive appointment of a new Divisional Director with presence at senior committees within the HB.Welsh Government no longer requires the Health Board to submit an annual plan for primary care, however a report is produced for internal purposes	30/04/2024					Completed/ Closed		0		Completed within report.				30/06/2024
External	2023.06 EA	Primary Care Follow Up	Not Rated	Director of Corporate Governance	Director of Corporate Governance	N/A	R3.1	a) Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	As with the other operational Divisions, Primary Care forms part of the Health Boards regular agendas across the various Committees and Boards. The Divisions performance is reported as part of the overarching reporting against the IMTP and is presented to each formal Board meeting and the Finance and Performance Committee.	30/04/2024					Completed/ Closed		0		Completed within report.				30/06/2024
Internal	2023.2	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Medium	R.1	The provision of the VPN from WAST should be formally documented within a service agreement.	ABUHB accepts that this should have been put in place but provision of VPN for RPA connectivity from WAST was only ever intended to be an interim solution. This will be discontinued as soon as the official solution from DHCW is available.	31/03/2024					Overdue		0						30/06/2024
Internal	2023.2	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Medium	R.1.2	Work should continue with DHCW as the providers of the national infrastructure to move this service to DHCW.	ABUHB accepts this recommendation, and a request has already been placed with DHCW to provide VPN service for RPA and other services requiring this functionality	31/03/2024					Overdue		0						30/06/2024
Internal	2023.2	IT Infrastructure	Reasonable	Director of Digital	Head of Ict	Medium	R5.1	A formal patch process for servers should be defined, which should split servers into patch groups, to ensure secure and stable application across the Health Board.	ABUHB accepts this recommendation. There is already a formal patch process defined for MS patching and a schedule of standard changes developed to manage this. Gap analysis to be undertaken to ensure all servers are included and also to identify patch groups to ensure robust and resilient deploymen	31/03/2024					Overdue		0						30/06/2024
Internal	2023.2	IT Infrastructure	Reasonable	Director of Digital	Head of Ict	High	R5.2	A process for ensuring switches are patched should be established.	ABUHB accepts this recommendation. A process for switch patching will be developed and implemented.	31/03/2024					Overdue		0						30/06/2024

Appendix 5 Post Update Overdue Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	-25.97				Overdue	Overdue	2		June 2024- the position remains the same, any leavers within Radiology we are informed alongside their Nadex being deactivated by the admin Team in Radiology. In the new PACS/RIS solution provided by Philips and Soliton the accounts will be linked to active directory. This will stop their access to Radiology systems alongside with their access to any PC's in ABUHB. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.				30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	-26.95				Overdue	Overdue	2		June 2024- the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution. March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.			30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	-25.97				Overdue	Overdue	2		June 2024- the position remains the same. The business continuity plans in Radiology are extensive and well versed. There will be a more extensive disaster recovery solution with the new Philips/RIS solution. The solution will be cloud based with 3 years of on site storage with the full PACS and RIS capabilities within which is pencilled in for the GUH datacentre. There will also be a smaller disaster recovery solution with hardware being pencilled into the YAB datacentre if there are issues with the GUH datacentre. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The BC plans in radiology are quite extensive and well practiced	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.			30/06/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024	-2.95				Overdue		0						30/06/2024
Internal	2023.05	Facilities - Jan 2024	Limited	Chief Operating Officer	Buisness Support Manager	Medium	R7.4	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Explore the use of safe care or alternative system to monitor staffs start and finish time this is part of the pre-enabling plan for the roll out Health Roster payroll drop down.	29/02/2024	-4.00				Overdue		0		This has been explored and is not feasible. Will be considered with wider HB and nationally to see if becomes viable in the future as part of wider Roster roll out March 2024: This has been explored. Unfortunately this is not possible at this stage. Other options are being explored.				30/06/2024

Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Director of Strategy, Planning and Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	31/03/2024	-2.98				Overdue	Overdue	1		June 2024: Work is ongoing to maintain premises which will remain in the Health Board Estate Portfolio with no immediate plans in place. Plans are currently being progressed for Nevill Hall Hospital and St Woolos in line with the Estate Strategy where estate condition is poor. Organisational Strategy will be complete end of calendar year. March 2024: mCapital priorisiation complete. Estate Strategy will follow org. strat.				30/06/2024
Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Director of Corporate Governance	High	R6	The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	At its meeting in January 2024, the Board approved its Revised Risk Management Framework which set out the revised hierarchy for risk management within the organisation, alongside an agreed Risk Appetite Statement. In-line with this Framework, the Head of Risk and Assurance will work with the Divisional Director of Estates & Facilities to review the risk management arrangements in place, ensureing appropriate escalation reporting from service to Board level.	31/01/2024	-4.95				Overdue	Overdue	1		June 2024 - The Head of Risk Assurance has scheduled a discussion with the Divisional Director of Facilities to look at how estate risks are monitored and escalated to determine if any estate risks require escalation. There is a commitment to bringing all risks into one report. March 2024 - The Head of Corporate Risk and Assurance will work with Estates to ensure that their divisional risk register is robust and up to date, underpinned by operational risk reporting, and that it feeds the hierarchy process to CRR and SRR (in accordance with the framework). Furthermore, the Finance & Performance Committee is responsible for seeking assurance on estates compliance matters, which has been included in the committee workplan 2024/25 to ensure sufficient assurance is built in. "				30/06/2024
Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Medium	4.1	Change control documents should be signed/ authorised using a recognised document control programme.	Noted – however the HB does not currently have access to such document control programmes. Will be considered for future projects including any cost implications. If it is not possible to progress with this, we will continue with email and ensure the email trail/ discussion is available for review as per this project.	30/11/2023	-6.98				Overdue		0		Health Board does not have access to document control programmes (e.g. docusign), but continue to use email or meetings as agreement to signing PCFs				30/06/2024

Appendix 4 Revised Timescale Requests

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recom-mendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	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	-74.85	30/06/2024	0.00		Overdue	Overdue	4		June 2024: "The EBME Service will be in a position to issue the user guide for the Medusa Customer Portal following the delayed major update to the Medusa database that is scheduled to be implemented on 12th July 2024. The ward and departmental audit of non-electrical medical equipment has been implemented. The output will be a local inventory/register of installed medical equipment not captured in other databases. This is generally non-electrical equipment" March 2024: The Health Board is compliant with the parts of the recommendation that, (a) registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details, (b) that the register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed, (d) discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded, and (e) going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues. The Health Board is currently partially compliant concerning the part of the recommendation that (c) each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. "A centrally managed industry standard pan-organisation medical equipment register (Softpro Medusa) is in place and operational. The database records medical equipment management information on each item of equipment, including the location where each item is deployed	January 2024: The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle. EBME have not had the resources to create the Customer Portal instructions and disseminate them. The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	January 2024: The dominant risk factor related to this recommendation is of unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified: · Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate. · Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment. · Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually. · Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH.	30/06/2024
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	-74.85	31/08/2024	2.03		Overdue	Overdue	4		June 2024: "A system of providing centralised training to cascade infusion device trainers has been established and training is in now workstream. A system of categorisation of the degree of training required against groups of equipment types has been developed. Reflection of this in the Medusa equipment management database is pending the major update that is scheduled to be implemented on 12th July 2024. Representation of the centralised essential-for-job-function training competencies in ESR is pending engagement sought from the ESR team." Nov 2022: An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised. - Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. • An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment.	January 2024: Ward and departmental managers need appropriate resources to engage in the identification and the making available of staff for training Obtaining a match with an appropriate level of quality for the Health Board's needs from the training that can be provided by the manufacturer needs scrutiny Lack of manufacturer personnel limiting ability to respond with support to run training sessions on a large scale	January 2024: The dominant risk factor related to this recommendation is that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster, this is assessed as a having a current risk exposure level of 9 (high). The following mitigation actions are identified: · Follow up on seeking responses to the infusion training questionnaire originally sent out to ward and departmental managers in January 2023 and update consolidated infusion training database accordingly · this would give assurance the organisation is running at an appropriate infusion training compliance level by providing an accurate denominating figure · Increase capacity for provision of infusion device training, including using manufacturer's training resource for revalidation training using a cascade training model This risk is currently being partially mitigated by providing ad hoc training sessions in a seminar room in OSU to ensure new starter training for end users is being delivered as able. Fresenius reps helping with staff updates as able prior to finishing in post. Cascade sessions delivered to paediatric nurses as able, to enable them to support with delivery of paeds updates.Need for fixed infusion device training base escalated and venue being sought.	New QPS Infusion Device Service Training Manager now in post.Consolidation of the infusion device training records aim to be achieved by end of Sept 23, Development of a dashboard to indicate compliance levels aim to be achieved by December 2023.Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies.	30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	-35.93	30/06/2024	0.00		Overdue		4		June 2024: Sign-off of the terms of reference has been delayed to the end of June to ensure consideration of clinical engagement and the role of the clinical council in the governance structure. March 2024: The Information Governance, Health Records and Cyber Security governance groups are now meeting and the first Information Governance Sub-Committee is being held on the 26/03/2024. The Digital, Data & Technology Sub-Committee terms of reference are completed and will be taken to the Executive Committee on the 11th April pending agenda setting.				30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	31/12/2022	-17.93	31/10/2024	4.03		Overdue	Overdue	3		June 2024: Phase 1 of the structural changes are underway to support formalisation of Service Management structures and WPAS product team. Job description development is underway for senior roles across the directorate. January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments.				30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for 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	-35.93	31/03/2025	8.98		Overdue	Overdue	4		"June 2024 - An Annual Operational Plan has been developed and used to in form IMTP. The IMTP identfies 7 strategic opportunities including the need to review and update the Digital Strategy. 3 sub strands of digital strategy development are in development: a Data, Analytics & Information Management Strategy, a business, a strategic outline business case for the Health Board's Electronic Health & Care Record and an ICT strategy to review the digital infrastructure needs of the Health Board. "Mar 24 - Divisonal engagement meeting dates for meetings are being established for Families & Therapies, Unscheduled car & MH&LD division and will be in place in April 24 subject to Divisional staff availability. January 2024: A new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requests are understood, are properly documented, and have sufficient detail to enable prioritisation. A key component of this will be strategic alignment with the core local and national digital strategies. The Digital, Data & Technology sub-committee of the Finance & Performance Committee will provide an additional governance space for assurance of the work of the directorate by its Health Board stakeholders as well as the Executive. Progress has been made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. Internal audit will shortly be undertaking an audit of our portfolio arrangements in line with best practice. Currently the new Data Strategy is currently under development and associated strategies for ICT and Cyber Security are planned for the first quarter this year.				30/06/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	-29.90	30/06/2024	0.00		Overdue	Overdue	3		January 2024: New Cyber Security Assurance Group will be meeting in January 2024 and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. In addition, the Cyber Resilience Unit will be visiting the Health Board in late January to discuss progress against the Network & Information System Regulations. In April 2024 work will commence on the Health Board's new security platform which will provide visibility of all assets connected to the network which will improve the visibility of critical assets which may not be managed by the directorate. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group.				30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	RS.1	RS.1 The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS.	Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	30/06/2022	-23.97	30/11/2025	16.98		Overdue	Overdue	2		June 2024- the position remains the same, we have got SOP's in place with the process of receiving a request from any referral source. There will still be some element of human error with this being a manual process to create the requests. The only true solution is electronic requesting that integrates with out RIS which we currently don't have but are looking towards for the PACS/RIS. The go live date for the new PACS/RIS is November 2025. This work should include working with IT and software development to integrate the new products and an electronic requesting system that will integrate with the new RIS. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.		Targetted training is provided to teams in the meantime.		30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	RS	RS The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	31/03/2022	-26.95	30/11/2025	16.98		Overdue	Overdue	2		June 2024- we are currently live in two GP practice using WCP's electronic requesting solution that integrates with our RIS so we it process the request electronically. We will be looking to roll this out in another two GP practices over the next 6 months. This is the chosen solution of RISP or whatever we currently have. There will be discussions with software development and the CCIO over the summer along with Philips and Soliton our new PACS/RIS providers to discuss true electronic requesting. Integrated electronic requesting was a part of RISP. The solution provided by Soliton the new RIS provider was not selected. There will be meetings between ABUHB and Philips/Soliton do discuss a live fully integration electronic requesting solution for the go live date of November 2025. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and this is currently being looked at by informatics	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			30/06/2024

Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-17.93	31/12/2024	6.03		Overdue	Overdue	3		June 2024: Work to associate critical assets to critical systems is progressing well but some way from completion. All assets are within CMDB and all services within Service Catalogue, dependancy mapping is ongoing March 2024: Cyber continues to attend GAG (Governance and Assurance Groups) meetings when scheduled with divisions to highlight the need of Information Asset Owners (IAO) and Senior Information Asset Owners (SIAO). CSAG (Cyber Security Assurance Group) meeting has been postponed due to circumstances within the team, this will be rearranged when applicable. Attendees have been identified and agreed with the SIRO. Terms of Reference will be covered in the first scheduled meeting. January 2024: The Cyber Resilient Unit assessment is now scheduled for 22/01/2024. There was a pre assessment meeting arranged with the CRU before the new year to discuss scope and this included Information Asset Owners.There is strong engagement through our divisional assurance arrangements where regular meetings are held between the divisions and our cyber security team. This will be further strengthened with the Cyber Security Assurance Group which will be meeting for the first time this quarter. Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dev to discuss scope and Digital will ensure this includes Information Asset Owners.				30/06/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	-17.93	30/09/2024	3.02		Overdue	Overdue	3		June 2024; "11/06/24 Work to establish SIAOs and IAOs continues within the GAGS. Once individuals are in place they will be fully involved in the next CRU NIS Audit program. March 2024: As part of the NIS CAF, CRU have supplied Cyber with a "Findings Update" Excel documentation, which allows Cyber to provide monthly updates against the outcome recommendations for the Principle(s). Currently, Cyber's responsibility is to gather updates for CRU from Remedial Action Owners until CSAG (Cyber Security Assurance Group) meetings are held; however, CRU require monthly updates and CSAG will be on a quarterly basis. We are reviewing the project management arrangements to ensure the reporting requirements can be met. January 2024: In our assessment with the Cyber Resilience Unit in Januarry we are discussing the documentation requirements and how we can ensure this audit recommendation can be satisfied going forward. Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessemnt scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023				30/06/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	-9.02	31/07/2024	1.02		Overdue	Overdue	3		June 2024 work continues as previously described. Revised Policy Management Framework to be presented to the Board for approval in July 2024 March 2024: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents. November 2023: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues	November 2023: Any new policies are checked for embedded documents prior to publication		30/06/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-9.02	31/07/2024	1.02		Overdue	Overdue	3		June 2024: work continues as previously described. Revised Policy Management Framework to be presented to the Board for approval in July 2024 March 2024: This will be included as part of the revised framework November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-9.02	31/07/2024	1.02		Overdue	Overdue	3		June 2024. Partially complete. SharePoint system in place and automated flagging and reminder system established./ Review of templates and submission process included within the revised Policy Management Framework scheduled for submission to Board in July 2024. March 2024: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed. November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this, escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-9.02	31/07/2024	1.02		Overdue	Overdue	3		June 2024. Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval. complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval. November 2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-14.98	31/07/2024	1.02		Overdue	Overdue	3		June 2024 Clarification of definitions of WCDs and Health Board vs local documents included within the revised policy framework, to be presented to Board in July 2024. March 2024: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database) November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.12	Records Management	Limited	Director of Digital	Head of Workforce and OD	Medium	R4	R4 The management of ward clerks should be centralised, and consideration should be given to manage shortages through "bank arrangements".	a.) Local ward clerk shortages will be escalated to the Assistant Directors of Nursingand subsequently escalated to the Executive Director of Nursing. Action plan will be agreed how to solve them. b.) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing hierarchy to the ward staff.	31/07/2023	-10.98	31/08/2024	2.03		Overdue	Overdue	2		June 2024 - The NDSR process is in place with fortnightly review meetings attended by DDAT senior team to review and manage the process but requires some additional internal governance arrangements to be concluded to support the management of NDSRs across the lifecycle from request to final delivery. It requires broader communication to socialise in the organisation. New request form will be provided on Seren (ICT Portal) in June 2024. Jan-24: First level of organisational process is underway and will commence in February. Nov 23: Will be discussed at Executive Committee and considered as part of the Digital Organisational Change Process				30/06/2024

Internal	2022.12	Records Management	Limited	Director of Digital	DPO & Head of IG	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023	-5.97	31/07/2024	1.02		Overdue		1		June 2024: Will be considered as part of WPAS product team support and changes, discussions are underway with Chief Operating Officer and Executive Director of Nursing so this can be aligned with the ward accreditation process. Mar 24- Closure of another library of records achieved at Llangennech and move of some mental health, children service records to vacated Antenatal Basement Library to relieve pressures. - Unable to provide a revised timescale at this stage.				30/06/2024
Internal	2022.12	Records Management	Limited	Director of Digital	CNIO	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.	31/03/2023	-14.98	31/03/2025	8.98		Overdue	Overdue	2		June '24 - WNCR now live in YYF and only 8 wards left. 2.5 release will include two more forms will will cut more from the nursing paperwork. This does not include the medical / AHP etc documentation still required in paper format on the wards. The reduction in paper reduces some of the risk however, records management team are still continuing with targeted training on wards where there have been issues identified. Jan-24: Ward visits undertaken by records management staff to ensure loose notes colelcted from sites. As a part of the Digital Strategy, a review will be undertaken for a review of digitisation of the remaining health records, with a key requirement being eForms. With reference to R4, we can pick up any further improvements to be made to loose patient record filing. Nov 23: The promotion of good practice continues and the roll out of WNCR at NHH has commenced.	Further rollout of WNCR in YYF, YAB, NHH will reduce the loose records and guidance will be provided to the staff on the wards in these areas.	Training of ward clerks where there are issues identified is ongoing and datix reports submitted where substantial breaches are identified.		30/06/2024
Internal	2022.12	Records Management	Limited	Director of Digital	DPO & Head of IG Interim ADI – Governance & Assurance	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	-5.97	31/03/2025	8.98		Overdue	Overdue	2		Jun 24 Business Case for digitisation of remaining services records awaiting agreement so that work can commence as per R5. Further risk identified where existing tracking on former Epex system has not been fully migrated to WCCIS. Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.				30/06/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Assistant Director for Strategy, Planning & Design	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transisition to service delivery	01/06/2023	-12.95	31/08/2024	2.03		Overdue	Overdue	3		June 24 - the RPA posts have been filled, handover is complete from the contractor architect. The operational service model is being defined. Jan-24: RPA posts are in the Trac process for readvert and interview. A draft operational model has been developed. Completion remains dependent on successful team recruitment Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services				30/06/2024
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Assistant Director of Nursing (PT Safety)	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-13.97	31/10/2024	4.03		Overdue	Overdue	3		June 202412/06/2024 Not yet complete, further training on AMAT required January 2024: In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."This will be implemented across the HB in April 2024. August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."				30/06/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024	-2.95	31/08/2024	2.03		Overdue		1		June: SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document . The SBAR was reviewed May 2024 and new version will be rolled out August 2024				30/06/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024	-2.95	30/09/2024	3.02		Overdue		1		June 2024: the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days', the Health Board has focused on implemeting these principles and the new electronic management tool will enable collaltion of data to demonstrate the impact. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded however the electronic data system is currently being rolled out .				30/06/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	-2.95	30/09/2024	3.02		Overdue		1		June 2024: The Welsh Nursing care records are rolled out to all areas and the discharge documentation is audited to ensure compliance. Further work is ongoingthrough the Intregrated Discharge board and focus groups to ensure that the checklist and discharge documentation is embedded meaningful and robust. This includes discharge champions in inpatient areas and a learning focus with the safer discharge group				30/06/2024

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Planning Director / Head of Performance	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be	01/10/2023	-8.95	30/09/2024	3.02		Overdue	Overdue	2		June 2024: An initial meeting has been held and a scoping document is being prepared to develop a business case for a new data capture system to enable greater depth of analysis on discharge data and infromation March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review				30/06/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	-12.95	30/09/2024	3.02		Overdue	Overdue	3		June 2024"Solicitors are working on Stakeholder queries. The dentist has requested a meeting to discuss the revenue costs. This is due to be set up this week. Further discussions have taken place within Project and agredd that this will be escalated to the Divisional Director and Clinical Director of Primary Care in order for them to discuss with the proctice. It is anticipated that this will be finalised by end of September 2024." March 2024: Tredegar Medical Practice (TMP) have recently has become an Independent Practice. Legal & Risk are in connection with TMP solicitors to sign off the Lease. Glan-Y-Afon (GYA), have changed solicitors, Legal & Risk are corresponding with GYA solicitors. GYA had queries which have been responded to. Jan 2024: Still being progressed by Shared Services Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	None	N/A	Aug 2023: Agreed leases	30/06/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	High	R4	Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	31/12/2023	-5.97	31/10/2024	4.03		Overdue	Overdue	2		June 2024: PALS team are now actioning all grade 1 and 2 concerns. 6 monthly evaluation report in progress. Closer liaison between PALS and PTR team. March 2024: The QPS resource centralised on 15th February 2024. We are in the process of reviewing and remapping the entire concerns pathway which will identify and address the barriers that are leading to poor complaince. The PALS service are now managing all grade 1 and 2 concens.				30/06/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R5	Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require followng OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability framecwrk between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023	-5.97	31/10/2024	4.03		Overdue		1		June 24: A centralised Learning Repository is also being developed which will provide a live bank of actions undertaken, updates. This will be supported by the utilisation of the actions functionality in Datix Cymru, which supports monitoring, ownership and accountability. March 2024: The orgaisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCi team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Working with datix team to ensure that actions are assigned on the datix system.				30/06/2024
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Chief Information Officer	High	R4.1	we reccommend that the Health Board devise a plan to address the longstanding underperformance in the monthly coding of episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	The Executive Committee approved the restructing of the Clinical Coding department in August 2023, the agreed restructure when comlete wil deliver on the monthly coding of episodes target.	30/06/2024	0.00	30/09/2024	3.02		Overdue		1		June 2024 Recruitment to implement the new Clinical Coding structure is on going and estimated to complete by end of September. When the structure is completed, iccremental improvements towards the monthly target will commence. Jan 2024: The Executive Committee approved the restructuring of the Clinical Coding Department in August 2023, the agreed restructure when complete will deliver on the monthly coding of episodes target.All posts have been approved by the vacancy scrutiny panel, they have been advertised on NHS Jobs and shortlisting / interview processes are completed. Some of the posts are being readvertised due to a lack of suitability of candidates.				30/06/2024
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	Chief Information Officer	High	R4.2	We reccommend that the Health Board devise a plan to address the longstanding underperformance in claering the backlog of uncoded episodes. The performance of the plan should be reported regularly to the Board or an appropiriate forum.	Backlog of episodes will be systematically coded when the new Clinical Coding Structure in implemented. The new structure provides the workforce with he capability to deliver on the monthly coded episodes target and address backlog.	30/06/2024	0.00	31/10/2024	4.03		Overdue		1		Recruitment to implement the new Clinical Coding structure is on going and estimated to complete by end of September. When the structure is completed, iccremental improvements towards the monthly target will commence. Jan 2024: Backlog of episodes will be systematically coded when the new Clinical Coding Structure is implemented. The new structure provides the workforce with the capability to deliver on the monthly coded episodes target and address backlog.Requires recruitment to new structure as above				30/06/2024
Internal	2023.06	Estates Condition Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Divisioal Director of Estates and Facilities	High	R5	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) and to inform a financial model for required revenuesupport.	Agreed - the Divisional Director will review the operational workforce required to manage the current level of reactive work and also to ensure compliance with the appropriate level of Planned and Preventative Maintenance (PPM).	31/05/2024	-0.98	31/07/2024	1.02		Overdue		1		June 2024: Work is ongoing within the Division including the use of data analysis provided with external (no cost) support. Due to competing operational pressures for the estates function during year end capital pressures and normal winter challenges there has been a delay. A paper outlining the issues will be brought through to Executives in July 2024. The issue has however been discussed at the Division's Annual Rreview with Executives.				30/06/2024
Internal	2023.10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance & General Managers.	Medium	R2.1	We recommend where assets are disposed of and are not being sold, or where disposal forms are completed retrospectively after an asset has not been found in a physical verification test, that asset owners are required to obtain the countersignature of their manager on the disposal form.	To ensure all asset disposals are approved appropriately prior to disposal, a counter signature from the General Manager for the Division will be added to the disposal form and the Financial Control Procedure will be amended accordingly. The policy change will need to be reported to and approved by the Audit Committee.	30/04/2024	-2.00	30/06/2024	0.00		Overdue		1			The Financial Control procedure has been updated to reflect the requirement for Divisional General Manager approval for asset disposals the change will be considered by the exeuctive team in June and reported to ARAC for approval & communicated out to Divisions.			30/06/2024

Internal	2023.10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance	High	R3.1	We recommend that the Health Board examine each exception individually and take appropriate action to rectifythe matter when the reason for the anomaly is determined.All items that were not found in the register during a physical asset test should be accounted for. Asset owners that did not submit a disposal form at the time of the disposal should be required to provide documentation to evidence the disposal method and to corroborate what took place.	Agree. These issues will be resolved in readiness for the end of year accounts and disposal forms requested for those assets that cannot be located.	31/03/2024	-2.98	30/09/2024	3.02		Overdue		1			Four of the seven asset issues have been resolved with the assets either located or processed as a disposal. Of the remaining three assets one is due to be disposed in June. The remaining two assets (total NBV £4k) are thought to be still within the Health Board but have not yet been located in GUH as they move with patients around the hospital. The Capital Finance team will work with EBME to locate these assets over the next few months and if not found will action a disposal.			30/06/2024
Internal	2023.11	Long Term Sickness Absence Management	Reasonable	Director of Workforce & OD	Director of Workforce and OD	Low	R1.1	The Health Board should review the Pack to ensure it is up to date and in line with the Health Board's processes and remains fully aligned to the NHS Wales Managing Attendance at Work Policy.	To update the pack, to include the enhanced OH referral process and any other appropriate updates, whilst recognising that the pack predicates on the policy, which requires national approval and update.	30/06/2024	0.00	31/07/2024	1.02		Overdue		1		June 2024: Working group led by Kevin Goode, Asst Workforce Business Partner established to review and upate the resource pack and template letters. Sickness Focus Group to approve.				30/06/2024
External	20219EA	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R4c	Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	Work has already begun and services such as Wet AMD for ophthalmology and extended skin are now funded as a core service which was initially established through pace setters			31/03/2025			Overdue		0		Budget transfer arrangements in place for extended skin services, which were orignally established through pace setter funding and awaiting WG sign off of the WGOS 4 transition plans for the implementation of integrated patheays for Medical Retina, Glaucoma and Hydroxychloroquine services. The expectation is that current ODTC centres will transition to WGOS 4 over the coming months and no later than March 25, an allocated core budget is in place for WGOS services. Buisness case developments are required for other beneficial models to support the "left shift" of resources, a case for Psychological Wellbeing Practitioners will be developed for consideration in 2025/26 financial year.				30/06/2024
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	Head of Board Business	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023	-9.93	30/09/2024	3.02		Overdue	Overdue	3		June 2024. In preparation for the new financial year revised fwps for committees have been developed with dialogue occurring with relative Executive Directors. This has been supplemented with greater planning in the development and timing of Chairs notes to guide the Chair during the meeting. To supplement this a performance tracker for meetings has been established which identifies those meetings which overrun. During Qtr. 4 1 meeting overrun. This was the Patient Safety, Quality Outcomes Committee with improvements in other committees noted. Work continues to address those circumstances where meetings overrun and this includes discussions with Executive Leads and Chairs. March 2024 -A review of Board Business processes and products has been undertaken and the outcome of this work is included in an Improving Board Business action plan and report that will be submitted to a future Board meeting. In terms of practical application there is greater focus taken at agenda setting meetings to ensure that sufficient time is allocated to support the meeting agenda. November 2023: The HOBB is undertaking a review of all board processes and procedures to secure greater consistency of approach and to ensure that all regulatory and statutory requirements are addressed though an action plan to improve board buisness. This will include the timeliness of meetings and scope of papers for consideration.				30/06/2024
External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	Medium	R1	The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could public unconfirmed committee meeting minutes shortly after the meeting	The Health Board remains fully committrf to operating with openness and transparency. Greater transparency of the Boards committee buisness will be implemented, building on existing practicies.	30/04/2024		30/09/2024			Overdue		1		June 2024 - This action is included with the Improving Board Business Action plan which is with the Director of Corporate Governance. The focus of activity has however been upon ensuring consistency of processes of board business through the development and agreement of a documented end to end process. Discussions at Director level continue regarding the move to live streaming meetings but a date has not been agreed.				30/06/2024
External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R3	The Health Board should establish a robust wuality assurance mechanism to review the quality of reports for its Board and Committees.	The Health Board is currently reviewing its Board and Committee administation processes, including key performance measures. This will include a focus on the quality assurance process with clarity on expected standards. This will also be supported by work in resepct of report writing develipment in recommendation 2.	30/04/2024		31/12/2024			Overdue		1		June 2024 - This action is included within the Improving Board Business Action plan which is with the Director of Corporate Governance. The focus of activity has however been upon ensuring consistency of processes and procedures within board business through the development and agreement of a documented end to end process.				30/06/2024
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R4	We found that the Health Board had workforce planning training and support, particularly in relation to the opening of Grange University Hospital, however this was paused during the pandemic, and it now needs to recommence. The Health Board should develop and implement a programme of workforce planning training and once in place create an evaluation framework to measure the success of its training programme. (	Plans are in place in provide formal training and education in line with the newly revised HEIW workforce planning competency frameworks. The Health Board will also be introducing workforce planning awareness into existing training management and leadership programmes	31/03/2024		31/12/2024	6.03		Overdue		1		June 2024: "Introductions to workforce planning have been presented to both DDX and CDx programmes in May 24. Business case templates have been updated to reflect workforce planning requirements (May 24). The timescales of this audit will need to change to align to the suite of tools that HEIW are developing. They are developing 4 levels of training (online, locally delivered, HEIW delivered and CIPD delivered). The Workforce Planning Competency Framework has been developed by HEIW but no dates have been set in relation to the roll out of the skills assessment tool or the foundation (online) or intermediate courses (in person). The preference would be to launch the training courses aligned to the competency framework to ensure target courses are the most appropriate audience and skills required and where to target. Locally delivered courses will then be aligned to this and dates set."				30/06/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Medium	R.1	The provision of the VPN from WAST should be formally documented within a service agreement.	ABUHB accepts that this should have been put in place but provision of VPN for RPA connectivity from WAST was only ever intended to be an interim solution. This will be discontinued as soon as the official solution from DHCW is available.	31/03/2024		31/10/2024	4.03		Overdue		1		June 2024 - Interim Solution - Risk will be mitigated upon closure of risk r1.2				30/06/2024

Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Medium	R.1.2	Work should continue with DHCW as the providers of the national infrastructure to move this service to DHCW.	ABUHB accepts this recommendation, and a request has already been placed with DHCW to provide VPN service for RPA and other services requiring this functionality	31/03/2024		31/10/2024	4.03		Overdue		1		June 2024 - Awaiting DHCW - Service request Submitted				30/06/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Head of Ict	High	R5.2	A process for ensuring switches are patched should be established.	ABUHB accepts this recommendation. A process for switch patching will be developed and implemented.	31/03/2024		30/06/2024	0.00		Overdue		1		June 2024- Partially completed, we do actively perform upgrades across our estate for all infrastructure requirements. Following this audit we have devised a patch flow process on how we evaluate published software loads/ fixes. This needs to be inserted into a SOP and adopted as a Operational working process. Target completion June				30/06/2024

Appendix 6 Completed recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager. b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements. b.The policy and process documents will be updated to reflect the amendments.	31/10/2021	-31.90	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	2		March 2024: A revised Standards for Business Conduct Policy will be submitted to the Board for approval in May 2024. January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				30/06/2024
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Head of Corporate Governance	Medium	R2	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	-31.90	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	2		March 2024: A revised method for the reciept and management of DoIs is incuded in the revised Standards for Business Conduct Policy. January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R1	R1 Clarity should be sought over the roles and responsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner. ABUHB Radiology internally request on service point If the department knows the server team need to undertake work. We will continue to do this.	01/03/2022	-27.93	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.		Targetted training is provided to teams in the meantime.	The SLA sit's with ICT in ABUHB and the service management is managed by Radiology in ABUHB. The position will remain unchanged until we have the new PACS/RIS solution in place where the roles and responsibilities are going to be clearly defined.	30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R4	R4 The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed.	There is a backup regimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	-26.95	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. 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	We have defined the process and routines for database back up's and maintenance tasks are in place.	30/06/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R6	R6 Password controls should be improved with an increased minimum length and the Board should reduce the default maximum attempts available.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have 5 attempts.	01/03/2022	-27.93	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Nov 2023: currently trialling in primary care which has been succesful and is with software developments and informatics bussiness analysist to scope out as this is the selected solution from RISP.	Would need to staple in WCP ETR into CWS once the project has been scoped and timlined.	We have got checks for clinicians with similar names for obvious booking errors.	The single user that had the issue with password control now complies and has the same restrictions as all users.	30/06/2024
Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Head of Pharmacy Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	-14.98		-1490.92		Completed/ Closed	Completed/Closed	2		Update March 2024: Policy extended with review date 31st May 2024. Revised policy due to be provided to Clinical Policy & Standards Group 9th May 2024. Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics). The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy. The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational	Delay due to HMRC licencing requirements		ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6 Policy reviewed and update approved at CSPG 9th May 2024	30/06/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022	-20.95		-1490.92		Completed/ Closed	Completed/Closed	2		March 2024: Due to unforeseen circumstances, Cyber has postponed the first meeting of the Cyber Security Assurance Group (CSAG) and is yet to set a rearranged date and time. Attendees have been agreed by the Cyber Security Manager and the SIRO and a Terms of Reference (TOR) paper has been created in readiness of this meeting. January 2024: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process and will form the basis of associated capital plans and potential bids to Welsh Government.			11/06/24 This action has been accepted by management and will form part of any future NIS engagement with CRU so can be closed. Documentation requested by CRU will be supplied	30/06/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security and the risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	-20.95		-1490.92		Completed/ Closed	Completed/Closed	2		March 2024: The first Information Governance Sub-Committee meeting has been postponed until March 26th; however, the Cyber Security Assurance Group (CSAG) are yet to have their first initial meeting. January 2024: The new Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024.Regularly report of cyber incidents, risk, awareness and training will be provided to the Finance and Performance Committee through reporting from the Information Governance Sub-Committee. Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani			Cyber Security Assurance group - reporting to IG Sub Committee has now been implemented and TOR accepted. Progress against NIS Improvement plan has been incorporated into the overall Cyber Security Action Plan and will be reported and monitored at CSAG	30/06/2024
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Flow Centre Nurse	Low	R3	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre	30/09/2022	-20.95	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	2		March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" 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		WAST provide a suite of KPI's for the SLA that are reported monthly to the COO & Deputy COO. This enables the HB to improve the delivery of the service. Call handling KPIs have also been developed and are discussed at the bi-weekly SLR meetings.	30/06/2024

Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Medium	R4	R4. We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	-23.97	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/C losed	2		March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •The BCP has been created/updated and is due for a further review in light of recent IT risks and the joining of the Urgent Care Division	Mar 23 recent Divisional changes have meant that the BCP now requires further refinement however, orginal recommendation was implemented.		The business continuity plan continues to be reviewed & updated following the establishment of the Band 7 Site Manager team.	30/06/2024
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Service Manager (USC)	Low	R4.1	R4.1 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	-19.97	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/C losed	2		March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •This is on hold until we return to our call centre.			The BC plan has been tested in the live environment due to recent issues with telephony. The BC is now being further updated following learning from these recent events.	30/06/2024
Internal	2022.05	Digital Benefits Realisation	Substantial	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to programmes or Service Delivery. This will provide internal assurance of the process and ensures that options are presented to Digital Delivery Oversight Board (DDOB) with a clear assessment of priority and recommendations. DDOB is the body that will make informed decisions on the prioritisation of Informatics programmes and projects. New national programmes will be tracked through the same process allowing the Health Board to locally prioritise and feedback these priorities back to national. This draft process needs to be signed off and fully implemented.	01/06/2023	-12.95		-1490.92		Completed/ Closed	Completed/C losed	2		March 2024: The new digital service request has been drafted and will be completed by end of March 2024 for dissemination and implementation and will be presented to Exec Board in April 2024. Jan 24: A new digital service request process will be implemented by March 2024 to funnel all new service requests using a request form in our Seren ICT portal through the DDaT senior leadership team with additional appraisal of requests undertaken by the business analysis team with requestors to ensure requests are understood, properly documented and managed and have sufficient detail to enable prioritisation and scaling to enable prioritisation and progression in alignment with Health Board priorities.			Cyber Security report going to IG sub Committee Finance & Performance Committee	30/06/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/C losed	2		March 2024: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework. November 2023: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			30/06/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Head of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	-9.02	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/C losed	2		March 2024: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status. November 2023: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status.	November 2023: capacity to review policies given current operational and financial pressures.			30/06/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	-12.07		-1490.92		Completed/ Closed	Completed/C losed	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The interim product specialist is implementing a beneits register. This work will be ongoing during April and May 2024. Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed			RPA requests are made through the NDSR process. As part of 'Definition' all requests are assessed for benefits both cash and non cash releasing. Benefits are captured on a Benefits Register	30/06/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	-14.98		-1490.92		Completed/ Closed	Completed/C losed	2		Mar 24 - a benefits management framework is being implemented in RPA. Benefits are captured duing the RPA opportunity assessment process (see above line 15). Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed			RPA requests are made through the NDSR process. As part of 'Definition' all requests are assessed for benefits both cash and non cash releasing. Benefits are captured on a Benefits Register	30/06/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	-15.97		-1490.92		Completed/ Closed	Completed/C losed	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being interviewed in April 2024 Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.			Recruitment is completed	30/06/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-15.97		-1490.92		Completed/ Closed	Completed/C losed	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being intrviewed in April 2024. Handover needs to be completed from the RPA contractor and the product specilist recruited to enable the work to be undertaken to complete this recommendation Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023			A robust change management process is in place	30/06/2024

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.	01/04/2024	-2.95		-1490.92		Completed/ Closed	Completed/Closed	0					Discharge programme of work through the intregrated discharge board is embedded through the defined work streams to support the safe and timely discharge in line with the 6 goals programme. The optimising discharge framework is rolled out and embedded cross divisionally and ongoing education is supported by key groups, events, workshops and ward based champions The Health Board continues to take forward a Discharge Improvement Programme, aligned to the WG Six Goals for Urgent and Emergency Care Programme, under Goals 5 & 6 – Return and Stay Well at Home. The focus over the last three months includes, roll out of a new D2RA digital solution alongside an education and training programme, supporting capturing meaningful data including red to green days, medically optimised discharge status and D2RA pathways to support patient flow across sites. The function and performance of the Discharge Lounges at RGH and NHH have been reviewed to support timely patient discharge. The RGH Discharge Lounge has relocated and is now aligned with the RGH Discharge Hub and the NHH	30/06/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.	01/04/2024	-2.95		-1490.92		Completed/ Closed	Completed/Closed	0					Welsh Nursing care record (WNCR) is established and embedded in all in patient areas and that include discharge documentation. Discharge documentation is audited to ensure compliance and standardisation. Audit results and areas for improvement will feed in to the safer discharge group, a cross divisional group to ensure that safer discharge principles are adhered to and that learning is evident from any examples of poor discharge. Board rounds and MDT rounds are a daily practice on in patient areas to facilitate a safe and timely discharge and ensures documentation and communication with patient and family	30/06/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC	01/04/2024	-2.95		-1490.92		Completed/ Closed	Completed/Closed	0				The Intregrated discharge board and the 6 goals programme board, alongside the focus group has a learning and improvement focus. Safer discharge group and the discharge group discuss and implement improvement and change as needed through patient experience and learning. Data and Audit supports the improvement and learning.		30/06/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	High	R3	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.	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.	01/06/2023					Completed/ Closed	Completed/Closed						Meeting has taken place Risk Register willl be finalised July 2024. Dashboards being rolled out under the new Project Director for the capital projects that include both risk registers.	30/06/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Project Director	High	R10	Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions	Agreed. Non-compliance to be advised to the Programme Board via submission of this audit report and the Director of Finance.	01/06/2023					Completed/ Closed	Completed/Closed						All future STA request are in line with Standing Orders.	30/06/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	-12.95		-1490.92		Completed/ Closed	Completed/Closed	1		March 2024: "OAMH dementia wards complete the Kings Fund audits on the three dementia wards. They are piloting the ABUHB Accreditation audits on Cedar Park which will be rolled out on al OAMH wards which include environmental audits. Ligature risk assessment audits are part of the ward OAMH yearly review. General hospital wards do not routinely use the Kings fund audits on wards, but the tool has been used to support individual ward improvement plans as part of the VIPS hospital dementia Friendly Hospital Charter implementation programme. UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards.			Older Adults have this process of Audit in place, other sites across ABUHB are requesting support with Audit as required.	30/06/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-9.93		-1490.92		Completed/ Closed	Completed/Closed	1		This is an ongoing action, monthly team meetings facilitate an opportunity to share feedback and consider how we use this feedback to influence practice and services. Patient feedback is used as a basis of QPS, Internal and external reporting. A 1 year reporting of VIPS will take place in April 2024.		June 2024: Patient stories continue to be collected and shared at relevant meetings. The PALS 6 monthly evaluation report contains a number of case studies for onward sharing and learning. Listening and learning from feedback is reported through QPSOC.	30/06/2024
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support and Complex Needs Senior Programme Managers	Medium	R1	The control and oversight of each individual mental health transformation project is formally allocated, documented and communicated to all interested parties to the project. This should include any third-party bodies engaged and ensure that any duplication or omission of effort is identified and addressed. There is a need to ensure that assurance mechanisms, including those provided by third-parties can be relied upon. b. Any such document should ensure that key aspects of a project's development and implementation are considered including time, cost, benefits, linkage of projects to strategic objectives, management of risk and ongoing monitoring of targets etc.	A review of the control and oversight of each of the individual mental health transformation projects will be undertaken to ensure it is appropriately allocated, documented and communicated to relevant stakeholders. The document will cover the areas outlined in recommendation 1.1b	01/10/2023	-8.95	30/04/2024	-2.00	08/02/2024	Completed/ Closed	Completed/Closed	1		Januray 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.		Within WPWS Programme the following Governance process & templates are revised and structured to meet all recommendations for current structure/workstreams. They will be available and active for any workstream that is 'directed and overseen' by WPWS- CSP, managed & co-ordinated by Senior Programme Manager. o Workstreams that were previously 'projects' initiated through this Programme were driven and implemented through active project workstreams. These were overseen, proactively monitored and supported via WPWS-CSP Board oversight, for a minimum of 6 months 'go live'. Supported by steering groups for each. Some workstreams are now active BAU, the operational responsibility and decisions now owned, managed through their respective Directorate/Division operational Teams, subsequently reporting organisationally to MHLD's SMT. Some Workstreams, were 'testing proof of concept' they were provided within limited funding, but are now ceased. The	30/06/2024
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Divisional Director and Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board and the Mental Health Transformation Board established to provide oversight have Chairs appointed who are independent of divisional management to demonstrate and deliver the independence required of such bodies.	A review will be undertaken regarding the Chairs of both the WPWS Crisis Support Programme Board and Mental Health and Learning Disability Transformation Board.	01/09/2023	-9.93	30/04/2024	-2.00	08/02/2024	Completed/ Closed	Completed/Closed	1		**January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. Nov 2023.** Dr Kathryn Walters (Joint Head of Psychology, Counselling and Arts Therapies) has replaced the Divisional Director as the Chair of the Whole Person Whole System Crisis Support Programme Board. A more detailed update on progress will be provided in the next reporting cycle.		The WPWS Board meetings now take place, attendance strongly encouraged in person, Teams(virtual) option on request. The meetings rotating physically on sites are offered to be 'hosted' by ALL strategic partner members. Members have agreed the principle this is supportive to the recognition of stakeholders voice at this Board. Attendance & contribution is improved over the last 3 meetings on rotated sites. Fyi - •March – hosted by Housing Partners •April – hosted by Gwent Police •June – to be hosted by Caerphilly LA New Stategic Change Board to be established and will meet on 26.04.24 to oversee development of new work programmes of work and ensure appropriate governance arrangements going forward.	30/06/2024

Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	The Whole Person Whole System Crisis Support Programme Board performs deep dives into projects to further scrutinise the information received in the Project Flash Reports.	Within the current structure of the Whole Person Whole System Crisis Support Programme Board there is currently the ability to focus on details regarding specific projects. However, a more formal approach to "deep dives" for individual projects will be introduced (12 monthly minimum) that will include comprehensive performance and benefits reporting.	01/09/2023	-9.93	30/04/2024	-2.00	08/02/2024	Completed/ Closed	Completed/Closed	1		January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. November 2023: The Board has agreed to carry out annual Board Planning and Development sessions where 'deep dives' will inform the onward planning for content. Dates in consideration for Jan/Feb 2024 being agreed at Nov 2023 Board	• Funding & locations of physical space to carry out sessions • Access to information with BAU teams for Operational Workstreams such as MH111p2 • Developments in systems to support in outcomes evidencing; eg Alt to inpatients theme. o Electronic PREMS/PREMS Programme have set up and manage collection of information. That information evidences qualitative & quantitative content for the services in the theme. The baseline comparators for BAU traditional services are not implemented electronically(EG Ward PROMS/PREMS) o The performance team priority has a request for virtual wards outstanding (2021) their focus has been with wider WCCIS issues.	• Funding - Looking at avaiblility rooms in wider HB estate & in discussion with partner stakeholders to ID any cost effective/neutral space in they may be able to offer as co hosts • Access to information from BAU leads (MH111p2) – SRO to meet with GM & AGM to discuss information requirements for Programme for benefits realization & whole system impact for all stakeholders. • Systems – o Programme Manager is able to support wards in 'spread & scale' to support them(on request from servcie leads) in implementing electronic PROMS/PREMS issue and reporting. o Performance team recognise the priority requirement for virtual wards set up, and requesting it is reprioritised.	Governance arrangements in place for WPWS Programme (see Recommendation 1.)	30/06/2024
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	WPWS Crisis Support Senior Programme Manager	Medium	R1	Consideration be given to the Whole Person Whole System Crisis Support Programme Board only receiving the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports	The Mental Health and Learning Disability Transformation Programmes (Whole Person Whole System Crisis Support Programme and Complex Needs Programme) will receive the Project Flash reports for all workstreams and those Boards will then report by exception to the Mental Health and Learning Disabilities Transformation Board.	01/09/2023	-9.93	30/04/2024	-2.00	08/02/2024	Completed/ Closed	Completed/Closed	1		January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.			The WPWS-Governance framework is reflective of the recommendations from NHS Audit: Whole Person Whole System Crisis Support Programme Board will receive the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports. The MHLD Transformation Board is ceased and successor Board, MHLD Strategic Change Board, will meet on 26.06.24 and fulfill gvernance functions in line with recommended best practice.	30/06/2024
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	N/A	Medium	R1.1	Business continuity plans and associated documentation should be completed for all service areas within the Health Board. The Health Board may wish to incorpoarte this process with the wider opeartional risk management processes. There needs to be an accountability and escalation routes if such plans/actions cards not completed.	Recommendation accepted - the requirement for business continuity plans is within the Policy and BG planing guidance. The emergency planning team have plans in place to further engage with specific service areas. The new intranet repository will provide further information and will provide further information and will be established to monitor the progress of plans. The newly established EPRR group will be well suited to be the forum for escalation.	31/01/2024	-4.95		-1490.92		Completed/ Closed	Completed/Closed	1		March 2024: All Divisions have been reminded of ther need to have their BC plans in place, each have a nominated lead. Guidance, templates and training/workshops are accessible to all areas to support developing plans. The repository in available on line and starting to be populated with plans produced. The first meeting of the EPRR Group has taken place with representation from all Divisions, the ToR identfy this as being a forum to review progress and escalate issues.		March 2024: Processes are in place but some Divisions are early in there development of plans - these will be monitored through the EP team and to the EPRR group	June 2024: All General Managers have been reminded that they need to have BC plans in place (more than one occasion) and have in place a lead. Templates and gudance have been shared with each area and meetings with leads to support the process. Training and workshops are available and have been uptaken by some areas. The repository is up and running and accessible to each area. Current BC status - based on the respository information has been shared with each GM for action. Reminders sent. Guidance sent and available on line. Training and workshops available to support areas. Repository up and running . Summery of current status sent through to each GM.	30/06/2024
Internal	2023.05	Facilities - Jan 2024	Limited	Chief Operating Officer	Catering Servce Improvement Manager	High	R1.1	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Standard Operating Procedures will be developed to detail each step of the new process. These processes will be shared with staff and be made accessible	29/02/2024	-4.00	30/04/2024	-2.00	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: Processes have been developed however upon reviewing it has been decided to enhance further. Final documents scheduled to be completed and signed off w/c 8th April (due to annual leave of key people)			SOPs implemented and monitoring in place	30/06/2024
Internal	2023.05	Facilities - Jan 2024	Limited	Chief Operating Officer	Head of facilities	High	R1.7	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: The Head of Facilities will consider the potential benefit of software to improve the efficiency, effectiveness and accuracy of stock management processes. Options to be presented to the Divisional Director for decision	31/03/2024	-2.98	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: Following completion of the actions above and the assessment of benefits of any additional software any proposal will be presented by the Head of Facilities to the Divisional Director by mid May			The current software (synbiotix) does have a module which can be used but would require additional work initially to enable that tool to be beneficial. This will be considered at a more appropriate time	30/06/2024
Internal	2023.05	Facilities - Jan 2024	Limited	Chief Operating Officer	Head of facilities	High	R2	Management should implement a consistent approach to stock ordering. This process should be based on current footfall and patient numbers, provisions already in stock and the quantities required per portion from the All-Wales recipes. Management should then complete monthly spot checks to ensure the process is being adhered to. Stock ordering should then be reported at the monthly Facilities meetings to ensure senior management have view of any issues.	ACCEPTED. The following steps will be taken to address the issue:Actions set out in agreed management action for matter arising R1.1-1.7	31/03/2024	-2.98	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: R2-6 completed. Anticipated that remaining two recommendations will be completed by May 2024.			Processes communicated and monitoring in hand but remains a constant need for monitoring	30/06/2024
Internal	2023.05	Facilities - Jan 2024	Limited	Chief Operating Officer	Senior Facilities Manager	Medium	R5.2	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.	1 Review processes for staff access. To ensure that processes are in place to ensure all goods are secured and accessed in a controlled environment.	29/02/2024	-4.00	31/05/2024	-0.98	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: Completed but but consideration of additional steps on specific sites including additional CCTV is now being scoped up and costed			All areas have access controls. Consideration of further monitoring of areas with cameras being added is ongoing and will be considered if deemed required.	30/06/2024
Internal	2023.05	Facilities - Jan 2024	Limited	Chief Operating Officer	Catering Service Improvement Manager	High	R6.1	Management should review how they measure and monitor waste and ensure a consistent approach across all sites. There should also be consideration of the use of extended functionality within Synbiotix and / or the recording of food waste for management information.	Develop a process, in flow chart form, to effectively monitor food waste	29/02/2024	-4.00	06/04/2024	-2.79	16/04/2024	Completed/ Closed	Completed/Closed	1		March 2024: This action has been completed locally. We have taken the decision to hold off implementing this new process whilst we assess it against the new waste regulations due to be implemented on 6/4/24			SOP in place and monitoring in place to manage compliance with new regulations relating to food segregation and no disposal through sinks/macerators	30/06/2024
Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Medium	R1.1	Minutes will be sufficiently detailed to record discussions, decisions, and actions.	Accepted. Will ensure this is undertaken for relevant project meetings and is carried forward onto other capital projects.	30/11/2023	-6.98		-1490.92		Completed/ Closed	Completed/Closed	0					Minutes now reflect clear actions and discussions. Ongoing Projects now include an actions log	30/06/2024

Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Medium	2.1	Welsh Government Project Progress Reports should be fully populated at each return.	Accepted. Will ensure detail is included in the next return and for future Capital Projects	30/11/2023	-6.98		-1490.92		Completed/ Closed	Completed/Closed	0					Project Returns now fully populated	30/06/2024
Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	2.2	Progress reporting within the PPR should reflect the current status/ progress, rather than only reporting when a target has been achieved.	Accepted. Will ensure detail is included in the next return and for future Capital Projects	30/11/2023	-6.98		-1490.92		Completed/ Closed	Completed/Closed	0					Project Returns now fully populated	30/06/2024
Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	3.1	The Welsh Government funded element should be presented as a subtotal on the cost report –i.e., prior to the inclusion of fundraising.	Noted – will apply to other projects where this is relevant	30/11/2023	-6.98		-1490.92		Completed/ Closed	Completed/Closed	0					No further projects have had an allocation of charitable funds - will ensure however that it is carried out should it arise	30/06/2024
Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	3.2	Include the breakdown of the cost to an item basis where large equipment or single items are contributing to a significant financial variance from FBC costings	Noted – will apply to other projects where possible	30/11/2023	-6.98		-1490.92		Completed/ Closed	Completed/Closed	0					Not applicable for this project as project has now completed but will roll out to other projects and have emailed Procurement to include within their costing schedules	30/06/2024
Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	4.2	Change Request Forms should be completed to include 'Change Log Number' field.	ccepted – will ensure this is included in future project change control.	30/11/2023	-6.98		-1490.92		Completed/ Closed	Completed/Closed	0					No further change control forms received for this project, however will ensure it is rolled out to other projects	30/06/2024
Internal	2023.09	Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Low	4.3	All Project Manager Instructions (including zero value and omissions) should be completed in a timely manner as required by the contract.	Noted – will endeavour to complete as recommended, however there will be some situations where it will not be possible to achieve the contractual timeline due to the complexity of the instruction/ change.	30/11/2023	-6.98		-1490.92		Completed/ Closed	Completed/Closed	0					Implemented where able due to nature of PMI. In relation to future projects, will ensure that this approach continues	30/06/2024
Internal	2023.10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance & General Managers.	Medium	R1.1	We recommend that additions forms are obtained from asset owners promptly following equipment purchase and that forms with missing data are returned to owners for completion.	The Capital Finance Team include the new asset form on the Capital Scheme approval email that is sent out to the responsible budget holder when a new equipment purchase is approved. The email requests the form be completed when the new equipment asset is received and returned to the Capital Finance Team. New assets are added to the Fixed Asset Register each quarter. Any missing forms are subsequently chased with the owning department. This process has significantly increased the number of forms received over the past two years.In addition to the above, the Capital Finance team will include a list of missing forms as an agenda item for each monthly divisional meeting and will return forms where information is incomplete. General Managers to ensure that forms are completed and returned to Capital Finance.	30/04/2024	-2.00		-1490.92		Completed/ Closed	Completed/Closed	0					The Capital Finance team have been circulating the list of missing asset forms to Divisions on a monthly basis as of April 2024. From April 2024 the same Divisonal lists of missing forms have been included as an agenda item for each monthly divisional meeting. Forms are being returned where they are incomplete.	30/06/2024
Internal	2023.11	Long Term Sickness Absence Management	Reasonable	Director of Workforce & OD	Director of Workforce and OD	Medium	R2.1a	The Health Board should encourage staff to ensure manager details are correct on ESR for all employees.	Periodic reminders to update details including manager details will be published on ESR portal. In additional, annual report to be run for review by division on manager allocation in ESR	30/04/2024	-2.00		-1490.92		Completed/ Closed	Completed/Closed	0					June 2024 Complete - Individual staff cannot review/change the management hierarchy to ensure accuracy. Managers are regularly reminded to check their management access reflects all staff who report to them. On an annual basis, hierarchy reports will be provided to divisional management teams to review.	30/06/2024
Internal	2023.11	Long Term Sickness Absence Management	Reasonable	Director of Workforce & OD	Director of Workforce and OD	Medium	R2.1b	There should be regular communications with divisions and prompts to ensure long-term sickness is managed effectively and all steps of the process are completed fully and correctly.	Review training material to ensure that all issues above are included. Long term sickness process to be updated in "the pack" plus internal sickness absence group to produce regular comms/tips on effectively managing and supporting staff who are absent.	30/06/2024	0.00		-1490.92		Completed/ Closed	Completed/Closed	0					June 2024 Complete - training updated and managers guide approved 05/06/2024	30/06/2024

External	2019.01EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R1	The Health Board should develop a fully costed Estates Strategy as soon as possible as recommended in our Structured Assessment 2017 (December 2017).	Draft Estate Strategy produced. Report to ABUHB Executive Team on Monday 19 November, with following recommendation:'The Executive Team is asked to consider the draft Strategy and advise of any material changes that need to be made prior to its consideration by the Health Board Development session on 19th December'	31/03/2019			-1490.92		Completed/ Closed	Completed/Closed	0		"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."			"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."	30/06/2024
External	2019.01EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R2	The Health Board should finalise the 'Six-Facet' survey report to inform the Estates Strategy.	6 Facet Survey information now available. Migration to Health Board preferred database ongoing. Survey data being utilised to inform Estate Strategy. Please see attachment in R1 above	30/11/2018			-1490.92		Completed/ Closed	Completed/Closed	0		"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."			"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."	30/06/2024
External	2019.01EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R3	The Division should include a range of Key Performance Indicators in its Performance Dashboard. These should include user satisfaction and completion targets.	Overarching Divisional KPI Dashboard is currently being developed which will incorporate performance data for each service discipline within the Division. Example of Estates Maintenance performance data attached, this datasheet will be revised to include user satisfaction and completion targets	31/01/2019			-1490.92		Completed/ Closed	Completed/Closed	0		"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."			"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."	30/06/2024
External	2019.01EA	Review of Estates	Not Rated	Director of Strategy, Planning & Partnerships		High	R4	The Health Board should ensure that it completes post inspections for apercentage of repairs as part of a systematic quality control process. It should include the results in its local performance management dashboard.	Quality assessments to be undertaken for every 10 requests received, along with customer satisfaction form for completion. Feedback to be collated and reported into the Divisional KPI performance dashboard.	31/01/2019			-1490.92		Completed/ Closed	Completed/Closed	0		"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."			"The implementation of the recommendation has not been tracked through the tracker due to an administrative error in entering it into the spreadsheet. However, it is part of an audit where all recommendations have been completed or superseded by subsequent reports."	30/06/2024
External	20219EA	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R3b	Review the frequency with which Board and committees receive performance reports regarding primary care.	Monthly reports are submitted via the assurance meetings. The Division also reports for both mid and full year reviews.						Completed/ Closed	Completed/Closed	0					Review completed and clarity providing that the PCCS Division reports in line with the Board Assurance Framework. Providing monthly reports for Divisional assurance meetings, reports for both mid and full year reviews, and specific reports as required for relevant programmes and Committees.	30/06/2024
External	20219EA	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R4b	Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs.	The Division has a dashboard which captures activity and performance which is shared with the NCNs.						Completed/ Closed	Completed/Closed	0					The PCCS Division has a centralised dashboard formed from the evaluation of new ways of working, capturing activity and performance metrics. The dashboard and key themes are shared with NCN leads and local NCN teams via the NCN and collaborative level meetings as well as pan-NCN in the ISPB meetings with wider stakeholders.	30/06/2024
External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R4	The Health Board needs to rapidly complete remaining work to identify and address assurance gaps on its Strategic Risk and Assurance Report and ensure it is actively owned by the Board and inform committee agenda setting.	The Health Board is actively progressing work to strenghen its strategic risk and assurance reporting, alligning risks to the board and Committee buisness cycles. This work will be processed alongside work to embed strenthened risk management and assurance arrangements at all levels of teh organisation R5	30/04/2024					Completed/ Closed	Completed/Closed	0						30/06/2024
External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R5	The Health Boards need to complete the remaining work on its risk management strategy and effectively embed arrangements accross the organisation to help to manage the significany finance, performance and quality risk faced.	The Health Board will consider its received Risk Management Framework and underpinning Policy at its meeting in January 2024. The audit, risk and assurance committee will receive these in draft form for comment in november 2023. Implementation of these throughout the organisation as the organisations approach to risk managemnet matures.	31/01/2024					Completed/ Closed	Completed/Closed	0						30/06/2024
External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Strategy, Planning and Partnerships	High	R6	In the Intergarted Performance Dashboard, the Health board should provide more information on the actions required to address underperformance, the impact of past actions taken and where apropriate include benchmarking with other health bodies	As part of the IMTP progress report specific attention has been given to address underperformance including assurance mechanisms. Thsi can be seen in the Quater 2 report and will continue to be strenthensed in futture reports. Where available the data for the current quater is presented and dates provided for data availability. Benchmarking data will be included in the dashboard where avaliable. Not all performance measures have benchmarking data avlaible, an asssessment of benchmarking data can be included in the dashboard.	31/12/2023					Completed/ Closed	Completed/Closed	0					June 2024 The Performance Reports and quarterly reports have been refreshed to align with the Annual Plan outcome and KPI's. These have been strengthened with the actions and plan for delivery over the next period	30/06/2024

External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Strategy, Planning and Partnerships	High	R7	The Health Board should strengthen the IMPT progress report to ensure that it can be used as an effective tool for monitoring progress against the delivery of its strategic objectives. By including up to date data, and clear narrative on the impact of past and ongoing improvement actions.	s part of the IMTP progress report specific attention has been given to address underperformance including assurance mechanisms. Thsi can be seen in the Quater 2 report and will continue to be strenthensed in futture reports. Where avaliable the data for the current quater is presented and dates provided for data availability. It remains important for the Health Board to maintain a mix of definitive progress measures and measures of longer term population outcome. for population outcome measures the Health Board may be the sole influencing factor and measurement may be reported over a long term timescale, however as a population health organisation it is important the Board is sighnted on these measures.	31/12/2023					Completed/ Closed	Completed/Closed	0					June 2024 The Quarterly outcomes report format has been updated maintaining the balance between a mix of definitive progress measures, and measures of longer term population outcome for population outcome measures that the Health Board may be the sole influencing factor. Data for Q1 will be presented based on availability at the time of reporting. The new format also supports including the actions and plans to address underperformance in key areas.	30/06/2024
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R2	The Health Board does not have an agreed funded establishment that covers all its services. The Health Board should determine its funded workforce establishment for 2024-25 and then introduce arrangements to update this annually.	an All-Wales group has been established to support the implementation of setting funded establishments.The Health Board has commenced work in relation to establishing agreed funded establishments supported by the assistant Finance Director and Workforce Information teams. A targeted approach is being undertaken to support completion e.g., by staff groups. The implementation of the medical E-Systems programme will also support this from a medical workforce perspective.	29/02/2024			-1490.92		Completed/ Closed	Completed/Closed	0					June 2024 Complete - The Executive Committee considered an establishment paper in April 2025 and will pilot an approach in specific areas. The Health Board will not progress further until more information is available regarding an all Wales approach to support establishment controls and the level of resources required.	30/06/2024
External	2023.06EA	Primary Care Follow Up	Not Rated	Director of Corporate Governance	Director of Corporate Governance	N/A	R2	The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care and publishing an annual report on primary care.	The Health Board's Integrated Medium-Term Plan is based on the life course approach and consequently includes key priorities for primary care to integrate across the whole health care system. Monitoring of the Primary Care related elements of the IMTP follow the same format as other areas, including Executive chaired monthly assurance meetings, mid-year reviews, end of year reviews and issue led discussion at Executive Team, Health Board and other committees.The Division has been invited to lead a number of Board development sessions over the past 12 months, notably the presentation of the Primary Care Sustainability plan, which includes the expansion of the primary care academy and is key in ensuring the workforce of the future.The weekly Executive Team meeting provides a forum to discuss any issues across the operational divisions, and primary care features regularly on the agenda. This will include updates from the primary care contracting team reporting on GP and other independent contractor changes. A potential risk that Primary Care could lose profile at Board level due to re-structure and cessation of the Executive Director for Primary Care post. However, stability has been brought to the Primary Care &Community	30/04/2024					Completed/ Closed		0		Completed within report.				30/06/2024
External	2023.06EA	Primary Care Follow Up	Not Rated	Director of Corporate Governance	Director of Corporate Governance	N/A	R3.1	a) Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	As with the other operational Divisions, Primary Care forms part of the Health Boards regular agendas across the various Committees and Boards. The Divisions performance is reported as part of the overarching reporting against the IMTP and is presented to each formal Board meeting and the Finance and Performance Committee.	30/04/2024					Completed/ Closed		0		Completed within report.				30/06/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Head of Ict	Medium	R5.1	A formal patch process for servers should be defined, which should split servers into patch groups, to ensure secure and stable application across the Health Board.	ABUHB accepts this recommendation. There is already a formal patch process defined for MS patching and a schedule of standard changes developed to manage this. Gap analysis to be undertaken to ensure all servers are included and also to identify patch groups to ensure robust and resilient deploymen	31/03/2024			-1490.92		Completed/ Closed	Completed/Closed	0					Patching process has been authored and automated patching to an agreed schedule is in place. There are a very small number of servers that fall outside this due to age of OS but these are being addressed by the critical server refresh project	30/06/2024

Appendix 7 : Not Yet Due

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	1452.00	31/07/2024	1491.93	16/04/2024	Overdue	Not Yet Due	3		"Mar 24 - Divisonal engagement meeting dates for meetings are being established for Families & Therapies and Unscheduled care division and will be in place in April 24 subject to Divisional staff availability. A communications an engagement plan that covers all the activities of the Health Board will be developed in Q1 2024/25. An annual operational plan has been developed to provide a detail account of the delivery plan for 2024/25 to sit alongside the IMTP Digital Enabler section. Divisional meetings are in place for Clinical & Support Services, Scheduled care, Primary & Community care & Urgent Care. New Digital Service Requests are in place to ensure all new requests are reviewed by the Senior Leadership team on a fortnightly basis. The digital enabler component of the IMTP has been completed A Microsoft Team Planner board is in place to track progress and outcome of requests to Projects or production. Internal Directorate communications are in place using Teams channels including a communications, learning & development and job vacancy segments. The Director of Digital has implemented regular online 'town hall' events for the Directorate. The Directorate has very regular lunch and learn sessions for internal and external speakers"Regular Divisional engagement meetings have been expanded to include Urgent Care leaving Mental Health & Learning Disabilities and Medicine to be implemented before the end of March 2024.				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	1458.00	31/07/2024	1491.93	08/02/2024	Overdue	Not Yet Due	3		January 2024: The Digital Champions network for Microsoft 365 has been relaunched and there are plans to further develop this through networking events and lunch and learns. Similar networks are being planned for Analytics and the refreshed Clinical Council. Nov 23: Progress has been made on the request process, business partnering and governance and will be completed by the 31/12/2023. The Digital Champions Network has recently been relaunched. Aug-23: New Digital Service Request process, business partnering and new governance group is under development May 2023 - A divisional engagement model has been agreed for managing new service request and work in progress activities. A CSS meeting has been established. Urgent care to be established next and roll out to follow as resources allow. March 2023 - Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post January 2023 - Funded CNIO and Nursing Informatics lead. First Divisional meeting scheduled for December				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021	1461.02	30/06/2025	1502.89	08/02/2024	Overdue	Not Yet Due	3		January 2024: No progress, wider asset management approach and configuration management approach to be formalised during 2024/2025 financial year. Aug 2023: Awaiting next HBDTS meeting.				
Internal	2021.00	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Chief Operating officer	SISU -Strategic Capital and Estates Programme Director and WPWS Programme Manager	Low	R3	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021	1458.00	31/01/2025	1497.97	08/02/2024	Overdue	Not Yet Due	1		January 2024: Remains Outstanding. June 2023 - Remodelling of service and introduction of APP to FC so KPI to develop in line with new modelling	Quality of data and minimal guidance for reporting on performance	Fortnightly performance meetings, Divisional assurance meetings and triangulation with other governance processes.	ongoing	
Internal	2021.05	Pathology	Reasonable	Chief Operating Officer	Assistant Directorate Manager	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2022	1462.82	01/09/2026	1516.92	08/02/2024	Overdue	Not Yet Due	3		January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24). Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. 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 utilised 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.	
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022	1464.95	30/04/2026	1512.85	08/02/2024	Overdue	Not Yet Due	2		January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable.				
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R2	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMB for an integrated electronic process cannot be delivered. The Health Board should carry out an analysis to fully identify its needs for a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	1463.97	30/09/2024	1493.93	08/02/2024	Overdue	Not Yet Due	1		January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and is with clincial apps and is being trialled in Primary Care on the 11/09/2023. There are discussion amonst informatics about integrating the WCP requesting within CWS and we have done early scoping exercises with a bussiness analysist reviewing this currently. May 23: The UAT has been passed and is with clincial apps and Mr Rice to look at.	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Care After Death Manager	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements.	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	31/03/2023	1475.93	30/09/2024	1493.93	08/02/2024	Overdue	Not Yet Due	1		January 2024: Partially completed. This risk has been resolved/removed by some minor changes to the current CAD database and development work that will make the body store details available in Qlik. Awaiting final verification of Qlik data. Estimated date of completion 31/03/24 November 2023 - new software was not procured due to cost implications. Work undertaken to cleanse databse and ensure that relevant fields are completed to enablel reports to be produced through Qlik. Work on reporting is currently underway.	IT Infrastructure Team resouce capacity may delay the implementation.	November 2023 - Meeting with IT and support has been put in place for basic maintence of database with reports being run through Qlik Mar 23 Ongoiong liaision with Associate Director of Informatics Strategy & Planning	Q4 of 2022/23	
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Care After Death Manager	Low	R4	R4 The Care after Death Team should: • develop call cascade lists to identify staff contact details in advance; • identify additional scenarios that may arise and detail action plans to overcome them; • test a range of continuity events regularly (at least once a year); and • identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.	The CaD Team accept this recommendation in full.	29/03/2023	1475.87	30/09/2024	1493.93	08/02/2024	Overdue	Not Yet Due	1		January 2024: Partially completed. BCP has been developed and fridge and freezer plans in place to manage winter pressure. Additional capacity has been implemented. Cascade lists still to be added to BCP by 31/01/24 November 2023 -fridge/freezer capactiy is still available on the database and space can be identified in the event of unavailabitliy. Work underway at RGH to install 56 further fridge/freezers (est completed December 2023). Decased patient storage business contuity plan is currently being updated to identify/reflect new or additional scenarios. Update August 2023 - fridge/freezer capactiy available on the database and space can be identified in the event of unavailabitliy. Mar 23 Being developed by CAD Manager. 24/03/2023 CAD Team have been sited within CSS Division since November 2022. Due to temporarily return to E&F in April; Facilities Manager to work with team to completion during Q1 of 2023/24.	28/07/23 Environment Act (Wales) increased recycling regulations to be enforced from Apr 24 (non-inpatient premises) and Oct 25 (inpatient premises). Requirements may change in the lead up to implementation of the Act		Q3 2022/23	

Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	1477.97	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March '24 - no confimation of resourcing to support clinical engagement. Position not changed. CNIO position to be reviewed with Digital / Nursing directors with the retirement of current CNIO in July '25 Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Executive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relauch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	1477.97	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed. HAR group review has identified a number of skateholders who would like to join the council Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Director of Digital/Chief Technology Officer	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023	1483.97	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: Application Process will close April 24 . We will receive applications for review and the standard interview process will start for an appointment September 24 "Jan-24: For Digital Specialist Procurement we have identified utilising Network 75, this combines a work placement and part time study as a route to a degree , the ethos of this scheme is for the directorate to grow their own talent for the future. •Analysis of current skills matched to Job Role has been largely completed and gap analysis is being undertaken. •Pre-requisite certification at Prince II foundation and ITIL v4 foundation desirable against all job roles. •Training Agreement has been implemented and is in use within the directorate but this needs consistency across all departments. •Budget restrictions have caused the removal of ring fenced training budget however many staff are taking advantage of non cost training (PLA etc) and being provided protected time for CPD. •Development of Learning & Develop Hub is making excellent progress •Need to agree on a skills management platform to implement "				
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	1477.97	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Programme Manager	Medium	R7	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity.	Agreed, the necessary collateral warranties will be obtained at the earliest opportunity.	01/06/2023	1477.97	28/02/2025	1498.89	28.11.2023	Overdue	Not Yet Due	1		November 2023: there are numerous collateral warranties that occur at numerous points in the contract therefore this would not be completed until the end of the contract , i.e. February 2025. At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties. Aug 2023: At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties.	Aug 2023: None	N/A	Aug 2023: None, CWs have so far not been required	
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	IWN Programme Manager	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25.	01/10/2023	1481.97	31/03/2025	1499.90	08/02/2024	Overdue	Not Yet Due	1		The IWN service was due to be evaluated by a process to consider the efficacy and impacy of all RIF funded programmes, due to conflicting priorities this has not taken place. We are therefore undertaking an internal evaluation to review the work of the IWNs to date and also undertaking a mapping exercise to see what resource exists at a community intervention level and there impacts. This also needs to be considered in the policy context of the new social prescribing fraemwork which will also inform delivery of community level interventions.	A larger piece of work is needed due to the new policy context.	The scoping of this work will be complete by end of March 2024 with a new service model designed and ready to be implemented by March 2025		
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set formal deadlines for reporting. Auditors' comment on management response We agree with the current approach in the absence of mandatory deadlines. Therefore, whilst formal deadlines may not be the most suitable approach, we believe that the Health Board should continue to focus on the key principles of the Standards and the	01/07/2024	1490.95		0.00		Not yet due		0					
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	R2	Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	1477.97	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: The challenge of raising awareness of the benefits of this biographical tool is part of an ongoing programme of improvements through the Meaningful Activities and engagement training delivered monthly from the patient Experience and Involvement team. The national Improvement Cymru team are facilitating an All Wales Biographical tool discussion and implementation group which will help support this message of this tool. Dates unconfirmed as being led by Improvement Cymru. Review September 2024 Nov 2023: Review of the outcomes from the National Audit of Dementia there is a recommendation for a relaunch of information to raise awareness of the diagnostic Code for Dementia on Clinical Workstation (136). The information will be added to the Internal Pulse web pages and shared through ABUHB e mail communication network.			June 2024: Patient stories continue to be collected and shared at relevant meetings. The PALS 6 monthly evaluation report contains a number of case studies for onward sharing and learning. Listening and learning from feedback is reported through QPSOC.	
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Informativc Programme Manager - WCCIS	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff	01/07/2023	1478.95	01/10/2024	1493.97	16/04/2024	Overdue	Not Yet Due	1		March 2024: Applying an Alert to WCCIS was not achievable. The system is not HB wide and time limited. As part of the National Audit of Dementia and the Dementia Hospital Steering group and alert has been introduced for the CWS (Clinical Work Station). An alert will be displayed on patient record using an input code of 136. A briefing document, flow chart and review process is in place to monitor the impact of this as a measurement of people with dementia on our inpatient wards and attending out patient departments. The GP read codes for dementia diagnosis have been reviewed by WG and a reminder document disseminated across MAS and NCN. Primary care divisions.				
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for OAMH / Informatics Programme Manager - WCCIS	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	1478.95	31/07/2024	1491.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: No further action via WCCIS. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.		

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	1479.97	31/10/2024	1494.95	16/04/2024	Overdue	Not Yet Due	1		March 2024: The Dementia Hospital Steering Group implements the All Wales Dementia Hospital Charter and as such are reviewing the KPI for measurement. The CWS Alert will help us to provide a framework to capture, admission, discharge, hospital moves and incidents. This Alert has been introduced in March 2024 and will be monitored and actions evolve as information is reviewed. The patient flow team have a regular invite to participate in the Dementia Hospital Steering Group. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.				
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager linking in with Patient Flow Leads	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023	1480.98	31/07/2024	1491.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: Invitations have been sent to the Patient Flow Team to join the hospital dementia group. Still awaiting representation to be confirmed. Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Language team.			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Language team who we collaborate with closely.	
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	1480.98	31/08/2024	1492.95	16/04/2024	Overdue	Not Yet Due	1		March 2024: Colleague from the Welsh language team are members of the Dementia Hospital steering Group. Language preference and choice have been included on the patient bedside boards introduced to the COTE and medicine wards. The patient Experience and involvement Team are participating in the Cultural Competency accreditation programme to ensure all activities supported through the team consider cultural awareness and accessibility. Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.			Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.	
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R1	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	1487.93	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: The OCP has now concluded on 9th February 2024. Centrailising all PTR teams to ensure PTR regulations are adhered to. Trajectory has been devised for all divisons the Health Board has comitted to be within the 75% Welsh Government target by September 2024.				
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Chief Operating Officer	High	R6	Actions to address the circumstances that have led to individual complaints and those that have been identified to address complaint themes through boarder learning pathways should be captired in actions plans. The delivery of the plans should be monitored by appropriate oversight groups.	Review all QPS resourses being undertaken via an OCP which will include learning.	31/12/2023	1484.95	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: The organisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCi team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Listenting and learning operational group commenced March 2024. Listenting and learning framework under development. Will be completed End of May 2024. QI coaches training September 2024.				
Internal	2023.05	Facilities - Jan 2024	Limited	Chief Operating Officer	Buisness Support Manager	Medium	R7.3	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	The division will be rolling out the AllocateMe function as part of the Health Roster payroll drop down project. (The Health Roster payroll drop down project is forecasted to take twelve months)	31/01/2025	1497.97		0.00		Not Yet Due		0						
Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Divisioal Director of Estates and Facilities	High	R1	Management should initiate discussion with NWSSP: Specialist Estates Services prior to the next submission of the EFPMS to confirm methodologies for assessment and measurement.	Agreed – the Divisional Director will ensure links with NWSSP prior to any submission of EFPMS data. The timing of this action will be subject to confirmed plans and timelines set by NWSSP for submission although at this point in time, the July 2024 date seems realistic.	31/07/2024	1491.93		0.00		Not Yet Due		0						
Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Divisioal Director of Estates and Facilities	High	R2.1	Appropriate surveys should be undertaken following dialogue with NWSSP: SES.	Agreed – the Divisional Director has, since the fieldwork for this audit, been involve in two national level conversations with NWSSP about the future of facet surveys and how they should be done. There is no formal funding for regular surveys and these discussions are ongoing relating to most effective and cost effective solutions with WG and NWSSP across NHS Wales and will dictate the final implementation of this action	31/08/2024	1492.95		0.00		Not Yet Due		0						
Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Divisioal Director of Estates and Facilities	High	R2.2	Planned disposals approved by the Trust Board should be removed from backlog data in accordance with guidance.	Agreed – guidance will be followed.This will be actioned for any future submissions for EFPMS and thus timeline will mirror that of MA 1.	31/07/2024	1491.93		0.00		Not Yet Due		0						
Internal	2023.07	Intergrated Performance Dashboard Data Quality	Substantial	Director of Digital	Director of Digital	Low	R1	We recommend that the Health Board develops a procedure document covering the steps to compile the Integrated Performance Report dashboard for Executive Management Team, committees and the Public Board Meeting.	With the development of the new electronic Integrated Performance Dashboard now being complete, a standard operating procedure for updating the dashboard to reflect reported performance will be developed.	30/09/2024	1493.93		0.00		Overdue		0						

Internal	2023.12	Risk Management	Reasonable	Director of Corporate Governance	Head of Risk and Assurance	Medium	R1.1	The Digital Directorate should ensure that there is no additional risk exposure through the current approach of recording divisional risks. Risks should be migrated to Datix as soon as functionality within the software becomes available	The Health Board is still waiting for an implementation date for the Once for Wales Risk Module (RLDatix). In the interim, the Head of Corporate Risk and Assurance is working with the Head of Health and Safety to improve the risk reporting form on the Datix legacy system, as the current format is onerous, overly complicated, and easy to override required sections. The Once for Wales Datix Risk Module is being trialled in Powys and has been well received; thus, the risk recording form from the RLDatix system will be replicated in the Datix legacy system to aid in the migration of locally held risk registers to Datix.The Digital Directorate will test the new form by adding all its risks to Datix. Training on the Datix system will be provided to ensure that all Datix Users within the Directorate understand how to use the system to manage risks and run reports to gain insight into the Directorate's risk exposure.	30/09/2024	1493.93		0.00		Not Yet Due		0						
External	2018.01EA	Structured Assessment 2018	Not Rated	Director of Digital	Head of Information Governance	High	R3	R3 The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bimonthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020	1439.05	30/06/2025	1502.89	08/02/2024	Overdue	Not Yet Due	1		January 2024: Training compliance is currently 83%. The additional national Cyber Security modules added to the Information Governance training has hindered progress in improving compliance due to the time required to complete the training package. There is particularly low compliance amongst Clinicians and the Data Protection Officer has discussed this with the Medical Director. He will be reminding them of their responsibilities to complete the mandatory training. Mandatory training compliance we will report to the Information Governance Sub-Committee and further plans will be put in place to improve compliance to the 95% target. Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB.	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress	In all revised plans		
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	N/A	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	1464.95	30/04/2025	1500.89	16/04/2024	Overdue	Not Yet Due	1		March 2024: "The Medical Workforce Rostering System will be implemented in the Health Board on a phased basis over an 18 month period. The absence management function of the new rostering system will enable the Health Board to record annual leave entitlements and will have a rolling balance of annual leave taken for individual doctors. The Health Board is in the process of setting up a new interface between ESR and Patchwork Rota to ensure all absence transfers from the new system to ESR. The implementation plan is being progressed and is phased by division and directorate. The plan is for the full implementation to be completed by April 2025. At that point all annual leave should be held on both erostering and ESR systems. The current medical annual leave policy is under review and a decision will be required before implementation on how annual leave will be recorded days/hours/sessions. " November 2023: Procurement completed. Draft Implementation plan being discussed with Divisional Directors. Roll out to commence in January 2024.	Aug 2023: Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full. Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full.	Aug 2023: Executive Team. Legal and Procurement advice	September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23.	
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Digital	N/A	Medium	R3	The HealthBoard should consider strengthening their IT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the 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 finalised version will be released within the coming weeks.v.All user accounts are processedin line with NHS Wales standards. There is a current risk that unless a service request had	31/12/2021	1461.02	30/06/2025	1502.89	08/02/2024	Overdue	Not Yet Due	1		January 2024: The work to remove legacy versions of Windows Server and Windows Desktop operating systems has gone well with no Windows 2008 servers remaining. No further action is required on change management had a robust process is in place with strong engagement with stakeholders and assessments for clinical safety. Further work is required to assess Backup and Recovery Policy and Starters, Leavers and Movers and will be part of the directorates workplan over the next two quarters. Nov 23: Critical Server refresh ongoing, KPI's being developed for presentation at Cyber Security Assurance Group Aug-23: No update - older servers are being replaced via critical server refresh project, updated figures to be provided by SC May 23: No further update				
External	20219EA	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R3c	Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care	The Division has monthly assurance meetings with their Executive Director. The Division also provides information at mid and full year to the Board.						Overdue		0						The PCCS Division has a centralised dashboard formed from the evaluation of new ways of working, capturing activity and performance metrics. The dashboard and key themes are shared with NCN leads and local NCN teams via the NCN and collaborative level meetings as well as pan-NCN in the ISPB meetings with wider stakeholders.	
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	Head of Board Business	N/A	R2	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.	31/03/2023	1475.93	31/12/2024	1496.95	16/04/2024	Overdue	Not Yet Due	1						
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	1475.93	31/12/2024	1496.95	16/04/2024	Overdue	Not Yet Due	2		March 2024: Digital Story repository now being considered on an all Wales basis. In the meantime, the Patient Experience Team will oversee all digital stories and manage in person attendance at Board. Where possible these will align to presented papers . June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. All Wales Experience Team reviweing. Review December 2024 Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital toolkit. The CIVICA system is being rolled out with a specific focus on supporting teams with training to retrieve their own data. Patient verbal narratives are not yet on the system. The first CIVICA report will be presented at Executive Team in September 2023.				
External	2023.04EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R2	The Health Baord should develop training for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	The Health Board will be working to review and update its corporate report templates, alongside developing clear guidence and support for the preparation of Board and Committee reports. Securing additional training will also be explored.	30/06/2024					Not Yet Due		0						
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R1.1	While the Health Board has a three-year People Plan, the current approach to strategic workforce planning is not balanced and instead biased towards shorter term transactional workforce solutions. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board should update its 5 and 10-year planning process, including clinical futures plans and workforce projections to ensure that they appropriately support the implementation of financially sustainable service models.	The Health Board is currently engaging and will be consulting on a renewed long-term strategy up to 2035 throughout 2024. This will involve developing the strategic outlook to inform and develop workforce planning.	31/12/2024					Not Yet Due		0						
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R1.2	While the Health Board has a three-year People Plan, the current approach to strategic workforce planning is not balanced and instead biased towards shorter term transactional workforce solutions. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board should update its 5 and 10-year planning process, including clinical futures plans and workforce projections to ensure that they appropriately support the implementation of financially sustainable service models.	The refresh of the People Plan for 2025 will include strategic outlook to 5 and 10-year forecasts based on the work currently undertaken on census, demographics and population needs analysis assumptions. This is addition to development and implementation of National Workforce plans supported by HEIW and Health Board workforce strategies e.g., Nursing, Midwifery, School and Public Health Nursing Workforce Strategy 2023-2026.	30/05/2025					Not Yet Due		0						

External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R3	Medium to long-term service workforce modelling is out of date and is needed to inform sustainable clinical service models. The Health Board should review their central workforce planning capacity and capability to ensure it is sufficient to support their longer term strategic and operational workforce planning requirements. (	We continue to provide longer term planning alongside National Workforce Strategies being developed by HEIW. We will undertake a review of capability and capacity following an assessment of workforce planning requirements via the 2024 IMTP.	30/07/2024					Not Yet Due		0						
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R5	The Health Board is intending to update its strategic priorities, linked to a review of its Clinical Futures approach. While it is re establishing a Clinical Futures Workforce Group there is insufficient programme infrastructure to support service workforce redesign. Once the Health Board has revised its sustainable Clinical Futures models, it needs to ensure there is a workforce programme to support the necessary redesign and service transformation.	We agree that formal governance and programme arrangements are required to support the delivery of the Health Board Strategic priorities. The Workforce group has now been formalised to take forward the development and delivery of the workforce plans	31/12/2024					Not Yet Due		0						
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R6	The People Plan update reports provide a reasonable coverage of the actions and meetings that have taken place since the last update. However, there needs to be greater assurance provided on the impact of delivery of the People Plan (i.e., the extent that it is making a difference). The Health Board should clearly structure its People Plan updates to better describe the impact that delivery is having.	The People Plan deliverables are subject to scrutiny through People and Culture Committee with updates provided to the Board. The People Plan deliverable benefits and outcomes are also supported by a monthly reported Workforce dashboard. We will look at different ways of time series measures over time to demonstrate outcomes and benefits where appropriate.	31/04/2024					Not Yet Due		0						
External	2023.05EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD		High	R7	Whilst the Health Board benchmarks with other health bodies in Wales, there is potential to benchmark with 'best in class' organisations and clinical models from outside of Wales. The Health Board should look to use benchmarking to inform plans for workforce redesign and service transformation ensuring similar system conditions, demographics and population characteristics make their comparisons valid.	We accept the recommendation to extend benchmarking and work with HEIW in this respect. The Health Board has a compendium of new roles to support and share good practice.The Health Board also has a dedicated intranet ite signposting to HEIW sites which also have compendium of roles. It draws on national workforce benchmarking and research when formulating its service workforce plans. This is in addition to workforce standards set by legislation and through respective Professional Bodies.	31/12/2024					Not Yet Due		0						
External	2023.06EA	Primary Care Follow Up	Not Rated	Director of Finance and Procurement	Director of Finance	N/A	R1	A) Calculate a baseline position for its current investment and resource use in primary and community care. b) Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	The baseline position for investment and resource in Primary and Community Care has been calculated and this has remained consistent across financial years.Work is ongoing to right size the offer in the community in order to divert demand away from acute.	30/09/2024					Not Yet Due		0						
External	2023.06EA	Primary Care Follow Up	Not Rated	Director of Corporate Governance	Director of Corporate Governance	N/A	R3.2	b) Review the frequency with which Board and committees receive performance reports regarding primary care.	The Primary Care Division will be updating the Health Board at the April Development session to report on progress against the sustainability workstream.	30/04/2024					Not Yet Due		0						
External	2023.06EA	Primary Care Follow Up	Not Rated	Director of Corporate Governance	Director of Corporate Governance	N/A	R3.3	c) Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care.	There is work ongoing to integrate the Divisions data into the Performance Report for the Finance & Performance Committee. Initially this will be a minimum data set with plans to expand reporting in the future.Ad hoc / topic specific reports are requested and shared with the Executive Team / Board on a regular basis.	31/12/2024					Not Yet Due		0						
Internal	2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Therapies and Health Science	Risk manager Quality and Patient Safety	High	R1.1	We recommend that a periodic physical verification control process is implemented across the Health Board to confirm the existence of ultrasound equipment and the accuracy of its listing in the MEDUSA database. This may be done by adopting the asset management RFID tagging process underway across all assets.	Medusa currently holds information relating to ultrasound equipment highlighting the location and owner department. A rolling 12-month programme of staggered audit will be implemented to ensure that departments visually check the ultrasound assets against the Medusa list, reporting any issues or potential faults with the equipment to EBME. A 6-month implementation period has been assigned to this action given the need to engage with ultrasound equipment owners, design the audit process, ensure audits are recorded in an appropriate electronic format. The Ultrasound Governance Committee will represent the strategic oversight forum to review progress against the defined actions documented within the management response in support of raising assurance levels. Completing the management response to fully meet the recommendation will require Health Board employees to comply with the policy; failure by any individual to have	01/11/2024					Not Yet Due		0						
Internal	2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Therapies and Health Science	Head of Capital Finance	High	R1.2	We recommend that the Health Board carry out periodic alignment / reconciliation checks between the MEDUSA equipment database and the finance owned fixed asset register with respect to ultrasound equipment. This may also be completed via an electronic interface with the asset databas	An electronic interface exists between the fixed asset register and MEDUSA equipment database however there is a current known fault with this interface. It is currently being addressed between EBME, Capital Finance and IT. Medusa also requires a software update to the latest revision which is also in progress. A rolling programme of audit will then be implemented to ensure reconciliation between MEDUSA and the fixed asset register (only applicable to assets where RFID has already been implemented). A 6-month period has been assigned to this recommendation given the uncertain nature of implementing the solution as well as designing an audit process and recording in an appropriate electronic format.	01/11/2024					Not Yet Due		0						
Internal	2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Therapies and Health Science	EBME Manager	Medium	R2	We recommend that services using ultrasound equipment ensure all items are covered by appropriate service or maintenance contracts and are tracked centrally.	Monitoring of service and maintenance contracts is managed through individual departments as well as the EBME service. The physical verification audit will be utilised to ensure equipment has a current maintenance contract as well as evidence that maintenance has taken place within the prescribed period. EBME will investigate potential for MEDUSA to hold contract information centrally on MEDUSA. The system can be set up to provide Alerts. The alert can be used as an early warning indicator for both EBME and the owner that equipment is approaching a maintenance period. If, after investigation, the potential is not viable or investment required not available, then this particular set up on the system will not be implemented; this is not critical to the Health Board meeting the recommendation. The Ultrasound Governance Committee will represent the strategic oversight forum to review progress against the defined actions documented within the management response in support of raising assurance levels.	01/11/2024					Not Yet Due		0						

Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be defined.	ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services	31/07/2024					Not Yet Due		0						
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Head of Informatics Service Management	Medium	R3	Infrastructure assets should be detailed within a single register / CMDB.	ABUHB partially accepts this recommendation. ITIL Best practice suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.	31/11/2024					Not Yet Due		0						
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Head of Ict	Low	R4.1	Alert thresholds should be configured to identify relevant issues promptly	ABUHB accepts this recommendation. Event management and alerting is under review with the aim to provide a consolidated platform (single pane of glass) for all alerts. Once the procedure outlined in 4.2 has been implemented this will be applied to any new infrastructure at install with existing assets being addressed over time.	31/07/2025					Not Yet Due		0						
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Head of Ict	Low	R4.2	A procedure for reviewing alerts and ensuring corrective actions are applied correctly and in a timely fashion should be developed. All staff should adhere to this review process, following a period of communication.	ABUHB accepts this recommendation. Event management and alerting is under review with the aim to provide a consolidated platform (single pane of glass) for all alerts. Once the procedure outlined in 4.2 has been implemented this will be applied to any new infrastructure at install with existing assets being addressed over time.	31/07/2025					Not Yet Due		0						
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Low	R6	Consideration should be given to enhancing the use of SolarWinds to enable full network monitoring and the use of the CatTool	ABUHB partially accepts this recommendation in so far as the need for full network monitoring is recognised and will be addressed. The specific tool to do this will be decided once the event management review outlined previously has been completed	31/07/2025					Not Yet Due		0						

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Procedure for Receiving, Finalising and Managing Internal and External Audit Reports and Recommendations
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk and Assurance Committee (the Committee) with an updated Procedure for the Management of Internal and External Audit Recommendations, for approval.

Cefndir / Background

Members of the Audit, Risk, and Assurance Committee have expressed concern that management responses contained within both internal and external audit reviews have not always been completed to the required standard, particularly in terms of target dates, which fall into one of three categories as listed below: -

1. Specific dates not provided (quarters rather than exact dates);
2. Unrealistic timeframes (this has been compounded by the number of requests to the Committee to approve revised target dates); and,
3. Conflicting terminology (e.g. Completed but remains ongoing)

Executive Directors have also expressed concern that draft and final reports have not been shared with them as key stakeholders before the approval of

recommendations and management responses and subsequent discussion at the Audit, Risk, and Assurance Committee.

In response to the concerns raised, at the last Audit, Risk, and Assurance Committee meeting on 21 May 2024, the Director of Corporate Governance agreed to review the current procedure to ensure that the point of entry into the Health Board and the conduit between the Health Board and the Auditors were standardised. The review would also provide an opportunity to incorporate quality assurance measures into the process before submitting Health Board responses to Internal or External Auditors.

Asesiad / Assessment

The draft internal process is attached as **Appendix A**. The updated information is presented in red font and a new process chart has been included at Appendix A of the document.

The revised procedure is intended to ensure that any draft or final audit report issued to the Health Board follows a robust internal governance process, that the recommendations and management responses meet the expected standard as outlined in the NHS Wales Audit Committee Handbook, and that the Audit, Risk, and Assurance Committee is assured that the following points have been considered and can challenge where this has not been done:

- Whether management has responded to the audit appropriately?
- Whether the report highlights issues relating to policies and processes, or with the people implementing them?
- Whether management has agreed a realistic and timely action plan to remedy any problems?

The draft document was distributed to Internal and External Audit colleagues for feedback; both were supportive of the updated procedure, agreeing that it would allow all relevant Executives / Responsible Officers to contribute to the draft report while also ensuring the quality of management responses.

The Executive Committee received the updated procedure at its meeting on 20 June 2024 and was supportive of the changes.

Argymhelliad / Recommendation

The Committee is asked to: -

- **DISCUSS** and **APPROVE** the enhanced governance arrangements.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Audit recommendations inform risk.

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

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

	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

PROCEDURE FOR THE MANAGEMENT OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

DRAFT

Purpose

The purpose of this Procedure is to set out the:

- requirement to have a comprehensive and considered management response and action plan in response to Internal and External Audit Reviews (signed off by the lead Executive Director);

- requirement for management responses and action plans to facilitate scrutiny and provide assurance that actions have been implemented in a robust and timely way;

- the role of the Audit, Risk & Assurance Committee in:
    - receiving final Internal and External reports, alongside management responses and action plans;
    - being assured of the adequacy of the management response to issues identified by internal and external audit and the arrangements for monitoring respective actions going forward;
    - challenging the pace of delivery of actions and approving any changes to the agreed timescales of actions;
    - agreeing the frequency of monitoring based on the level of risk and priority of actions; and
    - overseeing the closure of action plans;
- requirement to have one central point for the receipt, logging, tracking, monitoring and reporting of progress against internal and external audit reviews and associated recommendations.

This procedure does not extend to the management of improvement actions arising from regulatory inspections or independent reviews (such as those conducted by Llais). The nature of which is handled separately and overseen by the Board's Patient Quality, Safety, and Outcomes Committee.

The Role of the Board in respect of Internal and External Audit

As set out within Standing Orders, the Board is expected to set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Health Board business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. The Board shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

In doing so, the Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit, Risk & Assurance (ARA) Committee.

The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards.

The Board will also seek assurance from the work carried out by external audit on the adequacy of the Health Board's assurance framework. However, that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

The Role of the Audit, Risk & Assurance (ARA) Committee

The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 *[WHC (2006) 090]* establishes the requirement for every NHS Board to establish an Audit Committee, and this has been incorporated into Standing Orders for Local Health Boards. At its meeting on 23rd March 2022, the Board reviewed its committee structure and approved the establishment of the ARA Committee, which can be found here.

The ARA Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by an effective system of assurance.

The ARA Committee's primary role is to ensure the system of assurance is valid and suitable for the Board's requirements. The ARA Committee will review whether:

- The system of assurance is appropriate for the organisation;
- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;
- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

In fulfilling its role, the ARA Committee will rely on the organisation's internal arrangements and take into account audit work.

The Role of Internal Audit

Internal Audit is a key source of independent internal assurance to the Board and Accountable Officer (Chief Executive Officer). The Public Sector Internal Audit Standards (PSAIS_1_April_2017.pdf (publishing.service.gov.uk)) describe the role of internal audit as enhancing and protecting organisational value by providing risk-based and objective assurance, advice and insight.

As such, its role embraces two key areas:

1. The provision of an independent and objective opinion (the Head of Internal Audit Opinion) to the Accountable Officer, the Board, and the ARA Committee based on an objective assessment of the framework of governance, risk management and control; and

2. The provision of an independent and objective advisory service, with the aim of supporting management to improve governance, risk management and control and contributing to the overall opinion of the Head of Internal Audit.

The Public Sector Internal Audit Standards provide an essential reference source for the ARA Committee in understanding what it can expect from internal audit and also when assessing the service provided.

To support the system of assurance, Internal Audit will develop a risk based annual internal audit plan which details all the audit reviews to be undertaken in the coming financial year.

The Role of External Audit

The Auditor General for Wales (the Auditor General) is the external auditor of NHS Wales. The statutory duties of the Auditor General in respect of individual NHS bodies fall under two broad headings – to review and report on:

- The audited body's financial statements, and on its Annual Governance Statement; and
- Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The external audit role is exercised in accordance with statutory provisions and the work of external auditors is subject to the 'Code of Audit Practice of the Auditor General for Wales' (Code of Audit Practice | Audit Wales) and 'the Statement of the responsibilities of the Auditor General for Wales and of the bodies that he or she audits'.

The Auditor General's representatives (the External Audit Team) will develop an annual audit plan designed to deliver a safe opinion on the accounts and to enable the Auditor General to draw conclusions on whether the NHS body has made proper arrangements for securing economy, efficient and effectiveness in its use of resources.

The audit plan will also cover issues such as regularity, propriety and value for money.

In developing the annual audit plan the Auditor General's representatives will take into account the audit needs of the organisation, using a risk-based approach.

Internal and External Audit – Audit Scope

The Annual Audit Plans will detail the audit assignments, lead executive officers, scopes, and proposed timelines. Before each audit, the responsible executive director(s) will receive a draft audit brief outlining the scope, objectives, audit resource requirements, and timing.

Once both parties have agreed on the draft brief, a final copy of the audit will be issued before fieldwork begins.

At this point in the audit process, the office of the Corporate Governance Director (Director of Corporate Governance and the Head of Corporate Risk and Assurance) should be copied in to ensure awareness.

Internal and External Audit Outcome Reports and Management Responses/Action Plan

For each review in both the internal and external audit plans, an audit report will be issued which includes an assurance opinion on how effective the internal controls are in the scope of that review.

Draft reports will be issued to the Health Board via the Corporate Governance Director's office to ensure process consistency and that the report is distributed to the Lead Director(s) and key stakeholders. The Head of Corporate, Risk and Assurance will distribute on behalf of the Director of Corporate Governance.

The Lead Executive should use the draft report clearance process to highlight for the attention of auditors any concerns they have about the wording, practicality or relevance of audit recommendations, this part of the process will remain between the Lead Director(s) and auditors. The Director of Corporate Governance will support discussion between the Lead Director (s) and auditors where appropriate.

When developing the management response and action plan, management must ensure consideration is given to the capacity and costs required to deliver the actions and any associated risks, ensuring value for money. Where actions require capital investment, consideration also must be given to managing the risk in the interim as capital funding to enable progress may not be available within the timescales committed to in the management response. In these circumstances, other action should be taken to manage the risk which must also be detailed in the action plan and, where appropriate, be added to operational risk registers.

There may also be occasions where recommendations fall outside the gift of the division/directorate/service/team audited to implement and therefore other functions within the Health Board, for example corporate teams such as IT or Estates, will be required to develop appropriate actions for management responses, and be responsible for the delivery of these.

Management responses must: -

- Respond directly to the finding and its recommendation(s);
- Provide specific actions that the Health Board commits to take to correct the finding;
- Exclude information that is not pertinent to the finding or its corrective action plan;
- Identify a specific individual for the implementation of an action;
- Provide a specific and realistic timetable for implementation; and
- Be SMART (Specific, Measurable, Achievable, Realistic, with a clear timeframe);
- Approved by the relevant Executive Director prior to finalising with internal or external audit.

It is also critical to determine early on whether the recommendations can be implemented solely by the Health Board or if implementation is beyond the Health Board's direct control due to third-party involvement and dependency. Such situations should be clearly communicated (to both auditors and the Committee) and formally documented in tracking database updates.

Once the relevant director(s) has approved the management response and action plan, they should be submitted to the Corporate Governance Director’s office, where management responses will be reviewed to ensure that they meet the expected response standards before being submitting to the respective audit team to ensure that the risks have been adequately addressed and the timescales are acceptable; once approved by the auditors, the report is issued as final.

The final report will be distributed to the Health Board via the Corporate Governance Director's office to ensure dissemination to the Lead

Director(s) and key stakeholders, as well as compliance with the Health Board's internal governance process.

The Executive Team will be provided with all final audit reports at an Executive Committee meeting for their awareness before they are presented to the ARA Committee, with a particular focus on limited or no assurance rated reviews. The ARA Committee will be required to understand the level of assurance provided, the recommendations for improvement made to management, and the response of management. This will ensure that the ARA Committee is promptly informed of all audit findings and assurances.

The Director of Corporate Governance will maintain a database of all Internal and External Audit Reports, inclusive of management responses/action plans.

A flowchart setting out the process for the management of audit reports when issued is set out at **Appendix A**.

Monitoring Implementation of Internal and External Audit Recommendations

An important responsibility of the ARA Committee is to monitor the implementation of agreed audit recommendations. The ARA Committee should ensure the organisation adopts a robust process for monitoring the implementation of agreed audit recommendations and that regular progress reports are provided to the ARA Committee identifying any that have not been implemented within agreed timescales.

The process for monitoring and reporting progress against the implementation of internal and external audit recommendations within the Health Board will be led by the Director of Corporate Governance.

The key principles associated with the monitoring of internal and external audit recommendations include:

- Audit Recommendations will be added to the Audit Recommendations Tracker, once the final Audit Report has been received by the ARA Committee;
- Executive Directors will be responsible for respective audit recommendations and ensure oversight of progress within respective teams;
- The ARA Committee will monitor progress against the implementation of all audit recommendations, regardless of priority rating (high, medium, low and not rated), as set out in **Appendix B**;

- Executive Directors, with their teams, will be asked to update on progress against the implementation of audit recommendations as the completion date arises and an update will be reported to the next meeting of the ARA Committee;
- Executive Directors will be responsible for approving the closure of audit recommendations, which will be subject to reporting to the ARA Committee;
- The ARA Committee will focus its attention at each meeting on those recommendations that are overdue past the original agreed timeframe for completion, those that have been closed during the last reporting period which require noting and the number of audit recommendations that are not yet due for completion;
- Both the Executive Team and the ARA Committee will undertake an in-depth review of the Audit Recommendation Tracker twice-yearly;
- The ARA Committee will be asked to approve the revision of any previously agreed dates within action plans, on the advice of internal or external audit;
- Internal and External Audit Teams will assess the position against previous audit recommendations as part of any relevant follow-up audit work.

Where the ARA Committee or Head of Internal Audit/External Auditor are concerned about the lack of implementation of audit recommendations in a particular area, the ARA Committee has the authority to invite the respective Director to attend and provide an update. This will be with a view to ensuring risks and identified weaknesses in internal control are mitigated, recognising that the initial action plan will have been approved by management.

Where it is possible to do so, as part of the updates to the ARA Committee, and particularly as part of a proposed closure of recommendations, reports will provide an indication of the impact that implementing the recommendation will have had on the Health Board in terms of quality improvement, the provision of more efficient and effective patient care, improved governance, increased security or better use of resources etc.

To ensure transparency and greater oversight of the progress of recommendation implementation, and aligned to the oversight of corporate and strategic risks, Board assurance committees will receive an extract of the Audit Tracker relevant to their remit, allowing them to discuss any by exception, e.g., specific recommendations, or to understand where there are issues and provide support to progress implementation.

Appendix A - Process for Distributing Draft and Final Internal and External Audit Reports

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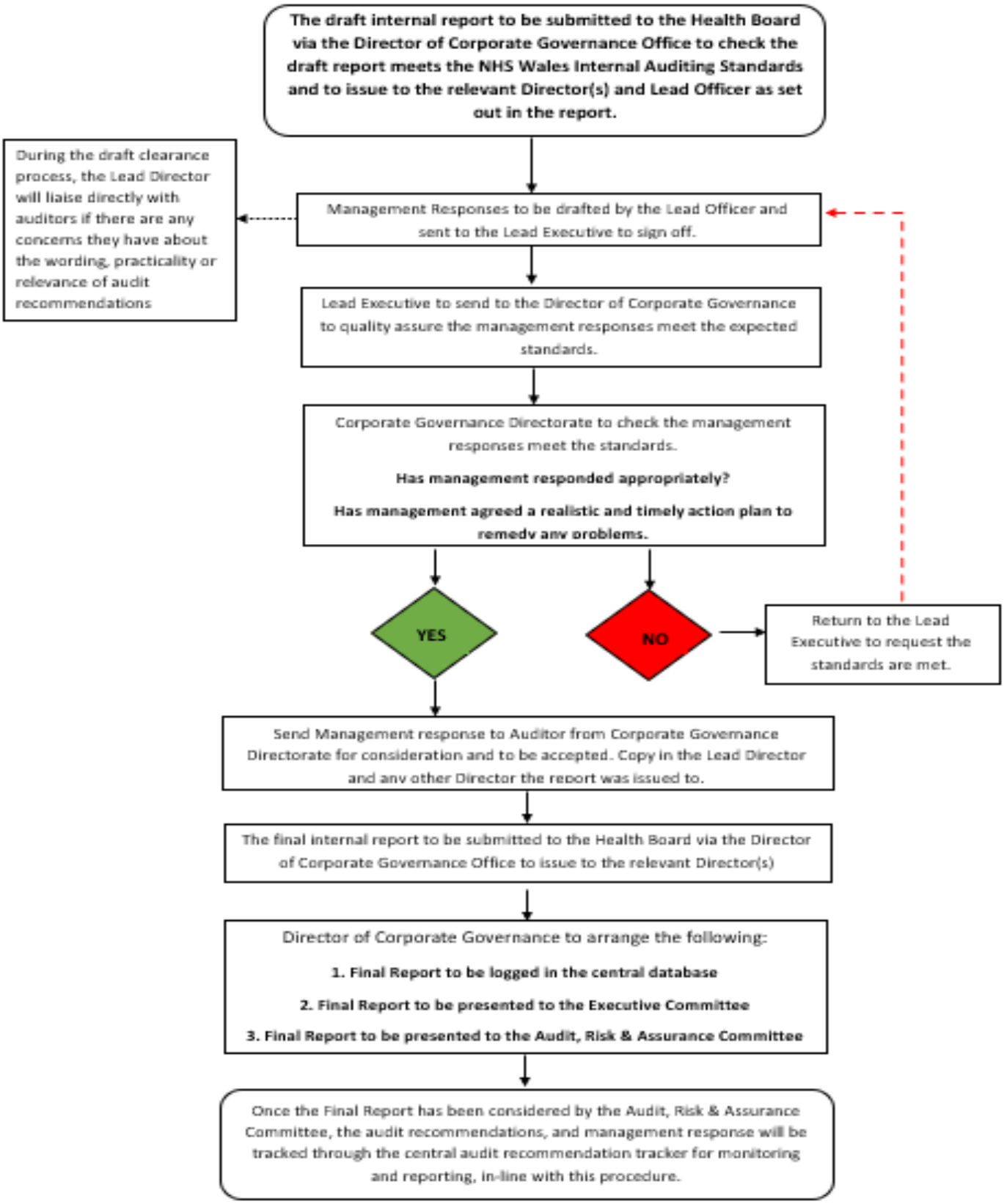

NB: Office of the Director of Corporate Governance refers to the Director of Corporate Governance and the Head of Corporate Risk and Assurance.

Appendix B - Prioritisation of Internal and External Audit Recommendations

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. **PLUS** Significant risk to achievement of a system objective OR evidence is present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. **PLUS** Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*
* Unless a more appropriate timescale is identified/agreed at the assignment.		

DRAFT

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Control Procedures (FCPs)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Heulwen Griffiths, Head of Business Systems and Governance

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an overview of any revisions to the Financial Control Procedures and revised full documents for reference.

The Executive Committee is asked whether assurance can be taken from the report and revisions to the FCPs which was confirmed at the meeting held on the 24.06.2024

Cefndir / Background

Financial Control Procedures are reviewed, as a minimum, on a 3 yearly basis.

The FCPs presented have been reviewed and updated in accordance with the renewal schedule.

There is an update to one procedure. The procedure is:

- Capital Assets and Charges (Appendix 1)

Asesiad / Assessment

1. Capital Assets and Charges

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

This procedure is to ensure that there are robust controls in place to set out the responsibilities of officers in relationship to the identification, accounting and security of capital assets.

This procedure details the principle for purchasing, recording, transferring, disposing and general financial management of capital assets for ABUHB.

The document has been circulated for comment as follows:

- Assistant Director of Workforce (Financial Strategy & Planning)
- Director of Finance, Procurement & Value
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
3	Disposal of Assets – strengthening of controls – all disposals must be approved by the Asset Owner and a Divisional General Manager via the Asset Disposal Form
Appendix 2	Disposed/Obsolete/Condemned Assets – strengthening of controls – General Manager Name, Signature, Date added to the form for completion

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to approve the above amendments to Capital Assets and Charges Financial Control Procedures.

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. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

Equality Impact Assessment (EIA) completed	
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

Aneurin Bevan University Health Board

Financial Control Procedure

Capital Assets and Charges

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 No: ABUHB/Finance/0242

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Introduction

This procedure is to ensure that there are robust controls in place to set out the responsibilities of officers in relationship to the identification, accounting and security of capital assets.

Policy Statement

The procedure sets out the requirements to ensure adequate controls over fixed assets. The procedure is compliant with the Aneurin Bevan University Health Board (ABUHB) Standing Financial Instructions and should be read in conjunction with the Welsh Government IFRS NHS Wales Manual for Accounts and the Capital Procedures and Guidance notes Financial Control Procedure.

Aims

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

Objectives

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

Scope

This procedure details the principle for purchasing, recording, transferring, disposing and general financial management of capital assets for ABUHB.

This procedure should be read in conjunction with the ABUHB Standing Financial Instructions, Capital Procedure and Guidance Notes and other financial procedures, for example,. Procurement, Accounts Payable etc. and the guidance in the capital chapter of the Welsh Government IFRS NHS Wales Manual for Accounts.

Roles and Responsibilities

The Director of Finance, Procurement and Value is responsible for:

- Maintaining an Asset Register to record the value of both purchased and donated assets.
- Calculating depreciation charges for each asset in use.

The Divisional Director of Facilities is responsible for:

- Managing ABUHB Land, Buildings and Engineering services including fittings.

Asset Owners

- Asset Owners are managers who have responsibility for managing assets and are responsible for:
- Managing Capital Equipment used in their departments.
- The security of their assets and notifying the Head of Capital Finance of any changes to assets.
- The Asset Owner is generally the Lead Manager who has submitted and signed the capital bid request. For new purchases, Asset Owners will need to be identified on the New Asset form (Appendix 1).

Main Body

ABUHB operates the REAL Asset Management system (RAM) to record details of its Capital expenditure on fixed assets in the asset register.

ABUHB operates the Radio-Frequency Identification Discovery system (RFID) to track and verify assets that are able to be tagged with an RFID label.

Property, Plant and Equipment expenditure is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the UHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and

- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward, or unit, irrespective of their individual or collective cost.

Expenditure that does not meet this definition is known as revenue expenditure and is charged to budget holder's annual revenue budgets.

A full audit trail must be available to trace all Capital Expenditure incurred.

Purchase of Capital assets

Capital expenditure can be funded as follows:

- Discretionary Capital
- All Wales Capital Programme
- Internally generated funds e.g., disposal of existing assets
- Charitable donations
- Other /Welsh Government grants

The Capital Procedures and Guidance Notes Procedure deals specifically with the approval processes for Capital Expenditure with the Scheme of Delegation setting out the delegation of Capital Expenditure approval.

Following approval of a capital bid, Asset Owners will be required to complete a New Asset form (Appendix 1) for all new equipment and return to the Head of Capital Finance.

Upon receipt of the New Asset form from the relevant Asset Owner, the Head of Capital Finance will:

- Validate the asset.
- Assign a unique asset register number
- Update the asset record on the asset register with the equipment details provided.

The Electro Biomedical Engineering Manager (EBME) and Head of Capital Finance will ensure that all capital equipment is assigned a unique RFID asset label where appropriate.

Capitalisation of Assets held off site

Timing issues can arise regarding the capitalisation of assets at financial year end for which delivery has not yet been made. The Welsh Government IFRS NHS Wales Manual for Accounts sets out guidance to establish whether ownership, title and control are deemed to have passed to the Health Board to inform when expenditure can be capitalised.

In circumstances where assets are capitalised by the Health Board, but delivery of the asset has not taken place, budget holders in conjunction with procurement should ensure risks are assessed and managed regarding:

- Damage to assets whilst held by Supplier;
- Deterioration & obsolescence of assets whilst held by Supplier;
- Supplier insolvency.

If an asset is capitalised it should not be depreciated until brought into use, but it should be reviewed for impairment if held by the supplier for a significant amount of time.

Valuation of Assets

The following applies to the valuation of assets held by Aneurin Bevan University Health Board:

- All assets acquired will be added to the register at cost - cost includes all direct costs to bring the asset into operation.
- Land and Building assets will be subjected to a formal valuation exercise every five years (or as directed by Welsh Government) by the Valuation Office Agency or other body determined by the Welsh Government. This is also known as the quinquennial revaluation exercise.
- Land and Non-specialised in use properties will be held at market value for existing use.
- Specialised buildings will be held at depreciated replacement cost value as determined by the Valuation Office Agency.
- Assets under Construction will be held at cost and will be valued by the Valuation Office Agency on becoming operational.

Indexation will be applied to all assets as follows:

- Land and building assets in line with indices provided by the Valuation Office Agency.
- Indices for equipment will be provided from data compiled by NHS Wales Shared Services Partnership (formerly Welsh Health Estates).
- Indexation is applied from 1st April in each year.
- Assets under Construction, Assets Held for Sale and IT assets will not be subjected to indexation.

The Health Board through the Head of Capital Finance will annually consider whether all assets are still being held at their carrying amount or whether they have been subjected to an impairment. Impairment indicators can include:

Welsh Government Category –DEL (Departmental Expenditure Limit)

- Loss or damage resulting from normal business operations.
- Abandonment of assets in the course of construction.
- The unnecessary over-specification of assets.

Welsh Government Category – AME (Annually Managed Expenditure)

- Any loss as a result of a catastrophe.
- Unforeseen obsolescence.
- Change in use of an asset where specialised assets are no longer required for their original purpose.
- Revaluation on the movement of an asset from Asset under Construction into use following the first professional valuation.
- Revaluation in relation to an asset becoming surplus with plans to dispose.

On assessing whether an impairment has occurred the Head of Capital Finance will liaise with the relevant Asset Owner or Facilities department where land, buildings and dwellings are concerned.

Disposal of Assets

Items can be available for disposal because they are:

- Not capable of performing the required operational tasks or being upgraded to do so.

- No longer required, due to changed procedures, functions or usage patterns.
- No longer complying with occupational health and safety standards.
- Beyond repair but able to be sold for scrap

The Asset Owner responsible for disposing of the equipment must be aware that:

- They are accountable for all decisions they take in the disposal process
- Proper accounting and audit procedures should be observed and all decisions documented.
- All disposals must be approved by a Divisional General Manager (Asset Disposal Form (Appendix 2) completed and signed).

Assets identified for disposal may be dispensed with using the procedures below.

- Acceptable methods of disposal are:
- Transfer of the asset to another part of ABUHB.
- Private Sale.
- Assets donated to a charitable organisation subject to the provisions set out below.
- Destroyed or recycled.

Choice of the most appropriate disposal option will normally be influenced by the age and functionality of the equipment for disposal and by market value.

In all cases assets disposed of must have prior approval by the Divisional General Manager and reported on an 'Asset Disposal' form (Appendix 2) to ensure they are removed from the central Fixed Asset Register. A more detailed description of each disposal option is set out below.

Private Sale - for Property or Land Disposals the Divisional Director of Facilities must be notified of surplus assets that could be available for disposal. All Land and Property disposals of any limit must receive the written approval of Welsh Government to confirm consent to dispose.

For equipment disposals, managers should contact the local procurement department who can arrange for the surplus items to be sold at auction if appropriate. An Asset Disposal form must be completed and authorised

by the Asset Owner and Divisional General Manager and then forwarded to the Head of Capital Finance for removal from the Fixed Asset Register.

Donations – ABUHB may authorise the donation of the equipment to another organisation. Such donations should be to organisations and not to individuals. The preferred recipient of such donations by the Health Board should be health or well-being related. All donations must be approved by the Divisional General Manager (Asset Disposal Form (Appendix 2) completed and signed).

Destroyed or Recycled Equipment - Items with no market value and no use to any other organisation or person may be destroyed in an appropriate and safe manner. An Asset Disposal form must be completed and authorised by the Asset Owner and Divisional General Manager and then forwarded to the Head of Capital Finance for removal from the Fixed Asset Register.

Donation or sale of active Equipment - Ensure the Client is aware that the recipient of the equipment should be advised in writing that ABUHB will not be liable for any Health and Safety issues surrounding the use of the equipment – sample wording is set out below:

"It is the recipient's responsibility to ensure that the equipment is suitable and safe for its intended use, installed correctly, and that it can be used without risk to health or safety. It is the recipient's responsibility to obtain any instructions for and advice on the installation and use of the equipment and to carry out or to have competent persons carry out all necessary checks appropriate to the equipment. Aneurin Bevan University Health Board will not be liable for any loss, damage, or injury arising out of the installation or use of the equipment, however caused".

Recipients should also be aware that maintenance is not included on the equipment.

All equipment recipients must be aware of the following: Aneurin Bevan University Health Board offers no warranty on the condition of the equipment it sells or donates. Sales or documentation should provide as full a description of the items as possible, specify that goods are sold 'ex works' or 'as is, where is', and invite prospective buyers/beneficiaries to inspect the goods before the sale/donation.

Summary of steps to be taken by Asset Owner on disposal:

- Identify assets for disposal.

- Validate serial numbers / identity of the asset with the Head of Capital Finance.
- Complete Asset Disposal form (Appendix 2) and forward to the Head of Capital Finance.
- Obtain Divisional General Manager approval to dispose of asset.
- Determine the market value of the asset.
- Select the best disposal option. If the item has a significant value then sale should be the preferred option.
- Remove items from maintenance arrangements.
- Obtain estimate of disposal costs (if required).
- Ensure clarity around no ongoing guarantee of quality is given where an asset is sold or donated.
- Ensure procedures are followed to remove any data from equipment prior to disposal.
- Oversee any sale including the collection of any income. Ensure that a receipt is given on sale / disposal / donation.

Upon receipt of the authorised Disposal Form from the relevant Asset Owner the Head of Capital Finance will:

- Validate the asset.
- Remove the item from the Asset Register and RFID Discovery asset tracking system.

Asset Owners must notify the Head of Capital Finance of any asset transfers by submitting a Transferred Assets form (see Appendix 3).

Donated Assets

Asset Owners must notify the Head of Capital Finance of all assets donated to the ABUHB that meet the capital definition on page 3 (Main Body) of this procedure by submitting a New Asset form (Appendix 1).

Disposals and transfers of donated assets follow the same process as set out on page 6 (Disposal of Assets) for owned assets.

Capital Expenditure Reporting

The Head of Capital Finance will be responsible for:

- Recording the capital expenditure incurred.
- Comparing actual capital expenditure against approved expenditure limits.
- Reporting the details to the Monthly Capital Group meeting.

- Submitting Capital Monitoring Returns and Project Progress Reports to Welsh Government as required.

Asset Register

The asset register must contain the minimum data set for all capital expenditure as defined in the capital chapter in the Welsh Government IFRS NHS Wales Manual for Accounts.

The asset register must be capable of calculating the annual depreciation for each asset. These charges must be calculated in accordance with the guidance in the capital chapter in the Welsh Government IFRS NHS Wales Manual for Accounts.

The Head of Capital Finance will be responsible for:

- Verifying expenditure deemed capital expenditure meets the capital definition.
- Entering the capital expenditure into the asset register.
- Reconciling capital expenditure entered in the asset register to that recorded in the ABUHB general ledger.
- Calculating, monthly, actual depreciation and posting the information into the general ledger.

The Head of Capital Finance will also be responsible for maintaining the asset register to record:

- Changes in valuation notified by the Valuation Office Agency.
- Changes in valuation arising from indexation.
- Details of assets transferred from one owner to another.
- Details of assets that are disposed/obsolete/condemned.
- Impairment of fixed assets.
- Accelerated depreciation.

The Head of Capital Finance must ensure that the relevant details are entered into the general ledger and ensure that such details reconcile to the asset register.

Asset lives used in calculating depreciation will be:

- Buildings – as notified by the Valuation Office Agency or other ABUHB nominated surveyor.
- Equipment – as per standard lives.

Owners Responsibilities

Owners are responsible for the security of their assets.

Owners must notify the Head of Capital Finance of any relevant asset information.

Owners must notify the Head of Capital Finance as soon as they are aware of the following:

- Details of new purchased or donated Assets following delivery to site (See Appendix 1).
- Details of assets that are disposed, obsolete or condemned (See Appendix 2).
- Details of transferred assets (See Appendix 3)
- Details of assets being replaced or planned to be replaced.
- Details of damage to assets.
- Details of any major parts of the asset that are replaced.

Divisional Director of Facilities Responsibilities

The Divisional Director of Facilities has additional responsibilities over and above owner's responsibilities.

The Divisional Director of Facilities is also responsible for:

- Liaison with the Valuation Office Agency when periodic revaluations are undertaken.
- Arranging for the Valuation Office Agency to revalue surplus buildings that are to be sold.
- Arranging for the Valuation Office Agency to revalue new buildings brought into use.
- Allocating building and engineering works capital expenditure to the appropriate asset block and asset category.
- Notifying the Head of Capital Finance of any changes affecting the revaluation of the estate.

Verification of Assets

The Head of Capital Finance will be responsible for undertaking RFID audits of equipment assets during each financial year to verify the

existence of tagged assets. In some instances, it may not be appropriate to tag an asset with an RFID label.

For those assets not able to be verified via the RFID audits, the Head of Capital Finance will be responsible for writing to Asset Owners to request them to verify that their assets are still in their custody and being used.

The Head of Capital Finance will:

- Arrange RFID equipment audits to be undertaken at Health Board sites during the financial year.
- Following the audit, produce a list of each Owner's unverified assets as recorded in the asset register.
- Send the list to each Owner.
- Request the Owner to verify that the asset is still in use.
- Request Owners to return their asset verifications by the given date.

Asset Owners will:

- Assist with the RFID equipment audit process to locate tagged assets
- For assets unable to be verified during the RFID audit, respond to the written request to verify whether the asset is still in their custody and still in use.
- Notify the Head of Capital Finance, and provide a suitable explanation, of those assets that are no longer in use.
- Return the list to the Head of Capital Finance by the due date.

The Head of Capital Finance will:

- Ensure the RFID equipment audit data is reflected in the asset register
- Update the asset register to reflect the written verification of asset returns.
- Investigate any discrepancies between the asset register and the verification of asset returns.
- Calculate the impact on depreciation charges.
- Post the revised depreciation to the general ledger.

- Report Non Compliance with the annual verification process to Divisional Managers/ Executive Team.

Depreciation and Impairment Estimates

The Head of Capital Finance will be responsible for completing the Welsh Government's annual depreciation and impairment estimates in accordance with the guidelines provided.

The estimates will include the latest information on ABUHB's planned discretionary capital expenditure, expenditure on All Wales Capital Programme Schemes and planned disposals.

The Head of Capital Finance will be responsible for ensuring that the estimates are reviewed by the Assistant Finance Director – Financial Strategy and Planning and signed off by the Director of Finance, Procurement and Value.

Implementation

This document should be implemented with immediate effect.

Further Information

Enquiries regarding this policy should be directed to the Head of Capital Finance.

Audit

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

Review

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

Appendices

- Appendix 1 - New Asset
- Appendix 2 - Disposed/Obsolete/Condemned Assets
- Appendix 3 – Transferred Assets

Appendix 1 Aneurin Bevan University Health Board

NEW ASSET

Asset Details

Capital Asset No.	
Asset Description	
Model	
Serial No.	
EBME Reference No.	
RFID Reference No.	
Supplier Name	
Manufacturer	
Asset Value	
Date Received	

Site, Department & Owners Details

Site	
Ward/Room Location	
Department	
Owners Name	
Owners Designation	
Signed	
Contact Telephone No.	
Date	

Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrechfa Grange, Llanfrechfa, Cwmbran.

Appendix 2 Aneurin Bevan University Health Board

DISPOSED/OBSOLETE/CONDEMNED ASSETS

1. Asset Details

Asset No.	
Asset Description	
EBME Reference No.	
RFID Reference No.	
Model/Serial No.	
Reason For Disposal	
Method of Disposal	
Date Disposed	
Sale Proceeds	

2. Site, Department & Owners Details

Site	
Department	
Owners Name	
Owners Designation	
Contact Telephone No.	
Signed	
Date	
General Manager Name	
Signed	
Date	

3. Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrechfa Grange, Llanfrechfa, Cwmbran.

Appendix 3 Aneurin Bevan University Health Board

TRANSFERRED ASSETS

Asset Details

Asset No.	
Asset Description	
EBME Reference No.	
RFID Reference No.	
Model/Serial No.	
Reasons For Transfer	
Date Transferred	

Site, Department & Owners Details

	Original	New
Site		
Department		
Owners Name		
Owners Designation		
Signed		
Date		

Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrechfa Grange, Llanfrechfa, Cwmbran.

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Functional Standard Returns 23/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Nicola Tillings, (Interim) Head of Counter Fraud

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

Er Sicrwydd/For Assurance

To provide assurance to the Audit, Risk and Assurance Committee of the work carried out by the Counter Fraud Department in 2023/24 in order that the Government Functional Standards GovS 013 are met and scored on a RAG basis.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The attached Counter Fraud report is the:

1. Counter Fraud Functional Standard Returns 2023/24

From April 2021 all NHS funded services are required to provide assurance against the NHS Counter Fraud Authority's Requirements of the Government Functional Standard GovS 013: Counter fraud. The Functional Standards Returns 2023/24 are prepared to provide assurance that the Counter Fraud Department has provided what is required by Aneurin Bevan University Health Board in order to have met its obligations under the Welsh Government Directives and the Government Counter Fraud Functional Standards GovS 013.
The Functional Standard Returns are completed by the Head of Counter Fraud and then reviewed by the Audit, Risk and Assurance Committee Chair and the Director of Finance prior to its submission to the NHS Counter Fraud Authority. For the year 2023/24 Aneurin Bevan University Health Board has achieved a Green rating for all areas. These returns were submitted to the NHS Counter Fraud Authority on 03/06/2024.

Cefndir / Background

This yearly report has been prepared by the Aneurin Bevan University Health Board Counter Fraud Department to comply with the Welsh legal directions and the NHS Counter Fraud Authority's Requirements of the Government Functional Standard GovS 013.

Asesiad / Assessment

Please read attached report:

1. Counter Fraud Functional Standard Returns 2023/24

Argymhelliad / Recommendation

This report is intended for Audit, Risk and Assurance Committee's assurance and information.

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

Gwybodaeth Ychwanegol:

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

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

Counter Fraud Authority

Counter Fraud Functional Standard Return (2023/2024)

ANEURIN BEVAN UNIVERSITY LHB

Your Overall Self-Assessment Rating is: GREEN

Submitted By: lcfs14475 - Michelle Morris

Organisational information

Name of the organisation	ANEURIN BEVAN UNIVERSITY LHB
Annual budget of the organisation	Over £ 1 billion
Staff headcount at the organisation including contracted employees	Over 15,000
Organisation code	7A6
Organisation/provider type	Health Board
For which provider organisations are you the commissioner?||Co-ordinating Commissioner for this provider	WALES Co-ordinating Commissioner for this provider
NHS England region	Wales

Personnel information

Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management	Robert Holcombe
Name of the Local Counter Fraud Specialist	Michelle Morris
Email of the Local Counter Fraud Specialist	Michelle.morris9@wales.nhs.uk
Name of the counter fraud supplier organisation (including in-house)	In House (Wales)
Counter fraud supplier type	Wales
Name of the Chair of the Audit Committee / equivalent body	Iwan Jones
Email of the Chair of Audit Committee / equivalent body	Iwan.Jones6@wales.nhs.uk
Name of the Counter Fraud Champion	Mark Ross
Email of the Counter Fraud Champion	Mark.Ross@wales.nhs.uk

Costs and days information

Proactive days used (Maximum 3 digits)	283
Reactive days used (Maximum 3 digits)	287
Total days used for counter fraud work	570
Cost of counter fraud staffing per financial year - Proactive	92684.22
Cost of counter fraud staffing per financial year - Reactive	93994.23
Total costs for counter fraud work	186678.45

Reactive information

Number of allegations received and recorded as an investigation during the most recent financial year	72
Number of allegations received during the most recent financial year and recorded as an investigation on the case management system	73
Rationale for any discrepancy between case management system investigations received and expected	One of our cases was passed to the NHS Counter Fraud Service Wales Team to investigate.
Number of investigations recorded and closed during the most recent financial year	62
Number of investigations closed during the most recent financial year as recorded on the case management system	60
Rationale for any discrepancy between case management system investigations closed and expected	There were a number of cases closed at the very end of 2022/23 that were not accounted for in the end of year reporting; so those cases missed from last years figures including those held on the First Management System had to be included for this years closures.
Number of investigations open as at 31/03/2024	27
Number of investigations open as at 31/03/2024 as recorded on the case management system	28
Rationale for any discrepancy between case management system investigations open as of 31/03/2024 and expected	As above the one case held by NHS CFS Wales remains open and is still showing on our figures.

Amount of fraud losses identified and recorded during the most recent financial year	274664.00
Amount of fraud losses recovered and recorded during the most recent financial year	220191.66
Amount of fraud losses prevented from reactive work and recorded during the most recent financial year	0.00
Number of criminal sanctions applied and recorded during the year	2
Number of civil sanctions applied and recorded during the year	21
Number of disciplinary sanctions applied and recorded during the year	6

Proactive information

Number of proactive exercises conducted and recorded during the most recent financial year	4
Amount of fraud losses identified and recorded from proactive exercises during the most recent financial year	22317.25
Amount of fraud losses prevented and recorded from proactive exercises during the most recent financial year	0.00
Amount of fraud losses recovered and recorded from proactive exercises during the most recent financial year	16466.47

1: Accountable individual

NHS Requirement 1A:

A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. N. B. 'Equivalent body' may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation

Your Rating is: **GREEN**

Comments:

Within ABUHB the DOF oversees all the counter fraud work undertaken by the ABUHB LCFS team and the investigations carried out on behalf of the HB by NHS CFSW. This work is communicated to him via quarterly reports that are submitted to him and the Welsh Government by NHS CFSW. There are regular meetings between the DOF and the Head of Counter Fraud. The work undertaken by the HB LCFS is presented quarterly via a report to the Audit, Risk and Assurance Committee (ARAC) which in turn scrutinises the work undertaken. This committee is made up of lay members and execs. The Chair of the ARAC has remained the same in this financial year. The ARAC and the DOF agree and sign off the annual work plan. Assistant Director of Corporate Finance remains as the fraud champion and is the line manager of the Head of Counter Fraud.

NHS Requirement 1B:

The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented.

Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.

Your Rating is: **GREEN**

Comments:

The ARAC oversees that senior managers know their responsibilities in relation to Counter Fraud. It is a standing agenda item on every ARAC meeting. Actions raised by ARAC are recorded and followed up. The Head of Counter Fraud meets quarterly a provides a quarterly report of the work undertaken by the Counter Fraud Team the previous quarter. The Head of Counter Fraud meets in private with the ARAC Chair and other ARAC lay members every six months as a standing agenda. But can approach the Chair at anytime to raise concerns if not dealt with appropriately by the HB. The end of year report 2023/24 provided assurance to the ARAC that the counter fraud service for the past year had been effective and met the current standards set by NHS CFA. This report was signed off by both the DOF and the ARAC. The Counter Fraud Champion in May 2023 was involved in the appointment of a new member of counter fraud staff (LCFS) which then brought the staff levels again up to 3 WTE.

2: Counter fraud bribery and corruption strategy

NHS Requirement 2:

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

Your Rating is: **GREEN**

Comments:

The ABUH annual report provides evidence that the work completed during 2023/24 was carried out in alignment with the strategy put forward by NHS CFA. ABUHB has a Counter Fraud, Bribery and Corruption Policy and Procedure which is adhered to and referred to when required. The policy is available to all staff via our Intranet and has been promoted again when the staff complete fraud awareness work . Again during this year the LCFS team this year has ensured to align any counter fraud, bribery, and corruption work to any recent changes in NHSCFA requirements. The annual CF plan in place directly aligns to the NHS CFA standards requirements to ensure that CFA strategy is mirrored within it. This year those risk assessments carried out have again been completed in direct alignment with cabinet office methodology and have been done when HB risks have been identified. These risks have then been shared with the relevant directorate for them to action.

3: Fraud bribery and corruption risk assessment

NHS Requirement 3:

The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.

Your Rating is: **GREEN**

Comments:

This past year the Head of Counter Fraud has sat on and played an active part in fraud proofing all policies and procedures that have come up for renewal in ABUHB this role was previously carried out by one of the LCFS. This aims to strengthen and reduce the risk of fraud due to poor policy or governance controls and will continue going forward. Throughout the year a number of local risks and an All-Wales risk has been identified and the risk assessment work has been carried out in accordance with NHS CFA requirements and the Cabinet Office Methodology. This has taken place in relation to Bank Staffing, Agency Working and Salary Sacrifice. The results of these have been fed back and left with their respective areas to register the risk, monitor, and maintain. The Agency Working risk identified is still ongoing into 2024/25 and it is hoped that there will be an All-Wales sharing of information approach to this risk going forward.

4: Policy and response plan

NHS Requirement 4:

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

Your Rating is: **GREEN**

Comments:

ABUHB has a Counter Fraud Policy in place, which is up to date and is in line with the requirements of NHSCFA. This policy has been presented to the executive board and the ARAC and had their approval and support. The Counter Fraud, Bribery and Corruption Policy's next review is on the 25th November 2025. The Counter Fraud Communications Strategy was reviewed and updated in March this year. Both are publicised on the HB Intranet site. The Standards of Behaviour Framework Policy also refers to fraud, bribery, and corruption within the HB. Our staff CF awareness is now more easily monitored as CF E-Learning has been mandated by ABUHB from February this year. Feedback is always requested following presentations given. Targeted presentations are aimed at groups of staff most at risk of fraud are also undertaken and feedback from management /staff is required following.

5: Annual action plan

NHS Requirement 5:

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

Your Rating is: **GREEN**

Comments:

The Counter Fraud, Bribery, and Corruption workplan for 2023/24 was agreed at the ARAC meeting in 2023 and was produced in direct alignment with the new Gov Standards SO13 that came into effect the previous year. The plan is always a fluid plan and had to alter to fit the needs of ABUHB. This is reported to the ARAC on a quarterly basis. In this past year more days were required for Hold to Account because of the number of referrals received from staff and the Fraud and Corruption Reporting Line via NHS CFA. There were again this year some issues with staffing due to promotion that were unforeseen, but the plan was delivered none the less. This was detailed in end of year report presented to the DOF and will be presented to the the ARAC on the 21st May 2024. The current plan for this coming year 2024/25 will been presented and agreed by the DOF and the ARAC during the meeting on the 21st May 2024.

6: Outcome-based metrics

NHS Requirement 6:

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

Your Rating is: **GREEN**

Comments:

With the continued assistance of the case management system provided by the NHS CFA (CLUE3) the collation of out-come based metrics is achievable at any time. Proactive and reactive outcomes and progress are recorded on the CLUE system. All sanctions (be they criminal, civil, or professional body) with their subsequent financial recoveries, losses and preventative figures are now all in one system. The majority of these out-come based metrics are reported to NHS CFS Wales on a quarterly basis and are then collated and compared against the other Welsh HBs and this is then reported back to Welsh Gov, the DOF and the ARAC via the audit chair. The CF annual work plan and quarterly ARAC reports detail work completed on strategic planning and present details of the out-come based metrics completed that quarter. Costs are provided quarterly with a full breakdown provided at the end of the year in the CF Annual Report.

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

NHS Requirement 7:

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

Your Rating is: **GREEN**

Comments:

ABUHB continues to receive fraud referrals via the NHS CFA Fraud and Corruption Reporting Line and the NHS CFA Online Reporting Tool. This information is initially reported to the NHS CFA CIT team and disseminated to ABUHB's CF team for actioning via the CLUE system. The HB has its own webpage (internal and external), and staff, contractors and members of the public can report any concerns via this webpage or direct to the CF team. The other reporting avenues are also detailed on the webpage. These reporting routes are formalised in the Counter Fraud Policy and in the Counter Fraud awareness programme for the HB which now includes E-Learning which is mandatory. Its effectiveness is evaluated via the referral data, which is reported to NHS CFSW, the ARAC meetings and DOF. Staff awareness is measured via E-Learning and presentations. The All-Wales Raising Concerns (whistleblowing) Policy is in place that allows staff to feel supported and protected when reporting fraud.

8: Report identified loss

NHS Requirement 8:

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

Your Rating is: **GREEN**

Comments:

ABUHB Counter Fraud team currently reports all instances of fraud, bribery, and corruption via the NHS CFA case management system CLUE 3. The previous system FIRST held similar but not easily accessible statistical information and the last ABUHB case on FIRST has now been closed. In Wales both the incident and the investigation mode of the system is utilised which is different to England but currently even though it is utilised for storage of statements etc, file preparation isn't utilised. Clue houses all investigations, LPE's, risk assessments, system weaknesses, sanctions, recoveries, losses, and fraud prevented. In Wales the Head of NHS CFSW oversee this and the information contained within the system is reported to NHS CFSW on a quarterly basis and this is then collated All-Wales and presented to the Welsh Government. This same information is also reported to the ARAC on a quarterly basis and the 2022/23 data is presented to them in the end of year Counter Fraud Annual report.

9: Access to trained investigators

NHS Requirement 9:

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

Your Rating is: **GREEN**

Comments:

Again during 2023/24 ABUHB saw a period of change in staff. In that one LCFS moved to take up a promotion in a neighbouring HB in June 2023. The vacancy was again quickly filled with employment of an accredited LCFS from another Welsh HB in August 2023. The trainee LCFS employed in October 2022 completed all of her LCFS training and became an accredited LCFS in September 2023. This LCFS is an experienced investigator having served in the Police for 30 years prior to her appointment. All LCFS have completed a number of IUCs in this past year which have been reviewed for compliance and quality. All the mandatory staff training provided by NHS CFA have been attended by all staff members this year. All nominations are up to date with no other movement of staff. The DOF, Fraud Champion and the ARAC Chair have remained the same.

10: Undertake detection activity

NHS Requirement 10:

The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.

Your Rating is: **GREEN**

Comments:

The referrals that are received by ABUHB Counter Fraud team are all assessed to see whether the fraud occurred due to a system or policy weakness. If so, then a risk assessment is completed and handed to the section that holds the risk to alter or put additional measures in place to stop the fraud happening again or minimise its re-occurrence. If concerns are raised nationally or locally then an LPE will be carried out to see whether there has been fraud or that the systems in place would allow fraud to happen. Again, as stated the risk assessment process would be followed to eradicate or minimise the fraud risk. These have been highlighted in the end of year report and the DOF and ARAC are fully aware of those undertaken in 2023/24. In 2023/24 car salary sacrifice highlighted a risk so the other areas were investigated and frauds discovered, following processes were altered. The National NFI programme has been concluded in 2023/24 all findings are reported back to assist the next one.

11: Access to and completion of training

NHS Requirement 11:

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

Your Rating is: **GREEN**

Comments:

In this past year 2023/24 fraud awareness sessions have and when required been done in person, but some are still are provided remotely. In the past year where fraud issues have come to light in a certain directorate a directorate/role specific presentation has been given. Some remote presentations have been given and this has been to accommodate more staff that have made use of the agile working policy of ABUHB where some choose homeworking. Again this year the Counter Fraud staff completed Fraud Awareness Week at various hospital sites within ABUHB. During this week they had stands to promote the counter fraud message. This work carried out hit the maximum numbers of people with the biggest footfall which would have included hospital staff, contractors, and members of the public. As well as the use of leaflets, newsletters, posters, the ABUHB internet pages that week to get the CF message out there to all. In February 2024 CF E-Learning has been mandated in ABUHB.

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

NHS Requirement 12:

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

Your Rating is: **GREEN**

Comments:

ABUHB currently has policies in place that cover the requirement of staff and non-executive board members to report any conflicts of interest. This is carried out on a yearly basis and is linked to our PADR system, all are made aware that this is an ongoing requirement and should be completed as and when the conflict or suspect conflict arises. This information along with gifts and hospitality is then collated in a register and held by the Director of Governance and shared with Counter Fraud. The requirement to disclose COI and gifts and hospitality together with the bribery act is covered in the ABUHB Fraud awareness session that is provided to all staff and also within the mandated CF E-learning. These polices are accessible on the ABUHB staff website and are updated in line with their renewal dates. Currently ABUHB is re-writing their Standards of Business Conduct Policy to be more encompassing of the Bribery Act. This policy was reviewed by the Head of CF who requested some changes

ACC Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.As the Audit Committee Chair, and in line with the audit committee's responsibility for the strategic assurance and oversight of counter fraud work as described in section 5.6 of the NHS Audit Committee Handbook, I confirm that the information contained in this self review for ANEURIN BEVAN UNIVERSITY LHB reflects the work reported to and considered by the Audit Committee.

acc14340 - Iwan Jones

Mon May 13 10:34:31 BST 2024

Opportunity to comment

DOF Declaration

I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.	dof14220 - Robert Holcombe Mon Jun 03 08:54:02 BST 2024

Opportunity to comment

Declaration

Overall Rating	Green
Please ensure that this functional standard return has been fully completed. If your Director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.	lcfs14475 - Michelle Morris Mon Jun 03 08:55:36 BST 2024

Agenda Item:3.2

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	Tuesday 9th July
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Post Payment Verification End of Year Report – 1st April 2023 to 31st March 2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rob Holcombe - Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Amanda Legge - All Wales Post Payment Verification Manager

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

Er Sicrwydd/For Assurance

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle.
PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

Asesiad / Assessment

The past year in 2023-2024, PPV began recovering from the backlog of work that we had, due to a new payment system within PCS and the inability for practices to submit NHS numbers to evidence their claims. This system was developed and enhanced which allowed us to return to Business as usual in April 2023, and has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

The following key points should be noted:

General Medical Services (GMS):

Due to the backlog of PPV work across Wales, we created the visit plan for 2023-2024 to try to complete as many visits as possible that we could in the year with the aim of condensing our normal 3-year rolling plan into 2 years. We managed to undertake all 166 routine visits across Wales with 35 for Aneurin Bevan University Health Board.

Regarding the revisits that were due in 2023-2024, and because we wanted to complete all routine visits along with Ad-hoc requests, we only managed to carry out a small number across Wales with 7 out of 21 completed for Aneurin Bevan University Health Board.

Firstly, in this financial year, we will be concentrating on all outstanding revisits, and if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

General Ophthalmic Services (GOS): The visit plan for GOS 2023-2024 was not finalised after explaining to our Health Boards that these visits were subject to change due to a new way of verifying claims. PPV began remote access options having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful. Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records.

Future visits will now be included in the 2024-2025 visit plan and is still changeable, and although we are hoping to increase the number of remote visits, we will also incorporate physical visits to carry us through this transition period of electronic patient records, which is being encouraged by Welsh Government.

General Pharmacy Services (GPS): In 2023/2024 NWSSP/PPV introduced a new service check after a successful pilot, which was the Quality and Safety Scheme and completed all visits planned. We are also beginning the Collaborative Working Scheme verification this upcoming financial year 2024-2025. We can verify both these services remotely.

We are also investigating other avenues for PPV in GPS and beginning another pilot early this year.

Additional Services:

After technical issues with our dispensing Data checks, and a lot of developing, we can now progress with our quarterly provision of these reports Nationally across Wales.

From the pilot we carried out and informing practices of the regulations surrounding dispensing eligibility, we have the data which shows the future success of this service.

Clinical Waste Self Assessments were piloted for GMS and have been Live this last year to ensure compliance with legislation. We are hoping to conduct a pilot with the Self Assessments for Pharmacies in the next few months in 2024-2025.

Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks. We are also investigating other avenues of savings from the provision of Clinical Waste services and now planning on producing a 'non-collection' 6 monthly report to all our Health Boards.

There are bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. PPV are planning to commence a National GPS Working Group to align with the above which has proved successful.

PPV training events and roadshows to Practice Managers have been delivered locally and we now record these in advance, based on our trend data analysis. In addition to facilitating one-on-one training requirements, particularly for new practice managers, we created a video recorded guide for both GOS and GMS.

Argymhelliad / Recommendation

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

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

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

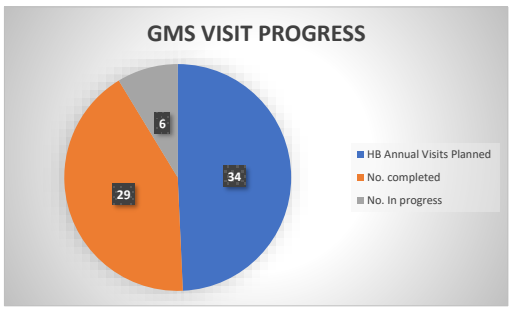
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Audit Report - 1st April 2023 to 31st March 2024 = Aneurin Bevan University Health Board

To Notes

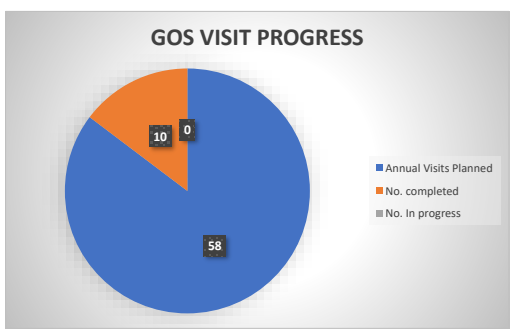
Above planned numbers were sent to HB for 23/24 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise
Training/support is provided to practices after visit where necessary

GMS	Visit Type	HB Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	34	29	6	0	563	£26,429.64	147	19	166	£105,274.77
	Revisit	21	7	0	0	1052	£24,973.05	15	15	131	£39,137.83
	Total	55									



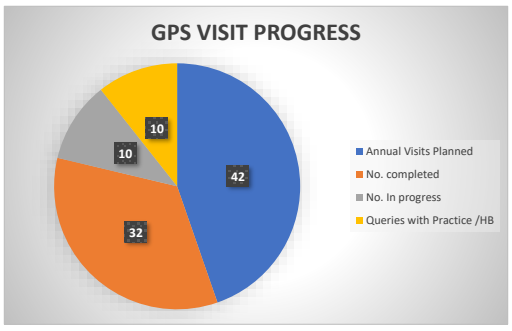
Summary of themes/findings/issues
Due to the new payment system, all Revisits across Wales were on hold until Dec 2023

GOS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	58	10	0	0	11	£432.34	39	5	301 Rolling Plan	£3,856.86
	Revisit	0	0	0	0	0	0	0	0	6	£0.00
	Total	58									



Summary of themes/findings/issues
As contractors are transistioning to electronic records, remote access visits are slow in progressing.

GPS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
Q&S Scheme	Routine	42	32	10	10	0	£0.00	229	0	229	£0.00
	Total										



Summary of themes/findings/issues
Nothing to report at this stage

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Report and Accounts 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In respect of the Annual Report and Accounts 2023/24, this paper presents to the Board the final draft audited versions of:

1) The Performance Report (Part 1)
2) The Accountability Report (Part 2), including:
   a) A Corporate Governance Report
   b) A Remuneration and Staff Report
   c) A Parliamentary Accountability and Audit Report.

for consideration and approval prior to being submitted to Welsh Government on 15th July 2024, in-line with HM Treasury Requirements.

Following presentation of the draft documents to the Audit, Risk and Assurance Committee on 21st May 2024, the final draft versions incorporate comments and feedback received from Welsh Government; Audit Wales; and Board Members, including those comments made by the Audit, Risk and Assurance Committee when reviewing the drafts.

Page numbers contained in the documents will be added once the 3 reports have been combined in to one consolidated document for submission.

Part 3 of the Annual Report and Accounts 2023/24 are the Financial Statements 2023/24, and these are provided to the Audit, Risk and Assurance Committee under separate cover.

Cefndir / Background

NHS Bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by Welsh Ministers and the approval of the Treasury.

The Manual for Accounts, issued by Welsh Government, has been prepared to ensure that those determinations and directions are consistent with the 2023-24 Government Financial Reporting Manual (FReM) which sets out the accounting guidance applicable to bodies within the Resource Accounting Boundary. In setting the requirements of the FReM the government is advised by an independent body, the Financial Reporting Advisory Board (FRAB). NHS bodies are required to follow FReM guidance except where a divergence has been formally agreed with the Treasury.

The Manual provides principles–based guidance to NHS bodies on how to prepare and complete their annual report and accounts and financial returns. Application of the principles to the individual circumstances of a NHS body is a matter between the body and its external auditors.

The Annual Report and Accounts as a whole must be fair, balanced and understandable and the Accountable Officer takes personal responsibility for it and the judgments required for determining that it is fair, balanced and understandable.

Asesiad / Assessment

Annual Report and Accounts – Requirements for 2023/24

As set out in the Manual for Accounts, NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes:

- The Performance Report, which must include:
  - An overview.
  - Performance analysis

- The Accountability Report, which must include:
  - A Corporate Governance Report.
  - A Remuneration and Staff Report.
  - Senedd Cymru/Welsh Parliament Accountability and Audit Report.

- The Financial Statements, including:
  - The Audited Annual Accounts 2023/24.

The detailed structure of the Annual Report and Accounts 2023/24, is set out at Annex A.

For the 2023-24 reporting period the deadlines for submission are:

Annual Reports 2023/24 - Key Dates	**2024**	
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	**Fri**	**10-May**
Draft Reports to ARA Committee Members	Tue	14 -May
ARA Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tue	**21-May**
Final Accounts & Accountability Report to Audit Committee Members	Wed	3-July
ARA Committee meeting to Consider Final Accounts, and Accountability Report	Tues	**9-July**
Board meeting to approve Final Accounts and Accountability Report	Thurs	**11-July**
Certification by Auditor General	Mon	**15-July**
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	**15-July**
Annual General Meeting – to receive the Annual Report and Accounts	Wed	25-Sept

Part One – The Performance Report 2023/24

The purpose of the performance section of the annual report is to provide information on the Health Board, its main objectives and strategies and the principal risks that it faces. The requirements of the performance report are based on the matters required to be dealt with in a Strategic Report as set out in Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013, No. 1970. The main features of the performance report should flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against that plan in the year of reporting.

The performance report must provide a fair, balanced and understandable analysis of the Health Board's performance, in line with the overarching requirement for the annual report and accounts to be fair, balanced and understandable.

The performance report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer).

The Draft Performance Report was considered by the Audit, Risk and Assurance Committee on 21st May 2024, where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft performance report for consistency with other information in the financial statements (Part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft.

Part 2 – The Annual Accountability Report 2023/24

The purpose of the accountability section of the annual report is to meet key accountability requirements to the Welsh Government. The requirements of the accountability report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006

and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The Accountability Report is required to have three sections:

- **Corporate Governance Report**

  The purpose of the Corporate Governance Report is to explain the composition and organisation of the Health Board's governance structures and how they support the achievement of the entity's objectives.

  As a minimum, the corporate governance report must include:
  - The Directors' Report;
  - The Statement of Accounting Officer's responsibilities; and
  - A Governance Statement.

    The Governance Statement is a key feature of the organisation's Annual Report and Accounts. It demonstrates publicly the management and control of resources and the extent to which the body complies with its own governance requirements, including how they have monitored and evaluated the effectiveness of their governance arrangements. It is intended to bring together in one place in the annual report all disclosures relating to governance, risk and control.

- **Remuneration and Staff Report**

  The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

- **Senedd Cymru/Welsh Parliament Accountability and Audit Report**

  The Parliamentary Accountability Report contains disclosure on the following:
  - Regularity of expenditure
  - Fees and charges
  - Public Sector Information Holders only - a statement is required if the entity has not complied with the cost allocation and charging requirements set out in HM Treasury guidance
  - A brief description of the nature of each of the organisation's material remote contingent liabilities (that is, those that are disclosed under Parliamentary reporting requirements and not under IAS 37) and, where practical, an estimate of its financial effect. (This is included in the Annual Accounts [Part 3]).

The Accountability Report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer), the Chair and the Director of Finance.

The Draft Accountability Report was considered by the Audit, Risk and Assurance Committee on 21st May 2024 where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft Accountability report for consistency with other information in the financial statements (Part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft. Welsh Government has also reviewed the draft accountability report and were content that the Health Board had made the appropriate level of disclosure against the requirements in Chapter 3 of the Manual for Accounts.

Material changes made since the first draft are highlighted in yellow within the attachment to support committee members in undertaking their final review.

Attachment One provides an overview of the comments received and changes made.

Argymhelliad / Recommendation

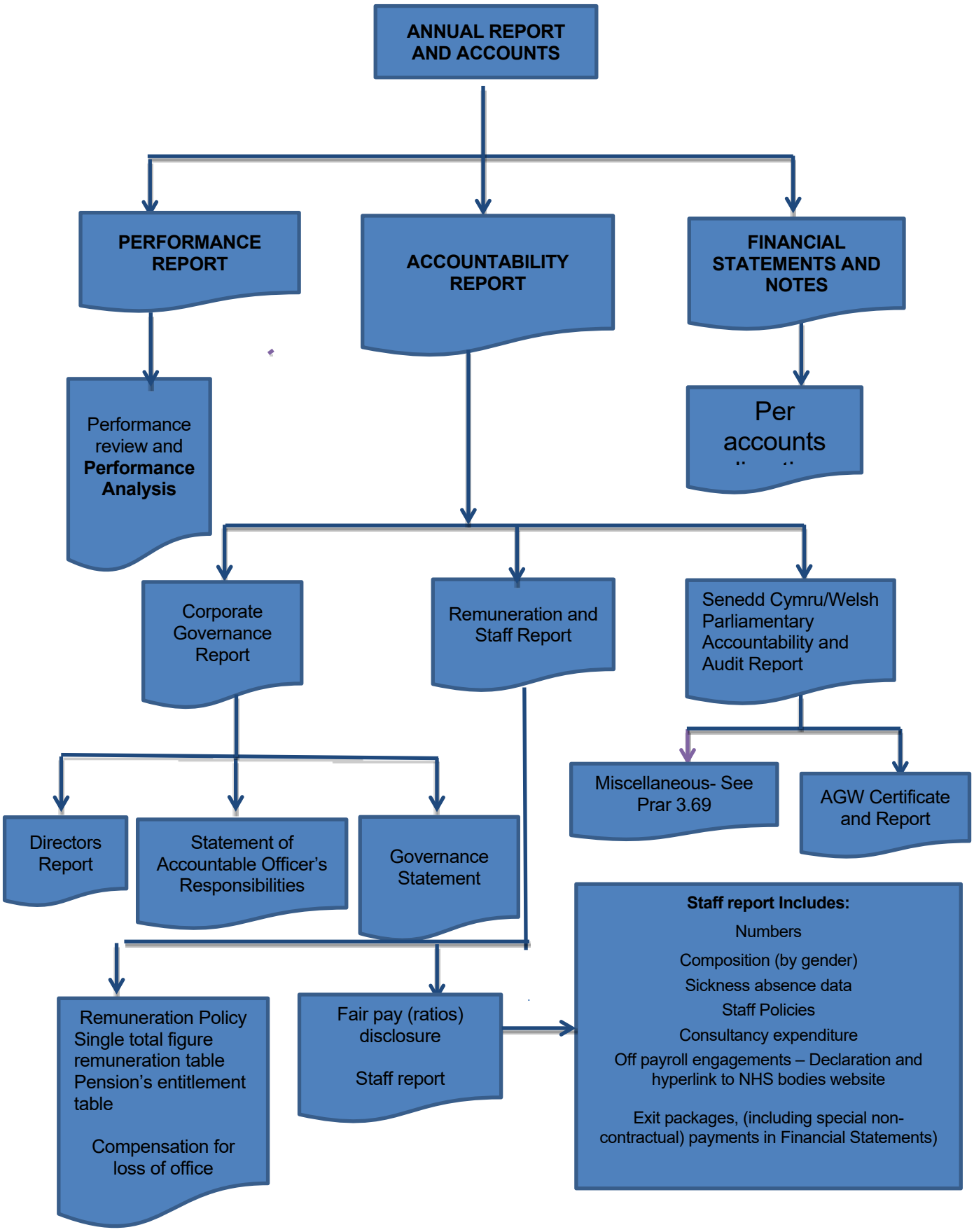
The Audit, Risk and Assurance Committee is asked to CONSIDER and REVIEW the Final Draft versions presented prior to being submitted for formal approval by the Board on 11th July 2024.

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	

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


ANNUAL REPORT AND ACCOUNTS
PERFORMANCE REPORT
ACCOUNTABILITY REPORT
FINANCIAL STATEMENTS AND NOTES
Performance review and **Performance Analysis**
Per accounts
Corporate Governance Report
Remuneration and Staff Report
Senedd Cymru/Welsh Parliamentary Accountability and Audit Report
Directors Report
Statement of Accountable Officer's Responsibilities
Governance Statement
Miscellaneous- See Prar 3.69
AGW Certificate and Report
Remuneration Policy
Single total figure remuneration table
Pension's entitlement table
Compensation for loss of office
Fair pay (ratios) disclosure
Staff report
Staff report Includes:
Numbers
Composition (by gender)
Sickness absence data
Staff Policies
Consultancy expenditure
Off payroll engagements – Declaration and hyperlink to NHS bodies website
Exit packages, (including special non-contractual) payments in Financial Statements)

Audit Wales Comments		
Page/reference	Comment	Response
Accountability Report		
Pg8	Is it Board assurance framework or in pg31 you refer to the BAF being replaced by the Strategic Risk Register (SRR)	Amended to refer to Strategic Risk Register
Pg13	TOR Audit, risk and assurance committee on the website following the link is out of date, needing review by March 2023. Same for the Finance and performance committee, Patient Quality, safety and outcomes committee, Charitable funds committee, partnerships, population health and planning committee, renumeration and terms of service, mental health act monitoring, people and culture committee. There were no terms of reference for the litigation group?	Correct. Section added to self assessment section (pg 22): "*In undertaking these assessments, committee members considered their composition, establishment and ways of working, the outcomes of which will inform a detailed review of Committee Terms of Reference in 2024/25".* Litigation Group information not published – this is not a public facing arrangement and therefore would not disclose details as this is about personal claims and, from an organisational perspective, much of the info is legally privileged.
Pg22	The links on the advisory groups takes you to the model standing orders. I appreciate that these may not be available due to the issues outlined later in the document.	The narrative states that the link is to SOs: *"Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board's website. "*
Pg34	(Strategic Risk Report) Is it possible to link directly to the paper rather than the public board meetings site	Link updated
Pg34	Would it be useful to provide an overview of the HB risks at 25 here including controls	There are no risks at 25 – highest is 20. Updated to include a heat map
n/a	There is no reference to partnership working with other HBs?	Section added to page 28
n/a	No reference to the health board organisational structure in relation to system of control	Para included under governance structure diagram, page 10
Pg65	typo - quoracy – a couple of the Feb 23 meeting should read 24.	amended

Pg74	typo - Attachment 3 - 2.1/2.2 first column refers to the trust as opposed to HB.	This is the text from the Corporate Governance Code
Pg86/87	I've got some queries on the ED and NEDs salary table figures but the team will pick those up via testing.	Discussed with finance
Pg88	'*Martin Blakebrough commenced with the Health Board on 3rd May 2023 but has yet to formally take up Board duties'* – query on whether this is correct given he did take up duties and attend the July Board?	* Absent in agreement with Chair and Welsh Government (effective 01/09/23 to-date)
Annual Report/Performance Report		
Pg3	Do you need to provide a bit more detail on the escalation status and the background to this for the lay reader	Added link to AGS which contains further info.
Pg20	I struggled to see the performance against the specific ministerial priorities in this section	Paragraph updated: This chapter of the report updates on delivery against the Clinical Futures programmes including those which deliver the key priorities set by the minister. There is a high degree of synergy between the Ministerial Priorities for 2023/24 that are designed to support a swift recovery of business as usual and to reduce growing waiting lists and waiting times. All priorities are underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services
Pg28	There was no detail on patient experience activity here, or information provided on complaint themes, NRIs or never events – more detail would be good	Additional information provided.
Pg35	section 9, equality – should the first bullet refer to 2023-24 data?	No- as per usual reporting we take data from 31/3 of the previous year in line with requirements for gender pay gap reporting . So 31/3/23 is correct.
Pg39	Long term Revenue Performance tables 2.1 & 2.2 – they don't cast across. The	Table amended to clarify the 3-year rolling programme as prior to 2021-

	total columns are only adding the last 3 columns	22 the figures are more for information
ARAC Comments		
Staff and Remuneration Report	Staff numbers: include narrative around the changes to staffing/increases in admin staff	Narrative included

Aneurin Bevan University Health Board Annual Report and Annual Accounts 2023/24

Our Annual Report is a suite of documents that tell you about our organisation, the services and care we provide and what we do to plan, deliver and improve healthcare for you. It provides information about how we performed in 2023/24, what we have achieved, how we plan to continue to improve next year and our plans for the future. This report also explains how important it is for us to work with you and listen to your views, to better deliver services that meet your needs, as close to your home as possible.

Our Annual Report for the period 1st April 2023 to 31st March 2024 includes:

- Our **Performance Report** which details how we have performed against our targets and the actions planned to maintain or improve our performance.

- Our **Accountability Report** which details our key accountability requirements and provides information about how we manage and control our resources, identify and respond to our risks, and comply with our own governance arrangements.

- Our **Financial Statements and Annual Accounts** which detail how we have spent our money and met our obligations.

Contact Us

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Performance Report

1. Overview from the Chief Executive

Over the past twelve months our organisation has remained under sustained operational pressure as evidenced through increased demand into our urgent and emergency care system, into scheduled (elective) care and an increased pressure on primary care and community services, as well as mental health services. These pressures are replicated in the services of our partners in social care.

Despite these challenges there have been many achievements and improvements in performance, across the breadth of our priorities. Much has been delivered over the past 12 months including:

- Opened a new Endoscopy unit and a new Breast unit with benefits already being seen through diagnostic and cancer waits,
- Progressing our approach to innovation as seen through our work on the use Artificial Intelligence to support the clinical prioritisation of radiology scans and positively impacting on cancer diagnosis times,
- Strengthened Six Goals Programme for Urgent and Emergency Care including enhanced focus on discharge with partners,
- Reduced very long waits for elective care from over 500 people waiting more then 3 years at March 2023 to 31 patients at the end of March 2024 and eliminated waits of over 4 years. 30 out of 36 specialties delivering the national standard of 104 weeks,
- Continued improvements in outpatient efficiencies, in particular "Patient Initiated Follow Ups" and "See on Symptoms" pathways,
- Opened the first phase of the Bevan Health and Wellbeing Centre in Tredegar with further progress on the Primary Care estate plan,
- 5 GP practices transferred from "managed practices" back to independent contractor status,
- Strengthened focus on quality, safety and patient experience.
- Development of a Patient Advice and Liaison (PALS) as a point of contact for patients, their families, and carers providing confidential advice, support and information on health-related matters.
- Reduced the use of agency workers to the value of £18m and increased the total number of substantive staff through innovative approaches to recruitment and retention.

This has been a year with new challenges including industrial action for the first time from our junior doctors. We are still recovering from the impact of the Covid-19 pandemic with many people waiting too long to receive care and treatment and our

urgent and emergency care system continues to experience too many delays at a number of points. Mental health services are also pressured and we have experienced significant demand increases for our services especially for children and adolescents. The rising demand is coupled with rising acuity demonstrated through the rate of working age adults reported in good health on a downward trend since Covid-19 and suspected cancer referrals have continued to exceed 3,500 referrals per month compared with pre-Covid-19 levels of 2,500.

Our plan for 2023/24 was set against our life course model, unpinned by some enabling actions and focus:

Reflections of 2023/24

Our delivery of change and improvements during 2023/24 is set against the backdrop of a change in demand for our services:

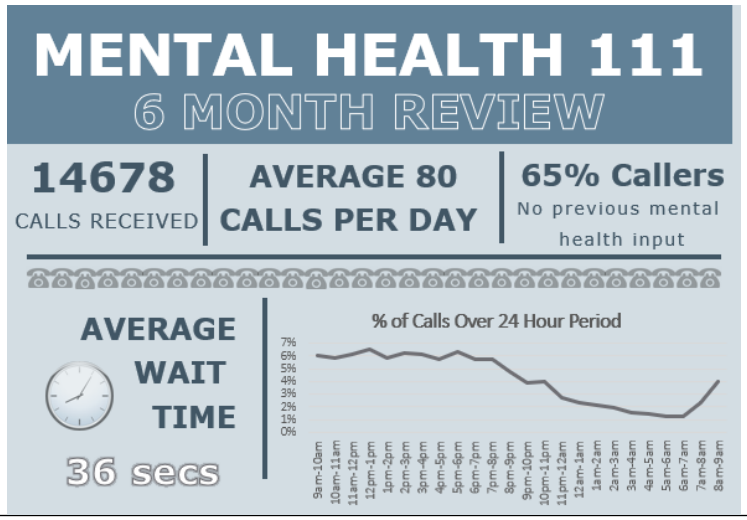
- Urgent primary care contacts increased from a weekly average of 1,622 to 1,994,
- People presenting to emergency departments and Minor Injury Units has increased from 170,113 to 173,671 attendances,
- A high number of emergency admissions has been sustained at an average of 1,883 per month,
- Emergency admissions average length of stay has improved but remains above pre-COVID levels at 11.3 days,

- Sustained high levels of demand at the Children's Emergency Assessment Unit with an average of 2,396 attendances per month,
- Referrals for suspected cancers continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500,
- Increase in outpatient referrals by 9% from 251,164 to 274,685,
- Referrals for primary care and specialist mental health services (adults and older adults) are well above pre-Covid-19 rates with 14,858 received in 2023/24,

In spite of these demand challenges there have been a significant number of achievements over this last year including:

Prevention and Population Health	Renewed understanding of our Population through the launch of the first Joint Strategic Assessment in Wales. A Gwent-wide partnership action to address inequity and the wider determinants of health as part of 'Building a Fairer Gwent. Sustained compliance with national standard of 95% of children receiving 3 doses of the hexavalent '6 in 1' vaccine by age 1. Integrated Wellbeing Networks have supported the development of connected communities. Strengthening community wellbeing and resilience through sustainable place-based care collaboratives, sharing wellbeing resources, prioritising equity and asset-based approaches.
Primary Care Services	Community Pharmacies have demonstrated continued success achieving a 46% increase in common ailment consultations over this year. Continuing to progress the level of service provided via NHS and Community Dental Services- over this year 325,904 patients have received dental care of which 24,182 were new patients. All Managed GP practices transferred to independent providers from 1st April 2024.
Urgent and Emergency Care System	Through our Six Goals Programme for Urgent and Emergency Care we have delivered a number of improvements including expanding our Acute Frailty Response Team and introduction of a new falls pathway to reduce ambulance conveyances. Embedding our Same Day Emergency Care service with a weekly average of 138 attendances at Grange University Hospital and 49 at Ysbyty Ystrad Fawr.

	Despite the extreme pressures upon the urgent and emergency care system, the performance measures of patients waiting fewer than four hours in Emergency Departments has been maintained during the winter period 73.8% (March 24) against a standard of 73% and higher than the Welsh average of 68%. The number and rate of patients waiting over 60 minutes to be transferred to the Emergency Department from an Ambulance has reduced significantly during March 2024 (1,107 – 36.7%) to the lowest levels seen over the last two financial years A number of programmes to support discharge have been implemented over the last year including a series of Patient Safety Team events aimed at facilitating the safe and timely discharge of patients working in partnership with the five local authorities. Overnight Discharges in 2022/23 were 21,410 and for 2023/24 increased to 23,542.
Planned Care and Cancer Services	Good progress towards eliminating patients who have been waiting over 156 weeks for treatment, with 31 patients waiting at the end of March 2024 compared to the to the March 2023 position of 553. The number of Single Cancer Pathway treatments undertaken has increased by 5.5% over the last 12 months and is continuing to increase month by month. Opening of new Endoscopy suite at Royal Gwent Hospital at the start of November. The impact of this investment has resulted in the number of people waiting over 8 weeks at the end of March 2024 reducing to 1,368 compared to 1,890 (November 2023) Welcoming our first patients into the Breast Care Unit at Ysbyty Ystrad Fawr as a whole system service delivering the best for our population. Patients waiting over 8 weeks for a radiology diagnostic has decreased from 3,802 (November 2023) to 1,600 (March 2024).
Mental Health Services	Child and Adolescent Mental Health Services choice referrals have achieved 100% in March 2024 compared to 87.5% December 2023 exceeding the national standard.

	Embedding of mental health services in our Neighbourhood Care Networks remains a priority and continues to be piloted in areas with a view to expand across all boroughs. Our new accommodation 'Acer House' for individuals with complex needs had its official opening on 24th October, in collaboration with United Welsh Housing Association. Three service users are currently being supported at Acer House and are thriving in their new environment. Our new Hiraeth Service aims to offer a whole systems approach to developing a cohesive and consistent care pathway for individuals who present with complex mental health needs, ensuring the ability to engage in the delivery of shared care and promote partnership working. Mental Health 111 press 2 has made significant achievements as summarised below: 

Our Workforce

We employ 13,082 whole time equivalent (WTE) staff members as at 31st March 2024 and are the largest employer in Gwent. This is an increase from this period last year of 514 WTE. The main increases are within Additional Clinical Services (95wte), Administrative & Clerical (64.97wte) and Nursing and Midwifery Registered (123.42wte).

There are also 1,296 WTE colleagues working in independent GP practices in primary care across the region. Our general workforce demographic profile remains relatively unchanged, as illustrated in figure 5.5. However, 36% of staff are now over 50 years old, which is an increase of 3% and turnover has also reduced from 11.4% to 9.2%. The number of staff we employee will decrease from April 2024 by 135 people due to

transfer of staff (under TUPE arrangements) to the NHS Wales Executive of national hosted functions and managed GP practices reverting back to independent status.

The highest increase, based on our staff groups, have been in Allied Health Professions (17%) following the introduction of the Physiotherapy MSK services. Other staff groups which have increased include Medical and Dental (10%), mainly as a result of an increase in speciality registrar posts, and Administration and Clerical (5.7%). Clinical Services have increased by 7.5%, Nursing and Midwifery have increased by 4.5% as a result of recruitment campaigns locally and internationally.

Sickness has decreased from 6.9% to 6.2%. Stress, anxiety and depression remains our highest reason for absence and represents 27% of total absence.

Whilst we have made progress in reducing the number of vacancies over the last year, we continue to experience high levels of vacancies across medical specialities and within our registered nursing, pharmacy and therapy workforce as well as within specific medical specialities. Our priority continues to be recruiting, developing and retaining directly employed staff, recognising the positive impact that a substantive workforce will have in building and sustaining effective teams to provide a positive patient experience.

We are now in year 3 of our People Plan which was agreed and launched in 2022. The plan recognises the importance of a healthy, engaged workforce and aims to support our staff to have a meaningful and positive experience of work.

It is aligned to the commitments of 'Healthier Wales: Our Workforce Strategy for Health and Social Care (2020)'. It also supports the practical actions and enablers outlined in the National Workforce Implementation Plan (2023) underpinning strong inclusive and compassionate leadership and improving retention and recruitment.

In delivering the plan we continue to engage with our Trades Union partners and support ways to develop partnership working. This year we have re-launched divisional partnership forums to complement our corporate forum to build on our commitment to ensuring staff are provided with an opportunity to share views, concerns and to influence plans that affect them.

The Plan focuses on three priority objectives:
1. Staff Health and Wellbeing
2. Employer of Choice
3. Workforce Sustainability and Transformation

Finance

Aneurin Bevan University Health Board, like most health boards across Wales is experiencing significant financial challenges to meet its statutory duty to financially balance over a rolling 3-year period or on an annual basis. Historically the health board has delivered consistent financial balance, however, the Health Board was not successful in this aim in 2022/23 with a £37m deficit. The 2023/24 plan set out a plan

which resulted in a financial deficit of £112m. The final outturn, following significant additional central support of £88.3m, was a £49.8m deficit. This was delivered against a Welsh Government target of reducing to a maximum of £13m deficit.

As part of this final out turn it is important to acknowledge the material level of savings achieved in 2023/24 of £43m and this is thanks to the huge efforts of our staff and renewed focus on efficiency that has enabled us to achieve this level of savings.

Moving forward into 2024/25 a deficit is forecast of £48.9m. These levels of deficit, driven by exceptional operational demand pressures and underlying financial challenges, mean the Board is aiming to show an intention to recover to a recurrent financial balance over the next 3-year period.

Despite our continued efforts and wide-reaching achievements, following the reissue of the Welsh Government Oversight and Escalation Framework – NHS Wales Organisations in January 2024, in February 2024, the Health Board's escalation levels were increased from Enhanced Monitoring (level 3) to Targeted intervention (level 4) for planning and finance and from Routine Arrangements (level 1) to Enhanced monitoring (level 3) for performance and outcomes related to urgent and emergency care at The Grange Hospital.

2. Reporting Requirements

The purpose of the Performance section of this Annual Report 2023/24, as set out in the guidance provided in the NHS Wales 2023/24 Manual for Accounts, is to provide information on Aneurin Bevan University Health Board, its main objectives and strategies and the principal risks that it faces. The requirements are based on the matters required to be dealt with as set out in Chapter 4A of Part 15 of the Companies Act 2006, as adapted in the Financial Reporting Manual and NHS Wales Guidance Manual.

The main features of the performance report flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against these.

It should be noted that the duty of quality came into legal force in April 2023 in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. 2023/24 is therefore the first year for the requirement of a Duty of Quality and Duty of Candour report. These reports will be prepared and published separately to this Performance Report. Further information is available in the Annual Accountability Report, Page XX.

3. Aneurin Bevan University Health Board

Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this

role, we are required to work with our partners and stakeholders in the best interests of the population we serve.

As a Health Board, we serve the population of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the South Wales valleys.

The Population Needs Assessment for the region can be found here: Demography - Gwentrpb.

The Health Board employs 13,082 WTE as at the end of March 2024 and are the largest employer in Gwent. Our workforce is ageing, as is the demographic profile of our population and the health inequalities of our population are also found within our workforce and 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans.

The Health Board has an annual budget from the Welsh Government of just over £1.7 billion per year from which we plan and deliver services for the population of Gwent. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015.

Detail on how the Health Board is governed is set out within the Accountability Report (Section 2 of the Annual Report and Accounts 2023/24).

4. Integrated Medium Term Plan 2023/24 – Life Course

The vision set out in the IMTP 2023-2026 was to:

> Improve population health and reduce the health inequalities experienced by our communities.

In order to achieve this vision, the IMTP focused on five life course priorities.

The Outcomes Framework is updated quarterly and, depending on data availability, the latest data is reported for each indicator. It comprises of metrics which should be captured over a longer time period than other routine performance indicators. For the 2023/26 IMTP, the Outcomes Framework was reviewed and aligned, where appropriate, with the newly published Public Health Outcomes Framework. The timescales for indicators vary according to the data source. Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. Some of the outcome indicators are reported on an annual basis for the previous year, we have provided the latest position available even those which state 2021 or 2022.

Of the 41 indicators, 27 have either improved or are statistically similar and 14 indicators have deteriorated over the past 12 months.

Type of change	P1 - Every child has the best start in life	P2 - Getting it right for children and young adults	P3 - Adults living healthily and aging well	P4 - Older adults are supported to live well and independently	P5 - Dying well as part of life	Total
Improved	4	2	8	4	1	**19**
Similar	2	1	1	1	3	**8**
Deteriorated	2	2	7	2	1	**14**
Total indicators	**8**	**5**	**16**	**7**	**5**	**41**

Delivering the IMTP Priorities 2023/24

Priority 1

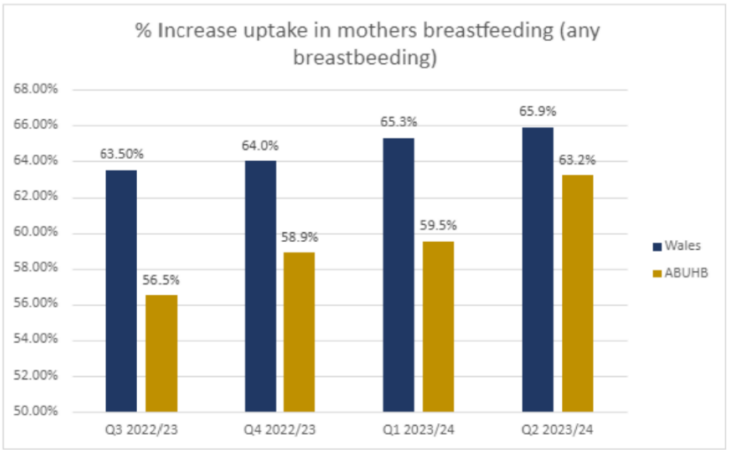
Every child has the best start in life

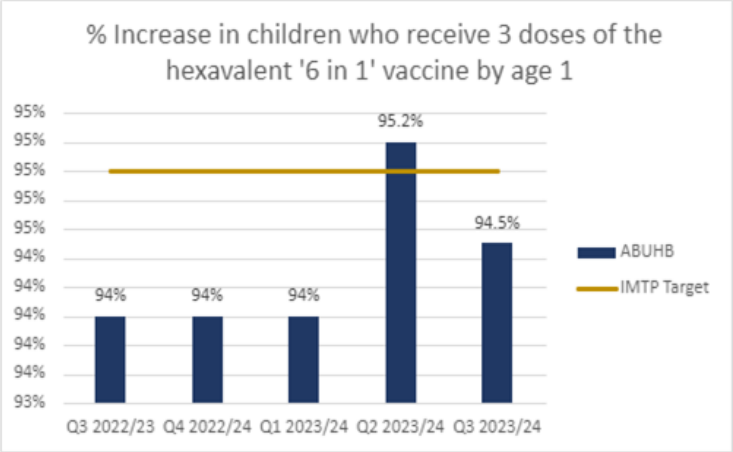
Early childhood experiences, including before birth, are key to ensuring improved health outcomes. The Health Board's IMTP committed to working with partners to take forward actions and activities that have a positive impact on the first 1,000 days of life. The table below sets out three core outcomes to be achieved in this area. Alongside identified measures, this information is used to target actions and identify priorities for the organisation.

Our Commitments	Our Measures	Indicator Value	Our Performance
Improving Good Health in Pregnancy	Decrease Low Birth Rates	6.1%	Increase in indicator between 2021 (5.1%) and 2022 (6.1%). In line with the All-Wales average.
	Decrease smoking rates @ birth	13.1%	Decrease from 13.7% in 2021 to 13.1% in 2022 and remains above the all-Wales average.
	Decrease still births	4.5 per 1,000	Increase in stillbirth rates between 2021 (3.9 per 1,000) and 2022 (4.5 per 1,000), however a 10% decrease in stillbirths have been observed over the last 5 years.
Optimising a child's long term potential	Increase uptake of women breastfeeding	63.2%	Indicator value has improved by 11.6% between Q2 22/23 and Q2 23/24.
	Increase of eligible children with contact at 10-14 days	89.8%	Significant improvement in indicator during the last 12 months (baseline 29.3%).
	Increase of eligible children with contact at 6 months	82.7%	Significant improvement in indicator during the last 12 months (baseline 42.1%).
Increasing childhood immunisation	% Children who received 2 doses of MMR by age 5	89.3%	Indicator value has remained stable (baseline 90%)
	% Children who receive 3 doses of hexavalent '6in1' vaccine by age 1	94.5%	Indicator value has remained stable (baseline 94%)

There has been mixed progress in the outcome **'Improving good health in pregnancy'**, with both the low birth rates and still birth rates increasing between 2021 and 2022. Whilst there has been a reduction in the indicator over the previous 3 reporting periods, the rate has increased between 2021 (5.1%) and 2022 (6.1%), which is in line with the all-Wales average. Additionally, still birth rates have increased from 3.9 per 1,000 in 2021 to 4.5 per 1,000 in 2022. Good progress has been made in decreasing smoking rates at birth. The current reported position is 13.1%, which is a decrease from 13.7% in 2021.

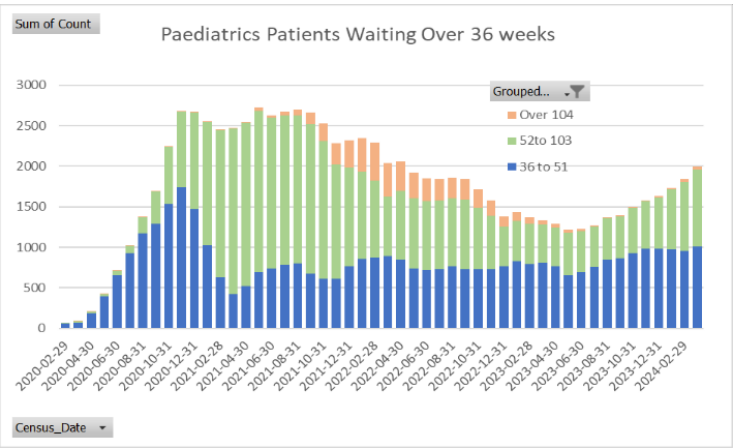
There has been an improvement in all three indicators of the outcome **'Optimising a child's long term potential'** with an increase over the last 12 months from 56.6% to 63.2% (Q2 23/24) in breastfeeding rates. As part of the Healthy Wales Child programme, there has been a significant increase over the last 4 quarters in the number of eligible children with contact between 10-14 days at 89.9% (baseline 29.3%) and eligible children with contact at 6 months at 82.7% (baseline 42.1%).





The position in the reported indicators in the outcome **'Increasing childhood immunisation and preventing outbreaks**' has remained broadly stable. Uptake of the complete three-dose course of the hexavalent '6 in 1' vaccination by age 1 is reported at just below 95%, demonstrating strong sustained performance levels and is consistent with national levels. Torfaen and Monmouthshire have the lowest uptake within Gwent with an uptake rate of 90.9%. Blaenau Gwent had the highest uptake rate of 95.1%.

The MMR vaccine protects against three infections – measles, mumps and rubella. The uptake rate in Gwent of the MMR 2 dose vaccine (age 5 years) was below the uptake for Wales between 2019 and 2021. From 2022 the uptake rate in Gwent and Wales have fallen, with Gwent now sharing the same uptake rate of 89.3% as Wales in quarter 4. Newport has the lowest uptake within Gwent, with a rate of 86.7%. Caerphilly had the highest uptake rate of 92.5%.



The number of children on the Health Board's waiting lists who have been waiting over 36 weeks increased during the pandemic and peaked during the summer of 2021. As of March 2023, there were 663 children waiting over 52 weeks for a new outpatient appointment and this reduced to 495 by March 2024. There continues to be focused efforts to reduce paediatric waiting times and consequently, intensive plans have been developed to reduce and maintain the waiting time for first outpatient appointments across all specialities.

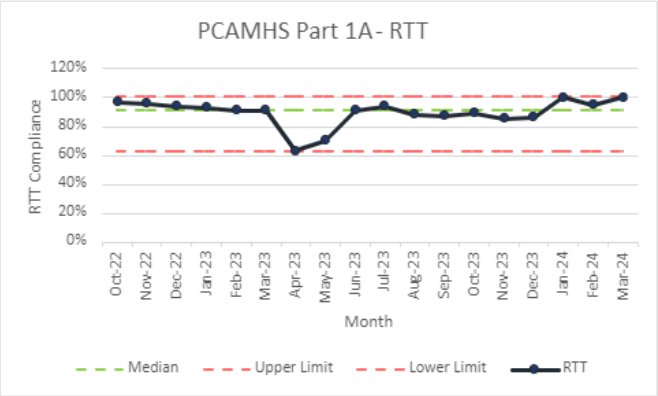
Priority 2

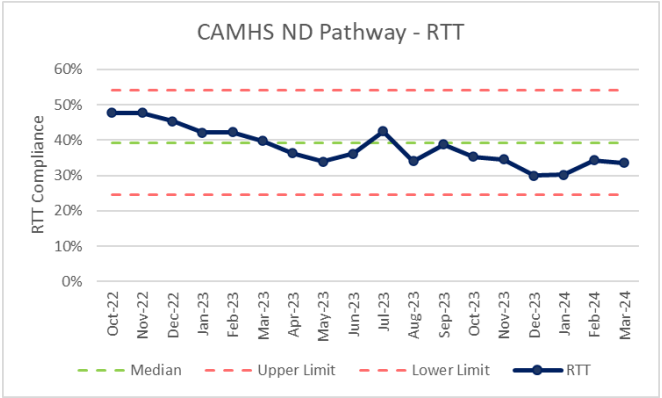
Getting it right for children and young adults

Nurturing future generations is essential for our communities. There is strong evidence that healthy behaviours in childhood impact throughout life; therefore, targeting actions to improve outcomes in these areas has a long-lasting impact on delivery. Young adult mental health is a Ministerial Priority area with CAMHS a focus in the national performance framework.

Our Commitments	Our Measures	Indicator Value	Our Performance
Improve mental health resilience	Decrease in 4-week CAMHS waiting lists	100.0%	Indicator improved significantly since last reporting period. National standard of 80% remains achieved at 100% compliance.
	Increased compliance in neurodevelopmental (SCAN) waiting list	33.5%	Indicator deteriorated over the last 12 months (baseline, 39.7%)
Support being a healthy weight	Increase in physical activity (for at least 60 minutes a day) in adolescents	15.1%	Indicator is lower than the Welsh average of 16.2% and has decreased over the last 12 months (baseline, 15.9%).
Improve healthy lifestyle behaviours	Decrease in adolescents using alcohol	40.9%	Similar to Mar 23 baseline (40.7%), however indicator is higher than the Welsh average of 40.2%.
	Decrease in adolescents drinking sugary drinks once a day or more	18.5%	Indicator has improved from 19.4% (Mar 23 baseline) to 18.5%.

Progress within the **'Improve Mental health Resilience in Children and Young Adults'** outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% standard of completing ND assessments within 26 weeks. 2023/24 has seen a continued demand of referrals requesting consideration of an ND assessment. There are on average 220 new referrals a month which is a 200% increase on the monthly average for 2019/20 and this challenge has resulted in an RTT compliance for the end of March 2024 of 33.5%. A recovery plan was implemented in April 2023 to be able to support the current waiting lists across the 0-18 years pathway by separating the cohorts of 0-5 years and the 5-18 years.





PCAMHS 1a performance against the ministerial target of 80% compliance has remained steady since 2022. As at March 2024, the reported position increased significantly to 100%, surpassing the ministerial target. However, Part 1b remains significantly off track at 7.5% compliance (March 2024). Despite workforce constraints, the waiting list is reducing. CAMHS Part 2 RTT has seen increased compliance since April 2023, however there is a slight decrease in the reported March 2024 position at 72.4%.

Within Gwent, the percentage of adolescents participating in at least 60 minutes of exercise a day is reported at 15.1%, a reduction from 15.6% the previous year. Physical activity diminishes with age, from 20.7% (age 11) to 12.4% (16) and by gender with 20.7% reported amongst males and 11.9% amongst females. Additionally, there is a reported variation based on deprivation, with those living in a more affluent area more likely to engage in exercise (18%) compared to those in the least affluent areas (14%).

Within the '**Improving healthy lifestyle behaviours'** outcome the indicators of 'percentage of adolescents using alcohol' and 'drinking sugary drinks once a day or more' have both reported higher rates than all Wales average. The average percentage of adolescents drinking sugary drinks once a day or more is currently 18.5% compared to the all Wales average of 16.4%.

People who begin drinking early in life run the risk of developing serious alcohol problems, including alcoholism, later in life. They are also at greater risk for a variety of adverse consequences and poor performance in school. The average percentage of adolescents using alcohol is currently 40.9% compared to the all Wales average of 40.2% and this rate rapidly increases by age, increasing from 15.2% at the age of 11 to 71.8% by the age of 16.

Priority 3

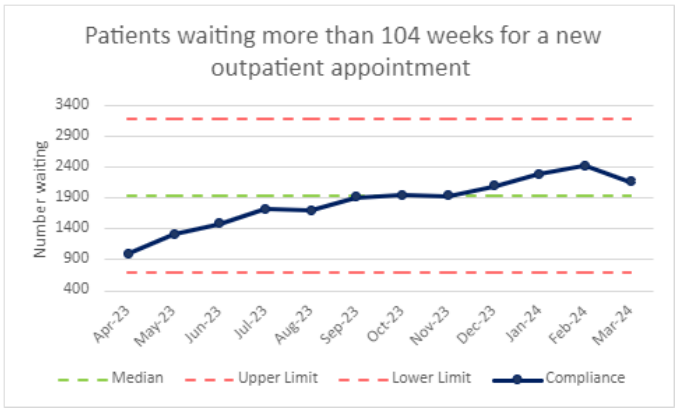
Adults living healthily and ageing well

Our ambition is for citizens to enjoy a high quality of life and to be empowered to take responsibility for their own health and care. A significant number of measures fall within this area, particularly in relation to maximising an individual's time. The outcomes and performance set out below underpin the work of the priority programmes and in particular the work of the Six Goals for Urgent and Emergency Care, Planned Care and Mental Health.

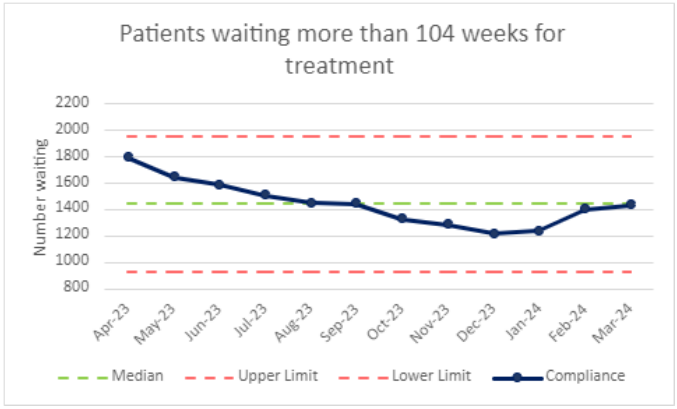
Our Commitments	Our Measures	Indicator Value	Our Performance
Maximise an individuals time	Reduction in the number of patients waiting more than 36 weeks for treatment	42,980	Indicator value has increased over the last 12 months (baseline, 32,202)
	Reduction in the number of patients waiting for a follow-up outpatient appointment	134,784	Indicator value has increased by 11.6% between Mar 23 and Mar 24.
	Increase in Urgent Primary Care Contacts	9,916	Significant increase in monthly contacts over the last 12 months (baseline, 5,456)
	Reduction of ambulance handovers over 1 hour	691	Significant reduction (Mar 23, 1,497) and improving trend.
	Reduction in patients never waiting in ED over 16 hours	399	Decrease in the indicator value for the last year (Mar 23, 498)
	Reduction in time for patients to be seen by first clinician	2.0 hours	Improving trend observed during 23/24 (March 23, 2.3 hours)
	Reduction in time for bed allocation from request	12.3 hours	Improvement in metric from 13.9 hrs (March 23) to 12.3 hrs (March 24)
Adults living healthily and aging well	Increase in adults meeting physical activity guidelines	49.9%	Since Covid-19, there has been a decrease in physical activity. Reduction from 52% (20/21 baseline) to 49.9% (22/23)
	Decrease in the % of adults smoking	13.6%	IMTP ambition met, however there is an observed increase in the percentage of adults smoking between 21/22 (12.9% and 22/23 (13.6%).
	Increase in working age adults of healthy weight	33.4%	For the first time since Covid-19, there has been a 14% increase. However, remains below the all-Wales average of 36.1%.
	Increase in working age adults in good or very good health	69.5%	Both the ABUHB and All Wales average have seen a decreasing trend over since Covid-19 (baseline 76.9%)
	Increase uptake of National Screening Programmes	70.2%	Improvements in indicator value observed (baseline, 64.2%)
Improve mental health resilience	Increase in life satisfaction among working age adults	79.2%	Indicator has improved between 21/22 (76.4%) and 22/23 (79.2%)
	Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	68.1%	Measure has deteriorated during the last 12 months (baseline, 75%)
Maximise cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	60.8%	Improvement in indicator since March 23 (56%) and March 24 (60.8%).
	Increase in 5 year cancer survival	58.6%	Significant improvement in indicator between reporting periods from 54% (2015-19) to 58.6% (2016-20)

Maximising an Individual's Time-Planned Care

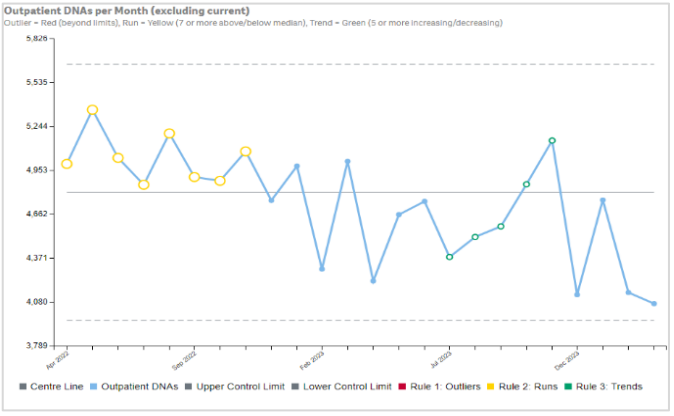
Maximising an individual's time is a core element of planned care. During the Junior Doctor Industrial Action in Quarter 4, a total of 3,298 outpatient appointments and 508 treatments were cancelled and this loss of capacity has had an impact upon performance levels. The Health Board has made good progress towards eliminating waits of over 156 weeks, with 31 patients waiting at the end of March 2024 compared to the April 2023 position of 642.



Improvements have also been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,430 at the end of March 2024.



There is a particular challenge within the surgical specialty of ENT where demand has outstripped capacity, along with reduced outpatient capacity. A 'GP gatekeeper model' has been introduced and is being piloted to review demand with the purpose of managing demand in the most appropriate way, and early indicators show that the additions to the waiting list have reduced. Ophthalmology have launched a new technician diagnostic hub to address the backlog of Glaucoma patients on the follow-up waiting list, with a particular focus on those waiting over 100% past their follow-up target date.

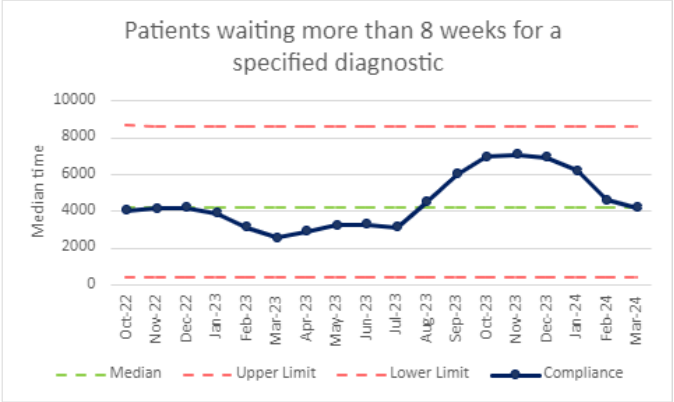


Improvement in outpatient performance remains essential to make the most of an individual's time and is a core focus of the Planned Care Programme. At the end of March 2024, there were 2,169 patients waiting over 104 weeks for a first outpatient appointment. There is mixed progress across specialities with ENT, Orthopaedics and Ophthalmology ending the year behind trajectory. There are extensive recovery plans in place across ENT and Urology including a clinical review of patients on the waiting list along with other solutions (e.g. audiology) supporting ENT and a focus on improving treat in turn prioritisation across all specialities.

Part of the outpatient transformation programme is focussing on the outpatient Did Not Attend (DNA) plan, of which the current rate for new outpatient appointments has been sustained at 6.1% (4,070) in March 2024.

Maximising an Individual's Time - Diagnostics

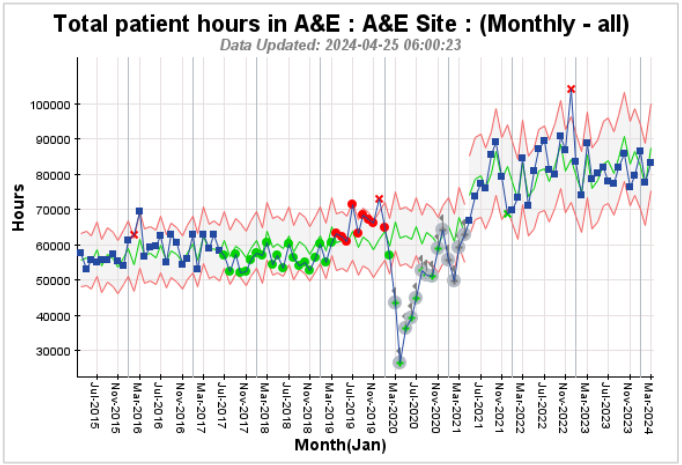
There has been a steady reduction in the number of patients waiting over eight weeks for a diagnostic since November 2023. Key issues in diagnostics include:

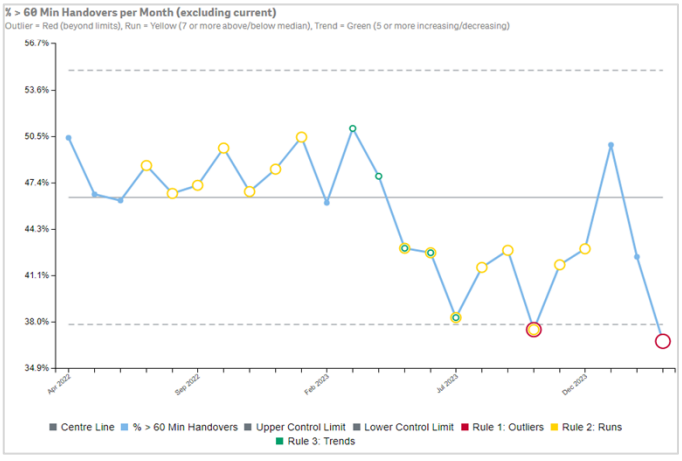


- Royal Gwent Hospital endoscopy unit opened in November 2023, with the purpose to sustain services and reduce backlog of those waiting. The impact of this investments has resulted in the number of people waiting at the end of March 2024 reducing to 1,368, compared to 2,061 (March 23),
- Radiology diagnostics patients waiting over 8 weeks has increased from 321 (March 23) to 1,155 (March 2024),
- Cardiology position has been maintained at 206 breaches in March 2024.

Maximising an Individual's Time- Urgent Care

Urgent Care services continue be under significant pressure both nationally, regionally and locally, making delivering timely care challenging. There has been increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and Minor Injury Units, increased acuity, increased bed occupancy for emergency care and high levels of delayed discharges linked with significant social care workforce challenges.





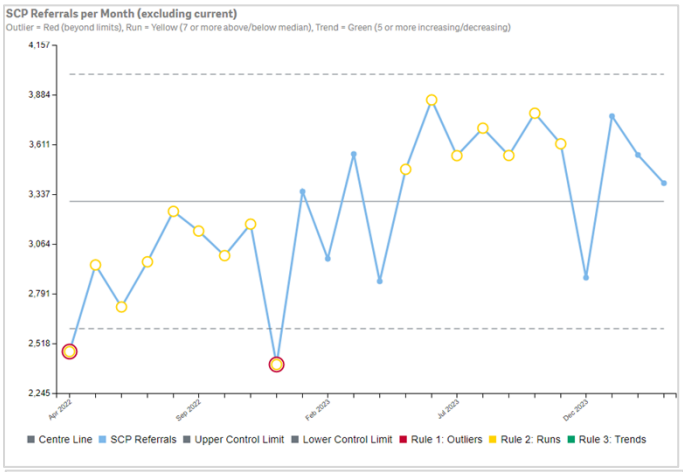
Over the last 12 months, there have been on average 516 daily attendances to the Emergency Department or a Minor Injury Unit, compared to 505 during the previous year, and the pressure on the urgent care system has resulted in patients staying in hospital for longer. The average time from arrival to departure in the GUH Emergency Department continues to be above the standard, with the total number of patient hours spent in A&E increasing significantly above pre-covid levels as the chart above demonstrates. The number and rate of patients waiting over 60 minutes to be transferred to the Emergency Department from an ambulance has decreased significantly from 1,597 in March 2023 to 691 in March 2024 and is the lowest level seen over the last two financial years. Whilst this remains high, as a result of poor flow through the system, there has been a concerted effort to decrease the number of

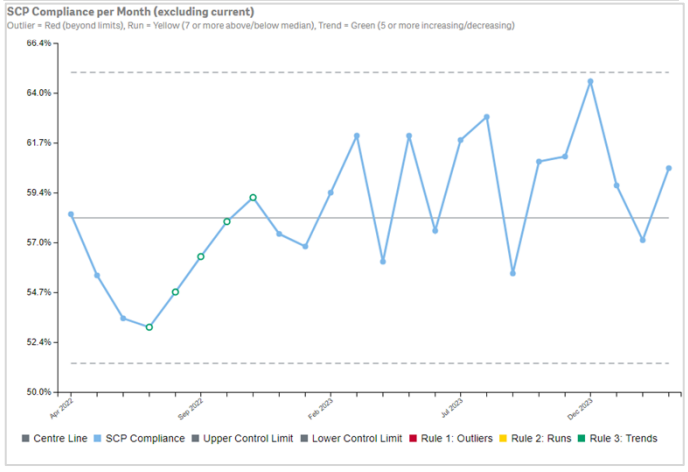
delayed ambulance handovers.

Despite the extreme pressures upon the urgent and emergency care system, the performance indicators for patients waiting fewer than four hours in ED has been maintained during the winter period and is currently reported at 73.8% (March 24) against a trajectory of 73%. The most recent national performance data reports that the Health Board's performance is higher than the Welsh average of 68%. Patients waiting over 12 hours in Emergency Departments was 1,477 in March 2024, compared to 1,606 in March 2023.

Maximising cancer outcomes

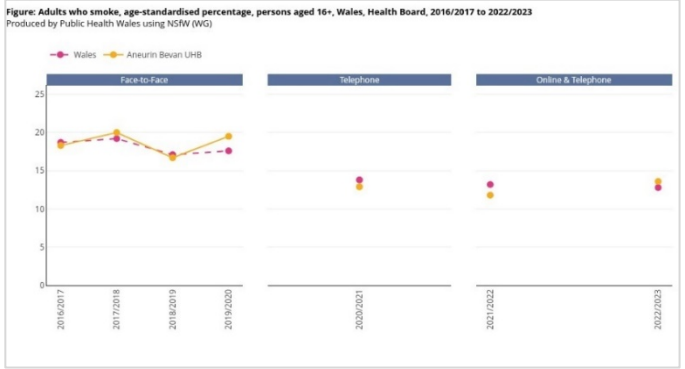
Overall, there has been significant improvement in the rate of five-year cancer survival reported over the last 10 years. However, whilst statistically similar, a slight decrease of 0.8% has been observed and cancer survival remains below the Welsh average for the third consecutive year.





Compliance against the 62-day standard for definitive cancer treatment has increased during 2023/24 from 58.2% at the end of March 2023, to 60.8% in March 2024. This is behind the performance ambition set in the IMTP. Drivers for this include the significant increase in demand alongside the focus on reducing the over 62 day waits, which will affect compliance. Significant increases in demand relating to the suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500.

The number of cancer treatments undertaken has increased by 5.5% over the last 12 months and is continuing to increase month by month. Despite the pressures of increased demand and capacity challenges, there has been an improving position in the number of patients waiting over 62 days over the last 6 months, reducing to 346 at the end of March 2024.



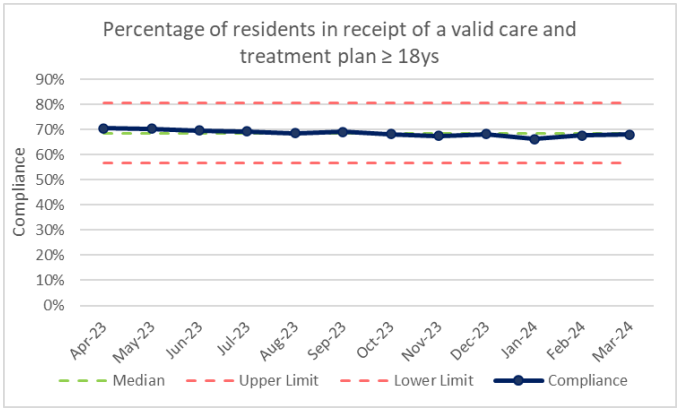
Adults living healthily and aging well.

Lifestyle factors such as diet and physical activity are closely associated with chronic health conditions such as cancer, diabetes, obesity and cardiovascular disease. The outcome 'Adults living healthily and aging

well' has seen a deterioration in the measure of the percentage of adults smoking. The rate has increased to 13.6% in 2022/23 compared to 11.8% in 2021/22 and is higher than the national average.

Over the next year the Health Board will be developing a cardiovascular disease risk assessment programme to tackle preventable cardiovascular disease focusing on behavioural risk factors including smoking which is the second highest risk factor following hypertension. This will be a holistic assessment and support model deployed across the neighbour care networks in Gwent.

Mental Health in Working Adults



Mental wellbeing and life satisfaction results in better subsequent health outcomes on some physical health indicators, health behaviours and psychosocial indications, including depressive symptoms. Mental wellbeing remains a key priority for the organisation and sustained performance levels have been observed in the 'improved mental health resilience in adults' outcome. As of March 2024, 68% of Health Board residents over 18 in receipt of secondary mental health services have a valid care and treatment plan.

There are concerns on the provision of assessment by mental health service within 28 days from referral which is currently at 17.6% (March 24) and interventions less than 28 days from assessment which is currently 7.3% both areas are being addressed in a 90-day action plan monitored by Executive Committee to ensure targeted improvement.

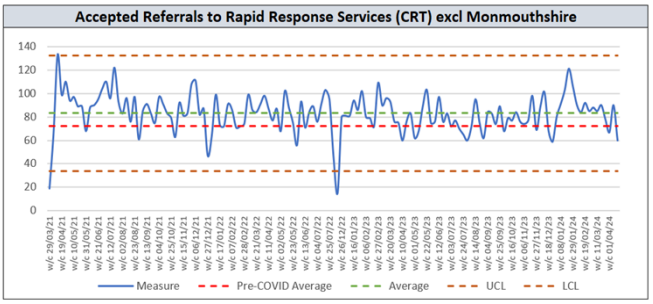
Priority 4

Older adults are supported to

Supporting older adults to live well and independently is a core component of the Health Boards' plan for a sustainable health and care system. We know we need to deliver improvement for this section of our population in our service offer. Within the Urgent and Emergency Care 6 Goals programme there is prioritisation in Goals 1 and 2 for redesigning services for older people.

Our Commitments	Our Measures	Indicator Value	Our Performance
Prevention and keeping older adults well	Increase in older people free from limiting long term illness	45.1%	Improvement in indicator from 43.3% (20/21) to 45.1% (22/23).
	Increase in life satisfaction among older people	85.5%	Increase in indicator over the last 3 financial years and remains above the all Wales average of 84.4%
	Increase in older people of healthy weight	41.2%	Increase in indicator from 38.7% (20/21) to 41.2% (22/23), surpassing the all Wales average of 39.6%.
Delivering care closer to home	Increase in accepted referrals to Rapid Response Services (CRT)	377	Improvement in indicator over the last 12 months (baseline 326)
	Increase in accepted referrals to Reablement & Falls Services (CRT)	76	Deterioration in referrals over the financial year (Mar 23, 214)
Reducing admissions and time spent in hospital	Reduction in the number of Emergency Admissions >65 years of age	1738	Significant increase in the number of emergency admissions from 1,427 (Mar 23) to 1,738 (Mar 24)
	Decrease (from 65 - 55%) in LOS over 21 days	55%	Statistically similar to last reported position (56% Mar 23)

Good progress has been made in the **'Prevention and keeping older adults well'** outcome with an improvement in all 3 indicator values. Firstly, there has been an increase observed in life satisfaction reported amongst older people from 84.2% (2021/22) to 85.5% (2022/23) and this remains above the all-Wales average of 84.4%. Additionally, there has been a significant increase in the percentage of older people of healthy weight. This has increased from 38.7% (20/21) to 41.2% (2022/23) and has also surpassed the all-Wales average of 39.6%. Finally, there has been an observed improvement in the percentage of older people free from limiting long term illness, increasing from 43.3% (20/22) to 45.1% (22/23).



The indicator values for '**Delivering Care Closer to Home'** outcome are mixed. As of March 2024, there were 377 accepted referrals to the Rapid Response Services and 76 to the Reablement & Falls Services. Goal 1 of the Urgent & Emergency Care Transformation programme has progressed the development of redesign of frailty services, including a Nurse-led Acute Frailty Response team at the Grange University Hospital (GUH) front door and the expansion and capacity build across Community Resource Teams to enable people to remain at (or close to) home, where this is safe and appropriate.

The outcome **'Reducing admissions and time spent in hospital'** has also seen mixed progress, with the number of emergency admissions for over 65 years of age increasing, throughout the year and particularly during Quarter 4 and is currently reported at 1,738 at the end of March 2024. The indicator 'decrease in the length of stay over 21 days' has remained statistically similar to the previous reported position of 55% in March 2024, which has resulted in the IMTP performance ambition of 55% being met.

Priority 5

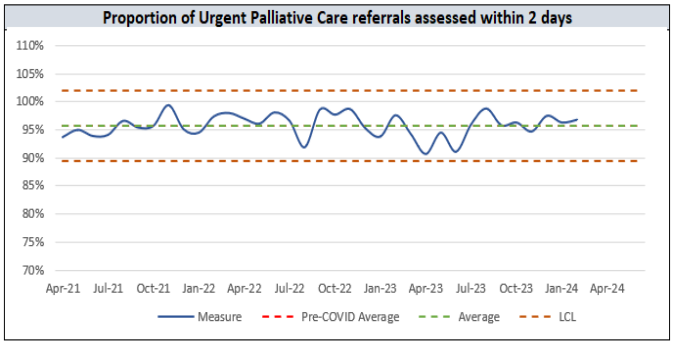
Dying well as part of life

The IMTP sets out the commitment to continuously improve how we meet the needs of people of all ages who are at the end of life. The measures represent indicators to support the organisation's understanding of how it is delivering in this area to support the population to die in their place of choice and have access to good care at the end of life.

Our Commitments	Our Measures	Indicator Value	Our Performance
Improved end of life care experience	Decrease in inpatient mortality rate	2.1%	Measure remains statistically similar (Mar 23, 2.1%)
	Reduction in End-of-Life Care complaints	21	Deterioration in indicator from 11 complaints received during 2021/22 to 21 during 2022/23.
Improved planning and provision of end of life care	Increase in referrals to Palliative Care Services	183	Indicator has increased by 17% between reporting periods (baseline, 171)
	Increase in proportion of Urgent Palliative Care referrals assessed within 2 days	97%	Despite significant increase in referrals, the proportion of Urgent Palliative Care referrals assessed within 2 days has been sustain and compliance with target remains (baseline, 99%)

For the outcome measure **'Improve care at the end of life'**, it is recognised that the relationship between mortality rates and the quality of patient care is a complex one. For this reason, the indicator 'decrease inpatient mortality rate' is used as a measure and trigger for further investigation, understanding that it may not indicate any deficiency in the quality of care. The rate in inpatient mortality has remained statistically similar and is reported at 2.1% at the end of March 24.

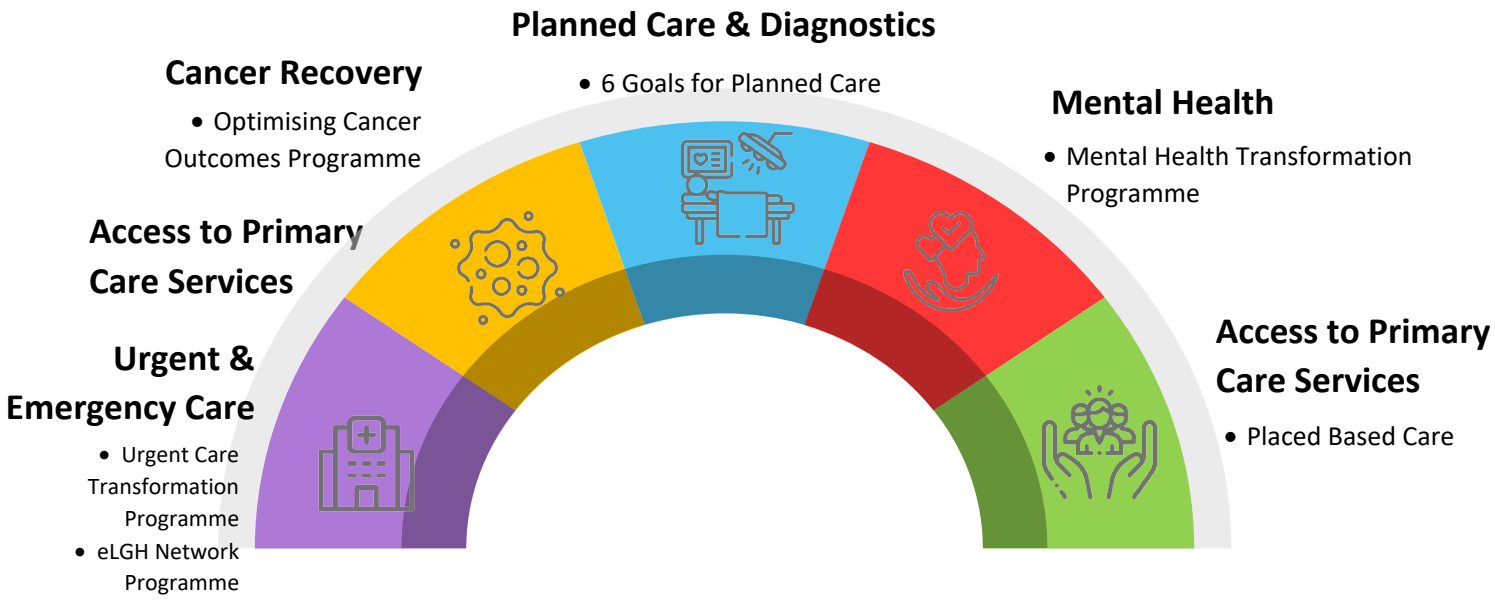
Good progress has been made within the outcome **'Improved planning and provision of end-of-life care'**, with the number of referrals to palliative care services increasing from 171 (Mar 2023) to 183 (Feb 2024). Despite this increase, the proportion of urgent palliative care referrals assessed within 2 days has been sustained



at 97% and the IMTP target remains met. Over the next year we will implement the National Bereavement Pathway for Wales, including the development of a single point of contact for death and offer surveys to bereaved people to obtain feedback on the quality of support received.

5. Integrated Medium Term Plan 2023/24 – Priority Programmes

This chapter of the report updates on delivery against the Clinical Futures programmes including those which deliver the key priorities set by the Minister for Health and Social Care. There is a high degree of synergy between the Ministerial Priorities for 2023/24 that are designed to support a swift recovery of business as usual and to reduce growing waiting lists and waiting times. All priorities are underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services



Urgent and Emergency Care

Prior to the pandemic, the pressures in Emergency Departments (ED) were becoming increasingly difficult, with demand soaring and the percentage of people being seen within the four-hour standard reaching an all-time low over the 2019/20 winter. Since the start of the pandemic, ED attendances decreased significantly which led to performance improvements. Since lockdown eased, demand has steadily risen, and a greater number of people with serious problems are presenting themselves in our urgent and emergency care system.

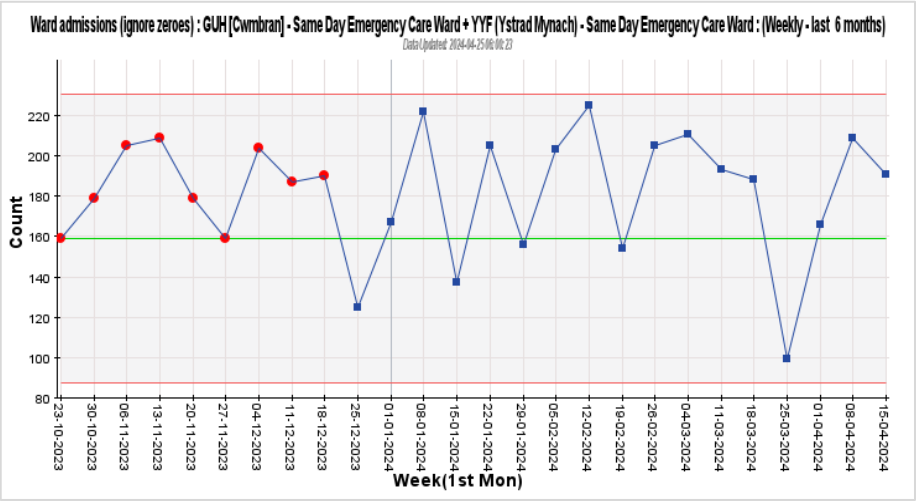
Some areas of progress include:

<u>Goal 1:</u>

- **Acute Frailty Response (AFR)** Team launched and substantive staff recruitment progressed.

- **Community Response Team (CRT)** Work in train to bring together GUH front door teams including service delivery and evaluation (AFR, CAATT, Home First, AMU SAS Dr).
- **Care Home** workstream established and Luscii technology pilot in care homes agreed (pending start date).

Goals 2, 3 and 4:



- **Same Day Emergency Care** patient volume sustained at an average of 138 weekly attendances at GUH and 49 at YYF.
- **Reducing Conveyance** Collaborative established with the Welsh Ambulance Trust (WAST) to develop joint solutions including strengthening falls response in community and a 111 first pathway.
- **Urgent Primary Care Demand:** Analysis completed to understand the increase in demand from Primary Care at start of 2024. Single phone number for Urgent Care launched February 2024.
- **Flow Centre** Transitioned to a Nurse led maker model releasing Medical resources where they are needed most into the Emergency Department.
- **Fracture Liaison Service** received development funding to recruit two specialist nurses with the aim of identifying patients at-risk of fragility fractures.

Goals 5 & 6:

- **Step Down Improvement** Optimising Hospital Flow Framework Refresher training being delivered as part of a development programme. Patient Safety Events across the hospital network including at GUH with a specific focus on patients planned for step down.
- **Hospital 2 Home** team now fully appointed, working with Monmouthshire and Newport Localities.
- **Discharge/Transfer Lounges** Royal Gwent Hospital (RGH) Discharge Lounge development to support an improved model of care. NHH Discharge Lounge now operating under new pull model. Modelling undertaken for options for the GUH Discharge Lounge.
- **Optimising Patient Flow** Discharge to Assess digital solution piloted across three wards, wider roll out now underway. Two Future Flow Design workshops delivered, and two areas of work identified – bed allocation and workforce model.

Enhanced Local General Hospitals:

- Relocation of two wards and repurpose of one ward at St Woolos Hospital (SWH) to RGH, at end of February 2024.

Cancer Recovery

Reducing prevalence of cancer and improving Cancer has remained an organisational priority. The Single Cancer Pathway, supported by Optimal Cancer Pathways for individual tumour sites, provides the roadmap to shorten diagnostic and treatment pathways once a person is suspected as having cancer. The Cancer Strategy, Delivering a Vision 2022-25, sets out the broader context with prevention, early detection, patient experience, living and dying with cancer, cancer research and access to novel therapies also key components to transforming cancer services for our population.

Some areas of progress over the last 12 months include:

- **YYF Breast Centre** in February 2024, the brand-new Breast Care Unit at Ysbyty Ystrad Fawr welcomed Gwent patients for the very first time,
- **Acute Oncology Service -** A Bevan Commission project between Velindre Cancer Centre treatment helpline, the Health Board Acute Oncology Service and SDEC teams has been completed and with a positive evaluation on patient experience,
- **Public Health Inequalities -** An Inequalities Action Plan has been developed following wider engagement to prioritise the actions required to reduce inequalities in cancer care provision and prevalence.
- **SACT Outreach Partnership** The launch of a programme of work with Velindre Cancer centre on expanding the provision of Systemic Anti-Cancer Therapy (SACT) outreach in Gwent and agreeing joint priorities with respect to improving the provision of care closer to home.
- **Enhanced Psychological Programme for those living with and beyond cancer/person** successfully recruited a Clinical Psychology Lead in March 2024.
- **Radiotherapy Satellite Centre** Positive progress of the new development via a joint project with Velindre Trust due to open in March 2025.

Planned Care & Diagnostics

During the pandemic services had to be paused to respond to the immediate demands and challenges of COVID-19 and capacity was reduced due to infection prevention and control requirements. As a result, the number of people waiting – and the time people are waiting – for planned care services are now longer than ever. This position is further exacerbated by those who did not access health care during the pandemic and in addition to the backlog of patients known to the services there is a potentially significant cohort of 'unreferred demand'.

Some areas of progress include:

- **Health Pathways** project which is targeted at improving management of demand through an improved communication between primary and secondary care via the "Health Pathways" website launched in April 2024 with the first 50 pathways. Phase 2 pathways allocated, to be reviewed against national and local priorities.
- **Outpatients** Further progress in the role out of See on Symptoms (SoS) and Patient Initiated Follow up (PIFU) pathways to address lengthy follow up waiting lists has been progressed. An Outpatient Treatment Unit has been established which supports the move of patients receiving treatment in theatre setting into an

ambulatory setting, Digital enablers to support outpatient provision continue to be developed including Automated Clinical Booking System, roll out of e-advice system and promoting the use of consultant connect .

- **Diagnostics** The development of the new endoscopy unit in RGH which has supported an increase in capacity and reduction in waiting times.
- **Theatres** Introduction of High Volume Low Complexity Lists (HVLC) in general surgery to improve productivity, development of timely benchmarking and operational data to support improvements in utilisation.
- **Planned Care Academy** to support, develop and promote the skills associated with good waiting list management for operational managers. Training modules developed and engagement with operational teams. 3 workstreams are progressing objectives.

The detrimental impact of COVID-19 on the mental health and wellbeing of our population has been significant. Demand is likely to exceed capacity threefold over the next three to five years. Demand for mental health and CAMHs services is sharply increasing, and we need to find ways of supporting people earlier to better support crisis prevention and recovery.

Some areas of progress include:

- A new housing scheme on the site of the former Brynmawr Clinic in Blaenau Gwent opened. **Acer House** provides homes and individual and specialist support for people to learn and develop their skills, experience, and confidence to thrive independently. It is a unique, collaborative service model by the housing and health sectors that puts residents at the core.
- **Implementation of 111 press 2** which provides support for urgent mental health care that is not life threatening.
- **Pathway Panel** established, providing MDT approach to reviewing all patients to ensure best possible outcomes for patients. This has resulted in significant savings and better life opportunities in the first few months of commencement.
- £1.2m of external funding targeted towards **Housing Projects**. MH&LD Division worked collaboratively with Housing Providers, including United Welsh, Melin, Newport City Homes and Bron Afon.
- Adults **ADHD Service** established
- CAMHs have surpassed 80% compliance for **CHOICE (New referrals) to assessment within 28 days** for Quarter 4 at 100% compliance. Monthly demand and capacity review undertaken to ensure that job plans have sufficient capacity to meet CHOICE demand. Continued implementation of workforce plans including efficient recruitment into vacancies.
- PCAMHS is continuing to flex capacity to meet the **Initial Assessment Part 1A 80% target** with March 2024 position of 78.12% despite significant vacancies and workforce deficits.
- **Under 18s Initial Assessment Part 1B recovery plan** continues to be implemented making reasonable progress.

The Primary Care Model for Wales set out how primary and community health services will work within the whole public sector system to deliver Place-Based Care. Collaborative work is at the core of this bringing together local health and care services to ensure care is better coordinated to provide care closest to home and promote the wellbeing of people and communities.

Some areas of progress include:

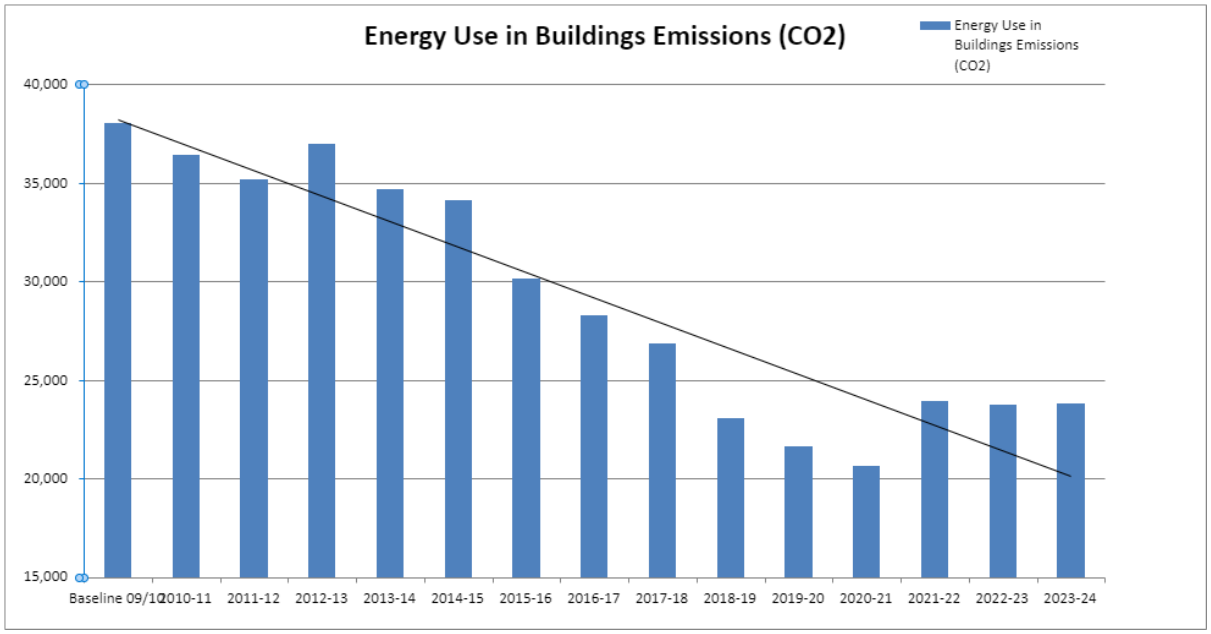
- **Professional Collaboratives** formalised governance arrangements for professional collaborative leads and agreed priorities for each professional collaborative for example; Pharmacy, Dentistry, Optometry and Therapists.
- **Access Standard** – 100% of GP practices have submitted data on a quarterly basis that allows us to measure the accessibility and quality of their services for example, opening hours, how to make contact and methods of communication.
- **Community Pharmacies** have demonstrated continued success achieving a 46% increase in common ailment consultations over this year.
- Continuing to progress the units and levels of patients accessing NHS and **Community Dental Services-** over this year 325,904 patients have received dental care of which 24,182 were new Patients. Development of new dental contract as part of Bevan Health and Well Being Centre in Tredegar opened in April 2024.
- Development of a **Palliative Care** Medical Champions Programme
- **Pharmacy** career pathways defined and scheduling of phase 1 undergraduate MPharm student placement scheme
- **Urgent Primary Care** contacts increased by 22% from 2022-23 to 2023-24
- All Managed **GP practices** transferred to independent providers from 1st April 2024
- Wellbeing collaboratives continues to be developed alongside Neighbourhood Care Networks (**NCN**s).

Sustainability and Carbon Reduction Plans

The Health Board continues to align its activities to complement and make progress towards the objectives and targets set out in the NHS Wales Decarbonisation Strategic Delivery Plan, published by Welsh Government in 2021. The Plan responds to the declaration of the climate emergency in 2019 and the ambition of Welsh Ministers for the Welsh public sector to be net zero by 2030.

During 2022/23 the Health Board established its Decarbonisation Programme Board, chaired by the Executive Director for Finance and Procurement. Four working groups are now well established, each working group having a suite of the national initiatives assigned to them to take forward and develop associated projects. In 2023/24, several workshops were held with the working groups to inform the development of the future 24/25 decarbonisation work plan.

Since 2010, the Health Board has made consistent reductions in carbon emissions from its building's portfolio. Up to this year (2023/24) the emissions from energy use in buildings has been cut by 37%, equating to a total saving of 14,241 tonnes of carbon.



Since 2020, and the early opening of the Grange University Hospital in response to the COVID-19 pandemic and with the opening of a new Hazardous Substances Decontamination Unit in Llanfrechfa as well as the new Bevan Health & Well Being Centre in Tredegar and the Unified Breast Unit located at Ysbyty Ystrad Fawr; mean that energy use and carbon emissions from buildings have increased as the size of the estate and clinical activity increases across the Health Board and premises occupancy returns to pre-pandemic levels. By making efficiencies in the operation of the building services (lighting, ventilation, heating, and hot water) throughout the year we have mitigated the emissions increase to 0.3% this year.

During 2023/24 the Estates and Facilities Division made considerable progress with its energy performance contract development. Through competitive tender the ReFit Cymru Programme contract was awarded to Vital Energi Ltd. This long-term partnership has the potential to deliver significant investment in low-carbon and renewable energy projects across the main hospital and community premises in the coming years and through several phases of work. The ReFit Programme will contribute significant carbon savings towards the decarbonisation ambitions of the Health Board.

The Facilities Division during 2023/24 were able to transition 13 traditional diesel fleet vehicles over to electric van equivalents. These were rolled out to hospital sites during the latter part of the financial year.

During 23/24 the Health Board was able to complete Initiative 9 of the NHS Wales Decarbonisation Strategic Delivery Plan – to appoint a full time Building Management Systems Officer. Throughout the year we have been working hard to optimise hospital building services. Aspects such as heating, lighting and ventilation systems have been appraised and technical changes made to ensure that systems are running as efficiently

as possible and operating only at times of occupancy. Current savings have been made in electricity and gas through these technical changes, delivering an annual carbon saving of 118 tonnes.

The Health Board continues to work towards introducing more sustainable and resource efficient methods of processing waste generated from health care activities. The Health Board is working towards a zero-waste to landfill approach (currently at approximately 3% landfill waste), in collaboration with external contractors. The vast majority of non-recyclable general waste now goes to energy-from-waste plants to generate sustainable electricity.

In April 2024 new legislation came into effect in Wales meaning that non-domestic premises have to segregate recycling into separate waste streams for collection. This law implements a number of actions to increase the quality and quantity of recycling which are included in the Welsh Government's Circular Economy Strategy for Wales. The main aim of the legislation is to address the levels of recycling rates in non-domestic properties thereby; turning waste into a resource, improving the quality of recyclable materials recovered and realising associated carbon reductions.
There is an extension for healthcare premises with in-patients until April 2026 for Health Boards to adequately prepare, but all non-inpatient sites are already included.

We will realise the carbon benefits of this initiative going forward, to be included in next year's report.

Another key element of the legislation is the segregation and separate collection of food waste. The Health Board is now compliant at all sites with patient dining and/or a catering retail function. This waste, which previously was disposed of to foul sewer or as general waste is now processed in an anaerobic digestion plant creating energy as a by-product.

The Health Board continues to operate a third party certified Environmental Management System (EMS) to the international standard ISO 14001:2015. The EMS has been developed to become the focal point for driving forward continual environmental and sustainability improvements. It provides a joined-up approach for the management of waste minimisation initiatives, recycling, energy and carbon management, sustainable procurement, and sustainable travel initiatives. The Health Board places high importance on continued certification to ISO14001:2015 and the assurance it provides to the Board and our stakeholders.

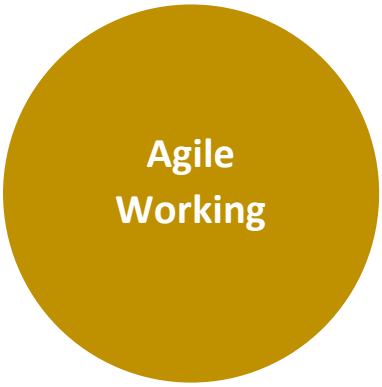
The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the estate. To this end, several local initiatives are in place including wildflower planting in conjunction with external art installations at the Grange University Hospital, the continued success and development of the Walled Garden at Llanfrechfa Grange by the charitable organisation 'Friends of Llanfrechfa Grange Walled Garden.' There was also a successful funding bid for a community orchard at Trethomas Health Centre which is now complete.

Biodiversity Enhancement Reports have been completed at St Cadocs Hospital, Serennu Children's Centre, Nevill Hall Hospital, Ysbyty Ystrad Fawr and Maindiff Court Hospital after securing funding from the Health & Social Care Climate Emergency National Programme in 2022/23. These enhancement reports will be used to inform any future biodiversity work the health board can deliver, where appropriate funding opportunities permit.

The Health Board proactively planned to remove the majority of Nitrous Oxide use from it sites, manifolds have been decommissioned in all eLGH sites and an audit is underway to understand the N2O usage in the Grange University Hospital and whether the manifold can also be decommissioned and replaced with portable cylinders.
Early indicators from a BOC Ltd report a significant reduction in the health board's use of nitrous oxide. Data will be provided in next year's report.

There is work underway on reducing the waste of non-sterile gloves. The use of these gloves more than doubled during the pandemic and there is a need to return the usage to pre-pandemic figures. Current CO2 emissions for gloves are 571, 235, 600 grammes.

The UK Climate Change Act 2008 provides a legal framework to cut UK greenhouse gas emissions and build the UK's ability to adapt to a changing climate. Responsibility for climate change adaptation is devolved, meaning national governments in Northern Ireland, Wales and Scotland are responsible for developing their own respective adaptation programmes and plans.



We understand the importance of agile and flexible working to staff wellbeing through giving greater autonomy of work and improving work life balance. During 2023/24 we strengthened our Agile Working Strategy and Vision and will continue to build on areas of good practice. The vision set out a number of principles to give a clearer steer and direction to people, a workplan of SMART objectives aligned to the Estate Strategy and Digital Strategy and a dashboard with measurable benefits of Agile/Hybrid working. Through our resetting our agile vision we have reviewed our guidance and toolkits which incorporated staff welfare facilities to ensure they meet minimum standards. We have engaged with our services across most of our estates, undertaken agile assessments and explored agile working options in line with our Estate Strategy and Decarbonisation Strategy and we will continue this programme of work through 2024/5.

6. Integrated Medium Term Plan 2023/24 – Quality and Safety

In April 2023, the Health Board published and implemented two Strategies. Both the Quality Strategy and Patient Experience & Involvement Strategy have been developed from the experiences of our patients, relatives, carers, staff and communities to focus on improvement, planning and assurance in the right areas. This is aligned with the objectives and aims of the Duty of Quality and in the context of meeting our obligations under the Duty of Candour.

As part of our ongoing commitment to quality and safety we have successfully implemented a Quality Outcomes Framework (QOF), which was approved by the Patient, Quality, and Safety Operating Committee (PQSOC) in Quarter Two. It was acknowledged this would become an iterative framework that was under constant development throughout year one. The reporting of the QOF recognises the development of some of the measures as new ways of reporting and capturing what is important for patients and the population and for the Board are brought in line. This process will continue to be refined by working with planning and the digital, data and technology team.

The Health and Care Quality Standards provide a clear framework to help plan, deliver and monitor healthcare services in Aneurin Bevan University Health Board. The Quality Outcomes Framework (QOF) is mapped to ensure the organisation develops and delivers our services around the six domains of quality and the six quality enablers. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Boards priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

Our quality strategy signals our intention to progress six pillars of quality to establish our level of performance. These are: patient staff and experience; incident reporting; complaints, concerns and compliments; health, safety and security; infection prevention and control and safeguarding. The pillars will be our Quality Markers in our quality management system. Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services. These 'pillars of quality' run through the organisation, ensuring that it delivers the highest standards of care under these domains. Providing data in these Pillars of Quality will enable the organisation to review our performance.

The patient experience and involvement strategy makes a commitment to delivering person-centred care that puts the need of the patient at its heart, to deliver a positive patient experience. The launch of the system to capture patient's experience across the Health Board (CIVICA), has provided the opportunity to received direct patient feedback. Through this Strategy, the Health Board are committed to:

- Respecting people's **values**, preferences and expressed need
- Improving **information** and education
- Improving **access** to care
- Improved provision of **emotional** support to relieve fear and anxiety
- **Involving** family, friends and people who matter to the individual

- Providing **continuity** and secure transition between healthcare settings
- Providing **physical comfort**
- Delivering **co-ordinated** care

As one of the quality pillars there has been a focus on complaints and concerns. The main themes relate to: Clinical treatment/assessment; Appointments and Communication issues across 2023/24. The effects of the Covid-19 pandemic continue to be evident in relation to concerns raised regarding clinical treatment and assessment; delays in receiving an appointment along with commencement of treatment plans. People continue to express concern about wait times, with waiting list times emerging as a recurring theme across the reporting period. However, the ongoing work of the Six Goals for Urgent and Emergency Care, Planned Care and Mental Health, seeks to improve clinical outcomes and patient experience.

Communication issues continue to be a recurring theme, however positive changes to the management of concerns from the point of receipt and throughout have been implemented, with the recent development of a central acknowledgement team. This affords people the opportunity to engage with the Health Board early on and ensure a person-centred approach to resolution of their concerns. Meaningful updates throughout the course of investigations to people and families is the focus of all concerns teams. Both approaches have been recognised by the Public Services Ombudsman for Wales, and Llais as positive steps.

Focusing on the reporting of patient safety incidents has enabled the Health Board to provide data on the number of serious incidents, national reportable incidents and the number of never events. Following a series of never events that occurred in theatre a quality improvement project was initiated. This included working collaboratively with

staff to look at human factors, psychological safety and wellbeing. Reviewing the implementation of the National Safety Standards for invasive procedures has allowed a number of change ideas (e.g back to basics and 'pause for gauze') to be developed and improve practice. For quarter four report, never events had reduced to zero.

As of 31st March 2024, the Patient Safety Incident team were managing 75 live Serious Incident investigations (moderate/ severe). A review of the Patient Safety Incident process and development of an updated policy, has provided many opportunities for improvement and learning. The team have developed a new Patient Safety Incident Report template with guidance notes, drawing on best practice, human factors methodology/ tools and from feedback received from staff, patients, families and HM coroner. Serious incidents are now presented weekly to the Clinical Executive team to formalise the decision regarding investigation and there has been Divisional engagement undertaken.

One priority this year was to focus on reduction and prevention of Health Acquired Pressure Ulcers (HAPU's) within the Health Board to meet the Welsh Government standard of 0% avoidable. A Pressure Ulcer Faculty was developed with aims to reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty and to eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty. Work has included the development of a teaching package by the tissue viability nurses, an app to support timely wound review and treatment and additional PDSA cycles. The Faculty has progressed this workplan, which demonstrated a reduced number of HAPU incidences of 5% over the last quarter.

There has been ongoing collaboration between NHS Wales Boards and Trusts, Improvement Cymru and the Institute for Healthcare Improvement, over the past 18 months under a Safer Care Partnership. The partnership aimed to provide nationally coordinated, locally deliver support for safe, reliable and effective care. This has enabled a refresh of the Health Board's quality improvement projects and strengthened improvement capability as a number of quality improvement projects were implemented. There has been national collaboration on the deteriorating patient throughout our organisation, which has been progressed via this national programme. This focused work will continue and involve developing a Sepsis Strategy for the Health Board, including implementing the updated NICE guidance and improving sepsis recognition and early assessment from primary care to acute services.

The Health Board is facilitating the development of a culture of shared learning and a joint approach to quality, patient safety and experience. A framework has been developed and approved which demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services. This framework will compliment and build on divisional and directorate assurance arrangements by adding a strategic approach to support the Health Board to learn lessons from a range of internal and external sources. This will form part of our learning repository, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

In summary, over the last year the Health Board delivered:

- ✓ Established a reporting framework and quality outcomes framework aligned with the six domains of quality
- ✓ Implemented Speaking Up Safely framework with action plan
- ✓ Launched an email address for staff to raise concerns in confidence
- ✓ Health Board Safety flow initiative in place with its primary aim to improve ambulance handover performance
- ✓ A new Falls Pathway introduced to reduce the number of non-injurious fallers conveyed by ambulance
- ✓ Review of the Serious Incident Policy
- ✓ Introduction and growth of Patient Advice and Liaison Service
- ✓ Increase in early resolution of complaints
- ✓ CIVICA overall satisfaction score is 88% (above the benchmark of 85%)
- ✓ RAMI score has decreased
- ✓ The number of hospital acquired pressure ulcers has decreased
- ✓ Improved provision of Safeguarding training
- ✓ Improved cancer programme outcomes through adoption of Quality Improvement methodology.

The full QOF report for Quarter Four is available on the following link.

7. Well-Being of Future Generations

The Wellbeing of Future Generations (Wales) Act (2015) ('the Act') has the central aim of improving the social, economic, environmental and cultural wellbeing of Wales, whilst also reducing health inequalities through long term prevention and the delivery of sustainable, outcome focused services. The Act has seven wellbeing goals and five ways of working which help organisations understand how they can work more sustainably together to meet the duties of the Act.

The seven wellbeing goals

The five ways of working

Source: Future Generations Commissioner for Wales

During 2023/24, Aneurin Bevan University Health Board has worked closely with partners in Gwent Public Services Board to turn the findings of the Gwent well-being assessment into a well-being plan which will improve the social, economic, environmental and cultural wellbeing of citizens in Gwent. Using the five ways of working, Public Services Board partners have worked together to develop a plan which will deliver ambitious and transformational change that cannot be achieved by individual organisations alone. The plan will cover the five-year period 2023-28, and is based on two strategic objectives and five steps. These are:

Gwent Well-being Plan strategic objectives:

1. We want to create a fairer, more equitable and inclusive Gwent for all.
2. We want a climate-ready Gwent, where our environment is valued and protected, benefitting our well-being now and for future generations.

Gwent Well-being Plan steps:

1. Take action to reduce the cost-of-living crisis in the longer term.
2. Provide and enable the supply of good quality, affordable, appropriate homes.
3. Taking action to reduce our carbon emissions, help Gwent adapt to climate change, and protect and restore our natural environment.
4. Take action to address inequities, particularly in relation to health, through the framework of the Marmot Principles.
5. Enable and support people, neighbourhoods, and communities to be resilient, connected, thriving and safe.

Alongside the Gwent well-being plan, Aneurin Bevan University Health Board has led Gwent-wide partnership action to address inequity and the wider determinants of health as part of 'Building a Fairer Gwent'. Based on the eight Marmot principles, this work has resulted in a comprehensive set of recommendations for Gwent over the next five years which are currently being taken forward as part of implementation of the Gwent well-being plan. Further information about 'Building a Fairer Gwent', including a copy of the final report can be found at:
https://www.gwentpsb.org/en/gwent-marmot-region/

The Marmot principles

1. Give every child the best start in life. 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives. 3. Create fair employment and good work for all. 4. Ensure healthy standard of living for all.	5. Create and develop healthy and sustainable places and communities. 6. Strengthen the role and impact of ill health prevention. 7. Tackle discrimination, racism and their outcomes. 8. Pursue environmental sustainability and health equity together.

Source: Institute of Health Equity

Aneurin Bevan University Health Board Wellbeing Objectives

During 2023/24 Aneurin Bevan University Health Board has continued to maintain a life course approach to its wellbeing objectives as it continues to endeavour to reduce health inequalities and improve population health. Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, the life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing of both current and future generations. Adopting the life course approach means identifying opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages, from the perinatal period through early childhood to adolescence, working age, pre-conception and the family-building years, and into older age. It also capitalises on the potential to deliver an intergenerational approach to health improvement and reduce health inequalities from generation to generation and improve conditions of daily life. Our health services are there to provide universal coverage to everyone throughout the life course, whilst also recognising that we need to provide more support to those in greatest need.

This approach requires holistic, long-term, policy and investment strategies and engagement that promote better health outcomes for individuals and greater health equity in the population. Aneurin Bevan University Health Board is confident this approach can achieve high returns for health and sustainable development, both by limiting ill health and the accumulation of risk throughout life and by contributing to social and economic development.

The five ways of working set out in the Act have continued to be demonstrated by Aneurin Bevan University Health Board in 2023/24. Through the regional partnership arrangements of the Regional Partnership Board and Public Services Board, **integration** has been demonstrated through joint approaches to wellbeing, health and social care delivery. Aneurin Bevan University Health Board's communications team have undertaken a number of public **involvement** and engagement activities during 2023/24. Through work on the Well-being Plan and Area Plan, Aneurin Bevan University Health Board has worked in partnership to establish a **long-term** vision for wellbeing in Gwent. Through 'Building a Fairer Gwent', Aneurin Bevan University Health Board has worked in partnership to deliver an approach to **prevention** embedded in the social determinants of health. Finally, the work of both Gwent Regional Partnership Board and Gwent Public Services Board demonstrate how Aneurin Bevan University Health Board is working in **collaboration** to achieve gains for the population of Gwent that cannot be delivered by individual organisations alone.

For further information, please visit:
Gwent Regional Partnership Board https://gwentrpb.wales/
Gwent Public Services Board http://www.gwentpsb.org/en/

9. Equality, Diversity and Inclusion

The Health Board has developed and published an Annual Equality Report 2023/24, in line with the Public Sector Equality Duty 2011, which summarises how the Board has

performed in meeting its legal duties as set out in the Equality Act (2010) and the Human Rights Act (1998). The report details the work the organisation has undertaken to further advance equality.

During the reporting period of 2023/24 the following improvements were made:

- A snapshot of our Equality data sets as of 31 March 2023, has shown that there is some improvement in our equality statistics (e.g., non-disclosure of sexual orientation via ESR is down by 3% since 2022; non-disclosure of disability via ESR is down by 4% since 2022; and our median gender pay gap has reduced to 16.20% from 18.72% in 2022).
- We have developed a framework around our Staff Diversity Network to ensure a mechanism for their voice. This has included the introduction of Executive Sponsors, nominations of Network Chairs, development of Terms of Reference, and approved protected time for Network members. This work will continue into 2024/25 to ensure that our Networks grow in maturity and to contribute positively and proactively to the EDI agenda.
- Development of an organisational level Anti-Racism Action Plan to meet our obligations under Welsh Government's Anti-Racist Wales Action Plan.
- The pre-consultation engagement and public consultation on our reviewed Strategic Equality Plan (SEP) for 2024-2028 has resulted in increased engagement and trust with both staff, community members and stakeholders, upon which we intend to build in the coming four years to ensure co-production and co-design are at the heart of everything that we do.
- Following the successful pilot of the SignLive service, which provides communication support for Deaf patients, their families and those that use British Sign Language, this service will be available across the Health Board.

The report highlights the Health Board's continued committed to proactively meeting the diverse needs of the communities who use our services and those we employ.

Equality, Diversity and Inclusion (EDI) and Human Rights are a golden thread of all activities and remain a key executive and board priority of the Health Board. We recognise the ongoing nature of this work and will continue to monitor and measure our outcomes.

10. Welsh Language Regulations

The Health Board works collaboratively with Welsh Government, the Welsh Language Commissioners office and our partners across NHS Wales and continues to make good progress in our work in relation to Welsh language service delivery. As we strive to deliver the best care to all those we service we recognise that the ability to communicate with our Welsh speaking service users in Welsh is key to this.

The Health Boards Welsh Language Annual Report 2022/23 addresses the statutory duty of Aneurin Bevan University Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011. The report has been prepared in accordance with Welsh Language Standard 120. The report shows our progress and

work in this field. It notes key achievements as well as our strategy and plans for the future.

The Annual Report for 2022/23 is available on-line in both Welsh and English
https://abuhb.nhs.wales/files/key-documents/other-reports/welsh-language-report-2022-2023-pdf/ English

https://bipab.gig.cymru/ffeiliau/key-documents/adroddiad-blynyddol-fersiwn-cymraeg-2022-23-pdf/ Welsh

The report for 2023-2024 will be published in September 2024.

11. Financial Management and Performance

The Annual Accounts 2023/24, at Section 3 of the Annual Report and Accounts 2023/24, Page XX, sets out the detailed accounts for the full year to 31 March 2024 for Aneurin Bevan University Health Board. These accounts are prepared under International Financial Reporting Standards (IFRS).

The Health Board has two statutory financial duties:

- To breakeven over a rolling three-year period; and
- To submit an Integrated Medium-Term Plan (IMTP) to secure compliance with breakeven over three years.

Revenue Resource Performance

Aneurin Bevan University Health Board has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24 period, the Board reported an overspend of £49,766K as shown below:

3 Year Revenue Breakeven Duty	2021/22 £000	2022/23 £000	2023/24 £000	Total £000
Underspend Against Allocation	249	- 36,842	- 49,766	- 86,359

Capital Resource Performance

In addition to a revenue resource limit the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The target of £56.742M was met in 2023/24 with a small underspend of £41K. The target is measured over a 3 year period as shown below:

3 Year Capital Resource Duty	2021/22 £000	2022/23 £000	2023/24 £000	Total £000
Underspend Against Allocation	50	43	41	134

Long Term Expenditure Trend

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services	2019-20	2020-21	2021-22	2022-23	2023-24
General Medical Services	103,343	108,993	112,524	116,217	122,671
Pharmaceutical Services	22,900	27,109	25,082	25,273	25,756
General Dental Services	36,608	33,079	38,030	39,817	39,870
General Ophthalmic Services	8,911	8,734	9,343	8,866	10,659
Other Primary Health Care expenditure	2,872	2,289	2,487	2,612	4,373
Prescribed drugs and appliances	102,280	106,852	106,282	114,331	121,947
Total	276,914	287,056	293,748	307,116	325,276

	£'000	£'000	£'000	£'000	£'000
3.2 Expenditure on healthcare from other providers	2019-20	2020-21	2021-22	2022-23	2023-24
Goods and Services from Other NHSbodies	103,179	103,278	117,637	117,587	129,254
Goods and services from WHSSC / EASC	144,458	161,384	177,035	198,320	208,640
Continuing Care	71,005	81,347	83,675	86,006	99,136
Other	61,107	71,795	85,054	72,240	71,368
Total	379,749	417,804	463,401	474,153	508,398

3.3 Expenditure on Hospital and Community Health Services

	£'000	£'000	£'000	£'000	£'000
	2019-20	2020-21	2021-22	2022-23	2023-24
Staff Costs	579,760	671,972	714,255	762,081	788,715
Non Pay	152,277	172,611	191,827	200,118	238,743
Depreciation and Impairments	23,197	96,361	31,056	30,804	59,994
Losses, special payments and irrecoverable debts	3,154	1,886	2,831	1,526	3,217
Other operating expenses	7,990	8,526	11,009	9,538	14,599
Total	766,378	951,356	950,978	1,004,067	1,105,268

Long Term Revenue Performance Trend

2.1 Revenue Resource Performance

	Annual financial performance		3-year rolling programme			
	2019-20	2020-21	2021-22	2022-23	2023/24	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Net operating costs for the year	1,319,803	1,551,819	1,598,803	1,676,282	1,818,468	5,093,553
Less general ophthalmic services expenditure and other non-cash limited expenditure	(161)	(1,423)	(58)	148	599	689
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	0	0	0	0
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	0	0	29	29
Total operating expenses	1,319,642	1,550,396	1,598,745	1,676,430	1,819,096	5,094,271
Revenue Resource Allocation	1,319,674	1,550,641	1,598,994	1,639,588	1,769,330	5,007,912
Under /(over) spend against Allocation	32	245	249	(36,842)	(49,766)	(86,359)

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24.
The Health Board will, in dialogue with Welsh Government, confirm the implications for reporting this deficit as part of the 2024/25 IMTP.
The health board received £49.9m of strategic cash support in 2023/24.

2.2 Capital Resource Performance

	2019-20	2020-21	2021-22	2022-23	2023/24	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Gross capital expenditure	133,286	112,376	52,167	41,011	62,681	155,859
Add: Losses on disposal of donated assets	7	0	0	2	1	3
Less NBV of property, plant and equipment and intangible assets disposed	(555)	(884)	(3,115)	(61)	(5,845)	(9,021)
Less capital grants received	(93)	(333)	(22)	(62)	0	(84)
Less donations received	(300)	(201)	(166)	(210)	(136)	(512)
Charge against Capital Resource Allocation	132,345	110,958	48,864	40,680	56,701	146,245
Capital Resource Allocation	132,373	110,971	48,914	40,723	56,742	146,379
(Over) / Underspend against Capital Resource Allocation	28	13	50	43	41	134

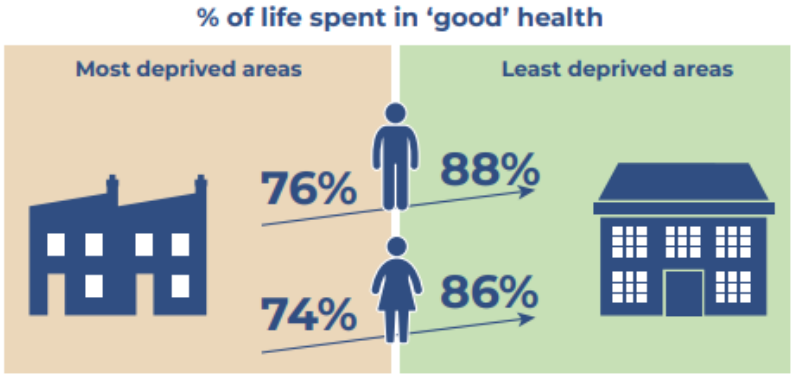
Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2021-22 to 2023-24.

The Health Board's financial statements have been prepared in accordance with the 2023/24 NHS Wales Manual for Accounts. The accounting policies contained in that manual follow the 2022-23 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

The Manual for Accounts makes clear that accounts should be prepared on a going concern basis where there is the anticipated continuation of service in the future. The assumption has been made that the services of Aneurin Bevan University Health Board will continue in operation. Consequently the going concern basis has been adopted.

12. Conclusion and Forward Look

The mission for the Health Board is to improve population health, and through doing this, reduce the health inequalities experienced by our communities. The current gap, 13 years (men) and 20 years (women), in healthy life expectancy between our wealthiest and poorest communities is significant. Our plan for 2023/24 and going forward articulates the steps we are taking to deliver a Healthier Wales and The Well-being of Future Generations (Wales) Act 2015.



Since November we have been working on the development of a new long-term strategy that articulates joint commitments with our population through to 2035. This will help shape our model of sustainability going forward. We are not waiting for our strategy to take action where we have evidence of quality concerns, workforce challenges and aging estate. Our plan for 2024/25 sets out the significant service redesign we will undertake to rightsize our service capacity aligned with patient need.

We are committed to continue our improvement on how the system is performing, whilst many people receive great care, we know there is more to do to improve our system. 23,232 people were waiting over the target time of 52 weeks for planned appointments and treatments at the start of 2024, behind each of these numbers is an individual story. Whilst improvements have been made in our emergency care system, waiting times for ambulances are too long and subsequently, we are not meeting the 4 hours target for the majority of patients to be seen, triaged, treated, and discharged in urgent and emergency care - we only meet this 75% of the time. People are also spending too long in our hospitals. There are regularly around 200 people who have completed the medical element of their care waiting to be discharged for a range of reasons related to wider support or care, many of whom are waiting over 3 weeks. We also frequently hear stories of the challenge of getting an appointment with a GP and support in the community and whilst there is much being done to improve this situation, we know there is still much more to do.

It is the ambition for improvement that drives the organisation forward in making improvements for the population

Part 2: Accountability Report

1st April 2023 – 31st March 2024

INTRODUCTION TO THE ACCOUNTABILITY REPORT

Aneurin Bevan University Health Board is required to publish, as part of our annual reporting, an Accountability Report. The purpose of the Accountability Report section of the Annual Report has been designed to demonstrate the ways in which the Health Board is meeting its key accountability and reporting requirements.

This Accountability Report has three sections:

1. Corporate Governance Report

This explains the composition of the Health Board, its governance structures and arrangements and how the Health Board seeks to achieve its objectives and responsibilities to meet the needs of the people we serve. The Corporate Governance Report includes:

A. The Directors' Report
B. The Statement of the Chief Executive as the Accountable Officer and the Statement of Directors' Responsibilities in respect of the Accounts
C. The Annual Governance Statement.

2. Remuneration and Staff Report

This section contains information about the staff of the organisation, particularly focusing on the remuneration of its Board and senior management, fair pay ratios and other staff information, such as sickness absence rates.

3. Senedd Cymru/Welsh Parliament Accountability and Audit Report

This section contains a range of disclosures on the regularity of expenditure, fees, charges, compliance with cost allocation, material remote contingent liabilities, long-term expenditure trends and charging requirements set out in HM Treasury guidance.

A: THE DIRECTORS' REPORT

Aneurin Bevan University Local Health Board is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under *The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778), "the Establishment Order".*

The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations") set out the constitution and membership arrangements of Local Health Boards, the appointment and eligibility requirements of members, the term of office of non-officer members and associate members. In line with these Regulations the Board of Aneurin Bevan University Health Board comprises:

- a chair;
- a vice-chair;
- officer members; and
- non-officer members.

The members of the Board are collectively known as "the Board" or "Board members"; the officer and non-officer members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All members have full voting rights.

In addition, Welsh Ministers may appoint up to three associate members. Associate members have no voting rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations")*, and continue to fulfil the relevant requirements throughout the time that they hold office. The Regulations can be accessed via the Government's legislation website:
http://www.legislation.gov.uk/wsi/2009/779/contents/made

Further detail on the Board's membership and composition during 2023/24 is available within Section C: The Annual Governance Statement.

Board Members' Interests

Details of company directorships and other significant interests held by members of the Board which may conflict with their responsibilities are maintained and updated on a regular basis.

The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Aneurin Bevan University Health Board, and staff across the organisation, in line with the Standards of Business Conduct Policy, as at the 31st March 2024. This information is available on the Health Board's Internet site and can be accessed by following this link.

Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's Office and "serious untoward incidents"

involving data loss or confidentiality breaches are detailed on page xx of the Annual Governance Statement at Section C.

Environmental, Social and Community Issues

The Board is aware of the potential impact that the operation of the Health Board has on the environment and it is committed to wherever possible:

- Ensuring compliance with all relevant legislation and Welsh Government Directives;
- Working in a manner that protects the environment for future generations by ensuring that long term and short-term environmental issues are considered; and
- Preventing pollution and reducing potential environmental impact.

The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the Health Board's estate.

The Board's Annual Report for 2023/24 and Integrated Medium Term-Plan (IMTP) 2022-25 (approved by the Board March 2023) sets out the Board's strategic priorities which have been set within the context (environmental, social and community issues) in which the Health Board is operating within.

The Performance Report (Part A) of the Annual Report and Accounts 2023/24 provides greater detail in relation to the achievements of the Health Board in delivering the IMTP during 2023/24.

Statement for Public Sector Information Holders

In-line with the disclosure requirements set out by the Welsh Government and HM Treasury, the Health Board confirms that it has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the 2023/24 year.

B(1): STATEMENT OF THE CHIEF EXECUTIVE AS THE ACCOUNTABLE OFFICER OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer for Aneurin Bevan University Local Health Board. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for

which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.

As Accountable Officer, I confirm that, as far as I am aware, there is no relevant audit information of which the Health Board's Auditors are unaware, and I have taken all the steps that ought to have been taken to make myself aware of any relevant audit information and that the Health Board's auditors are aware of that information.

As Accountable Officer, I confirm that the Annual Report and Accounts 2023/24 as a whole is fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining it as fair, balanced and understandable.

As Accountable Officer, I am responsible for authorising the issue of the financial statements on the date they are certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.

_____

Name: Nicola Prygodzicz, Chief Executive **Date:**

SECTION B(2): STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2023/24

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Aneurin Bevan University Health Board and of the income and expenditure of the Health Board for that period.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board

Signed:

Ann Lloyd, Chair
Dated:

Nicola Prygodzicz, Chief Executive
Dated:

Robert Holcombe, Director of Finance and Procurement
Dated:

C: ANNUAL GOVERNANCE STATEMENT 2023/24

SCOPE OF RESPONSIBILITY

The Board is accountable for Governance, Risk Management and Internal Control. As Chief Executive of the Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated and assurance has been sought and provided. Where necessary additional information is provided in the Governance Statement, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

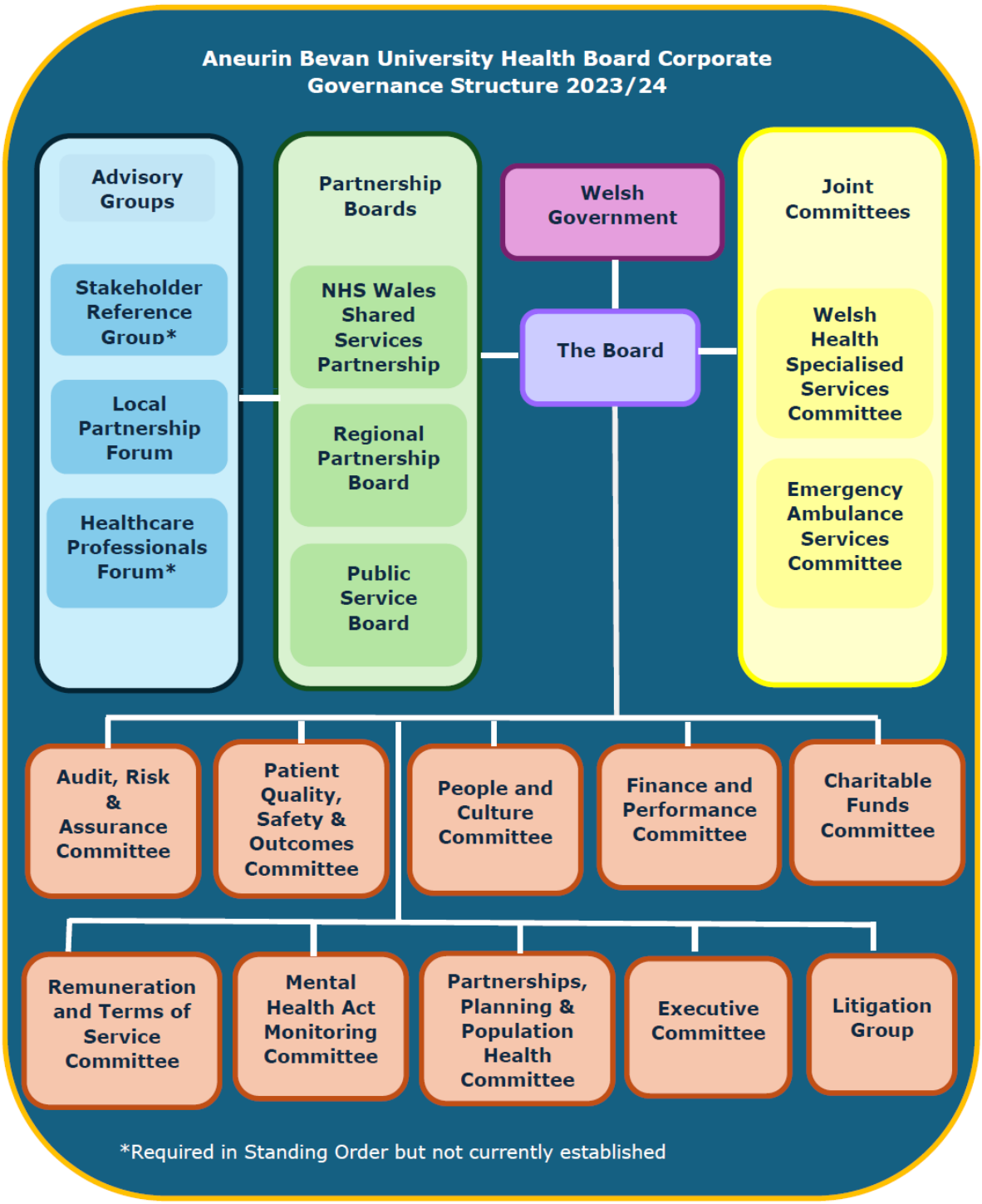
Welsh Government's Escalation and Intervention Arrangements for NHS Wales sets out the collective arrangements in place between the Welsh Government and external review bodies for identifying and responding to serious issues affecting NHS service delivery, quality and safety of care, and organisational effectiveness. As at 31st March 2024, Aneurin Bevan University Health Board was in 'Targeted Intervention' for planning and finance and 'Enhanced Monitoring' for performance and outcomes related to urgent and emergency care pathways as a result of extended waits for patients in ambulances and emergency department clinical assessment at the Grange University Hospital. The Performance Report (Part 1) of the Annual Report and Accounts for 2023/24 provides greater detail on the Health Board's performance and improvement actions in these areas.

OUR GOVERNANCE AND ASSURANCE FRAMEWORK

Aneurin Bevan University Health Board has agreed Standing Orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and together with the adoption of a scheme of matters reserved to the Board, a scheme of delegation to officers and others and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These documents, together with the Strategic Risk Register and a range of corporate policies set by the Health Board make up the

Governance and Assurance Framework and arrangements of the organisation.

The diagram below outlines the corporate governance structure in place during 2023/24:



Delivery of the Governance Assurance Framework within the organisation is deployed through the Executive Team (as noted below in table 1), with each Executive Director having an agreed portfolio of delegated responsibilities. This is underpinned by operational divisions which lead operational planning and service delivery across primary and community care, mental health and learning disabilities, acute services, estates and facilities, all of which have ultimate accountability to the Chief Operating Officer.

Membership of the Health Board and its Committees

Attachment 1 provides the Board's membership during 2023/24 and attendance at Board and Committee meetings respectively for this period. The membership of the Board and changes during 2023/24, are outlined in Table 1 below:

Name	Designation	Dates (If not full year)
Executive Directors		
Nicola Prygodzicz	Chief Executive	
Hannah Evans	Director of Strategy, Planning and Partnerships	From 01/04/2023
Chris Dawson-Morris	Interim Director of Planning and Performance	Until 03/04/2023
Rob Holcombe	Director of Finance and Procurement	
Dr James Calvert	Medical Director / Deputy Chief Executive	
Sarah Simmonds	Director of Workforce and OD	
Jennifer Winslade	Director of Nursing	
Peter Carr	Director of Therapies and Health Sciences	
Tracy Daszkiewicz	Director of Public Health	
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services	Until 30/04/2023
Leanne Watkins	Director of Operations	Until 30/04/2023
Leanne Watkins	Chief Operating Officer	From 1/05/2023
Independent Members		
Ann Lloyd	Chair	
Pippa Britton	Vice Chair	From 3rd May (interim prior to this)
Shelley Bosson	Independent Member (Community)	
Louise Wright	Independent Member (Trade Union)	

Name	Designation	Dates (If not full year)
Richard G Clarke	Independent Member (Local Authority)	
Professor Helen Sweetland	Independent Member (University)	
Paul Deneen	Independent Member (Community)	
Iwan Jones	Independent Member (Finance)	
Dafydd Vaughan	Independent Member (Digital)	
Martin Blakebrough*	Independent Member (Third Sector)	From 03/05/2023
Penny Jones	Independent Member (Community)	From 15/01/2024
Directors in Attendance**		
Paul Solloway	Director of Digital	From 28/06/2023
Special Advisors to the Board***		
Phil Robson	Special Advisor to the Board	
Associate Members******		
Vacant	Chair, Stakeholder Reference Group	
Vacant	Chair, Health Professionals Forum	
Vacant	Director of Social Services	
Director of Corporate Governance********		
Rani Dash	Director of Corporate Governance	

* Absent in agreement with Chair and Welsh Government (effective 01/09/23 to-date)

***The Director of Digital is not an Executive Post. The Director of Digital is therefore not a Board Member and attends meetings of the Board in an ex-officio capacity without voting rights.*

****The Board has discretion to appoint Special Advisors to support it in achieving its responsibilities. Special Advisors are not Board Members and therefore attend meetings of the Board in an ex-officio capacity without voting rights.*

*****Associate Members are Members of the Board but do not hold voting rights.*

****** Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within the Health Board. The Director of Corporate Governance is responsible for providing advice to the Board as a whole and to individual Board members on all aspects of governance.*

The Role of the Board

The Board, chaired by Ann Lloyd CBE, has been constituted to comply with the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

The Board is made up of individuals from a range of backgrounds, disciplines and areas of expertise. The Board comprises the Chair, Vice Chair and nine other Independent Members and the Chief Executive and eight Executive Directors. There are also Associate Independent Member positions, Special Advisors and other senior managers who routinely attend Board Meetings. The full membership of the Board and their lead roles and committee responsibilities are outlined in **Attachment 1**.

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide strategic direction and control. The Board is accountable for governance and internal control in the organisation and the Chief Executive as Accountable Officer, is responsible for maintaining appropriate governance structures and procedures.

In summary, the Board:

- Sets the strategic direction of the organisation within the overall policies and priorities of the Welsh Government and the NHS in Wales;
- Establishes and maintains high standards of corporate governance;
- Ensures the delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility;
- Monitors progress against the delivery of strategic and annual objectives; and
- Ensures effective financial stewardship by effective administration and economic use of resources.

The Health Board must agree Standing Orders for the regulation of proceedings and business which are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegations to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These documents, together with the range of corporate policies set by the Board make up the Governance Framework.

Committees of the Board

Section 3 of Aneurin Bevan University Health Board's Standing Orders provides that "*The Board may and, where directed by Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance in the exercise of its functions*". In line with these requirements, the Health Board had in place a Committee Structure for 2023/24.

The committee structure has been designed to enable an appropriate balance between strategy, delivery and performance, and culture and takes into consideration feedback from Board Members and Audit Wales in respect of effectiveness.

During 2023/24, the following Committees were in place:

- Audit, Risk & Assurance Committee
- Patient Quality, Safety & Outcomes Committee
- People & Culture Committee
- Finance & Performance Committee
- Partnerships, Population Health and Planning Committee
- Mental Health Act Monitoring Committee
- Remuneration and Terms of Service Committee
- Charitable Funds Committee
- Litigation Group

The Terms of Reference and Operating Arrangements, meeting agendas and papers for each of these Committees can be found on the Health Board's website.

These Committees are Chaired by Independent Members of the Board. The Chair of each Committee reports regularly to the Board on the committee's activities. This contributes to the Board's assessment of risk, level of assurance and scrutiny against the delivery of objectives. In addition, and in-line with Standing Orders, each committee is required to produce an annual report.

In addition to the Board's formal meetings and formal Committee meetings, the following informal arrangements have been established to support the Board to fulfil its responsibilities:

- Board Development Sessions, held bi-monthly (6 times yearly), to focus on the development and effectiveness of the Board as a cohesive and unitary Board;
- Board Briefing Sessions, held bi-monthly (6 times yearly), to focus on key matters where informal discussion is required and to raise awareness of matters such as changes in policy or legislation; and

- Board Strategic Planning Sessions, held quarterly, to allow the Board informal development time to discuss collectively strategic developments and horizon planning.

Conducting Business with Openness and Transparency

In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the Board and Committees are required to meet in public. Following the COVID-19 pandemic where the public health risk posed resulted in limitations on public gatherings, the Board and its Committees moved to meeting in a virtual setting meaning that it was not possible to allow the public to attend meetings of the Board and Committees.

Members of the public have been able to attend all Board meetings in person during 2023/24. In addition, the Microsoft Teams link is also published with the agenda and on social media channels to enable members of the public to observe the meeting in real time if they are unable to attend in person. All Board meetings in 2023/24 were recorded and published to the Health Board's You Tube Channel within 24 hours for public viewing.

During 2023/24, the Board's committees have continued to meet virtually and, due to capacity constraints, the Health Board has not been able to stream these in real-time for the public's viewing. Work is underway to address this in 2024/25 to ensure that the Health Board's business operates with full transparency and openness.

As the Health Board has not been able to allow the public to attend all meetings of its committees during 2023/24, the Health Board has not complied with its Standing Orders in this regard.

It is acknowledged that a hybrid approach to meetings will continue to be required in the future and the Health Board will work to ensure members of the public can attend meetings in person and/or virtually.

To ensure Board and Committee business was conducted in as open and transparent manner as possible the following actions were taken:

- All Board and Committee meeting agenda packs have been published to the Health Board's website in advance of meetings;
- Meetings of the Board have been recorded and published to the Health Board's You Tube Channel within 24 hours;
- The Health Board's Annual General Meeting in September 2023 was livestreamed, with in person attendance also permitted.

The Health Board and its Committees have sought to undertake a minimum of its business in private sessions and ensure business, wherever possible, is published in the public domain. The Committees that do not publish information publicly is either because of the confidential nature of their

business, such as the Remuneration and Terms of Service (RATS) Committee, or they are informal developmental type meetings such as the Board Strategic Planning Sessions discussing plans and ideas often in their formative stages.

Meetings of the Board and its Committees are formally recorded with minutes considered for approval at the next available meeting, respectively. In addition, the Director of Corporate Governance maintains Decision Logs for all decisions taken by the Board and the Executive Team.

Items considered by the Board in 2023/24

During 2023-24, the Board held 6 scheduled meetings, as well as its Annual General Meeting on 27th September 2023.

All the meetings of the Board in 2023/24 were appropriately constituted and quorate. The key business and risk matters considered by the Board during 2023/24 are outlined below.

Further information can be obtained from the published Board meeting papers on the Health Board's website via the following link.

Business Cases:

- Approved the **Regional Cataract Business Case**, subject to funding from Welsh Government.
- Approved the **Same Day Emergency Care (SDEC) Business Case** for Ysbyty Ystrad Fawr.
- Endorsed the **Velindre Cancer Centre Business Case.**

Governance and Assurance

- Received assurance in respect of arrangements for compliance with the **Nurse Staffing Levels (Wales) Act.**
- Approved the **Annual Report and Accounts 2022-23.**
- Approved the **Charitable Funds Annual Accounts and Annual Report 2022-23**
- Received the following **Annual Reports**:
  - Trade Union Partnership Forum
  - Communications and Engagement
  - Health and Safety

Plans/Strategies/Policies/Service Change

- Endorsed the **Nursing, Midwifery and Specialised Community Public Health Nurses Workforce Strategy.**
- Approved an urgent service change to **consolidate Stroke Services** to a single Hyper Acute Stroke Unit (HASU) at the Grange University Hospital and a single rehabilitation ward within YYF initially, pending a more detailed plan.
- Received the evaluation against the implementation of the **Integrated Winter Resilience Plan 2022/23.**
- Endorsed the proposal for a **Proof of Concept and Service Evaluation for Enhanced Care at YYF**, to improve quality, safety and patient experience.
- Approved the **Nursing and Midwifery Strategy 2023-26**.
- Approved the **Quality and Safety Systems Framework for Speaking Up** and associated action plan.
- Approved the **Winter Plan 2023/24**.

- Received the **Audit Wales Annual Audit Report and Structured Assessment.**
- Approved a revised **Risk Management Framework.**

Routine Business

- Ratified actions taken by the Chair, on behalf of the Board, to seal documents affixing the Health Board's Common Seal.
- Considered and discussed the Health Board's financial performance and the related risks being managed by the organisation.
- Considered the Board's performance against key local and national targets and the actions being taken forward to improve performance.
- Considered performance against the Health Board's Quality Outcomes Framework.
- Received assurance reports from the Committees and Advisory Groups of the Board.
- Received update reports from the Executive Team in respect of key issues locally, regionally and within NHS Wales.
- Reviewed the Corporate Risk Register and sought assurance on the management of mitigating actions.

- Approved consultation and engagement on the **Strategic Equality Plan.**
- Approved **Patient Incident Reporting and Management Policy**.
- Endorsed the **consolidation of services at St Woolos Hospital.**
- Noted the outcome of engagement for the **MIU provision across Gwent** and approved the implementation of the preferred option.
- Approved the draft opening **Capital Programme for 2024/25.**
- Approved the **All Wales Individual Patient Funding Request Policy**
- Approved the **Annual Plan 2024/25** and the **Delegated Budgets for 2024/25.**
- Agreed to support the signing of the pledge to become a **Corporate Parent.**
- Approved the **Strategic Equality Report** and updated **Strategic Equality Plan**.
- Approved a revised **Major Incident Plan.**
- Received the **Director of Public Health Annual Report**
- Considered the **Cancer Services Annual Report**

Patient Experience and Public Engagement

In March 2023, the Board approved its Patient Experience & Involvement Strategy. The Strategy's goals and objectives are to improve services and their effectiveness and safety and to improve people's experiences. It encompasses the Health Board's intent to engage patients, families, carers, staff and the wider community, with a commitment to listen to feedback, learn and therefore improve healthcare across all of our services.

The Board has remained committed to hearing and learning from the experience of staff and patients. During 2023/24 the Board received patient/staff stories in respect of:

- **Alcohol Care Team** - how proactive work makes a real different to patients' lives.

- **Children's Rights Participation Forum** – heard about the experiences of those using the Health Board's services who had been diagnosed with, or were awaiting diagnosis for, neurodivergence.
- **Tyleri Ward Community Resource Team** (CRT)– Nurse led approach on Tyleri Ward and its functioning as a CRT Direct Admission Unit.
- **Psychological Recovery in Cancer Services –** improvements to the service following patient feedback.
- **Volunteer to Career –** turning volunteering opportunities into meaningful employment.

Throughout 2023/24, **Llais, Gwent Region** attended meetings of the Board to provide an overview of recent issues of concern and positive observations or public feedback being addressed by Llais in relation to the planning and delivery of health services in Gwent.

Items considered by Committees of the Board

During 2023/24, Board Committees considered and scrutinised a range of reports and issues, in line with the matters delegated to them by the Board. These included a range of internal and external audit reports and reports from other review and regulatory bodies, including Healthcare Inspectorate Wales.

As was the case in previous years, the Committees' consideration and analysis of such information has played a key role in the assessment of the effectiveness of internal controls, risk management arrangements and assurance mechanisms. The Committees also considered and advised on areas of local and national strategic developments and new policy areas.

An overview of the key areas considered by the Committees of the Board is provided below:

Audit, Finance and Risk Committee	Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered: • Update Report on the Clinical Audit Plan • Update Report on Clinical Audit Activity • Audit Wales Orthopaedic Services in Wales: Tackling the Waiting List Backlog – National and Local Report • Audit Wales Primary Care Follow-Up Report • Audit Wales Stakeholder Perception Research Report • Compliance with Welsh Health Circulars (WHC) and Ministerial Directions • Implementation of the Governance Priorities set out within the IMTP 2022-25 • Adequacy of arrangements for declaring, registering and handling interests

	• Implementation of the Risk Management Strategy Realisation Plan • Counter Fraud, Bribery and Corruption Policy • Counter Fraud Annual Report, Workplan and activity reports The Committee reviewed and approved the audit strategies and plans from Audit Wales and Internal Auditors, NWSSP Audit & Assurance Services and received audit reports produced in support of them during 2023-24. In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile. During the year the Committee received Internal Audit reports in line with the agreed programme for 2023-24, including the management response from the relevant Executive Director. There were 29 individual reviews in the Internal Audit Plan 2023/24 and an additional review included regrading facilities. Subsequently, 3 audits were deferred leaving 27 in the plan. Of these, as at May 2024, 17 have been reported as final, 7 are in draft, 3 are in the planning stage and 3 have been deferred to 2024/25.
Patient Quality, Safety and Outcomes Committee	Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered: • Regular Committee Risk Reports detailing the key risks allocated to the Committee • Update in relation to the management of medical devices and equipment within the Health Board • Updates regarding progress made in the development of the business case to replace the Pharmacy Robot at the RGH • Quarterly reporting on the Performance of Patient Quality and Safety Outcomes, including: – Duty of Candour triggers – Infection Prevention and Control – COVID-19 Investigations – Falls – Health, Safety and Security – Complaints, Concerns and Compliments – HIW Inspections • Annual Reports: – Blood Management – Pharmacy and Medicines Management – Research and Development – Infection Prevention and Control – Safeguarding – Annual Clinical Audit Activity Report

	• National Incident Reporting Policy • Recommendations, relevant to the Committee from internal and external audit reports: – Health & Safety – Medical Equipment and Devices – Medicines Management – Monitoring Action Plan – Discharge Planning – Dementia Service – Structure Assessment – Putting Things Right: Advisory Review
Charitable Funds Committee	• Scrutinised applications for charitable funds • Reviewed charitable funds income and expenditure • Considered and endorsed the Charitable Funds Accounts and Annual Report 2022/23 • Received the Audit Wales – Audit of Accounts Report 2022/23
Mental Health Act Monitoring Committee	The role of the Mental Health Act Monitoring Committee (MHAMC) is to monitor and review the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983. The Committee therefore receives a quarterly report which provides assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act. During the year the Committee also reviewed and agreed the revised Mental Health Act Managers Policy, strengthening arrangements for the recruitment and retention of Associate Hospital Managers. A **Power of Discharge Sub-Committee** has been established as a formal sub-committee of the MHAMC. The membership of this Committee is comprised of Associate Hospital Managers and provides advice and assurance that the processes associated with the discharge of patients from compulsory powers, used by the Sub Committee, are being performed correctly and in accordance with legal requirements. The Sub-Committee reports routinely to the Committee for assurance and developmental purposes.
People and Culture Committee	Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered: • Key matters relating to Employee Relations and suspensions over 4 months. • Assurance regarding the retention of staff including progress

	against the action plan. • Delivery of the Welsh Government's Race Equality Action Plan for Wales and associated Health Board Implementation Plan. • Workforce Planning and Education Commissioning Numbers. Progress with the implementation of the People Plan 2022/25 • Results of Staff Wellbeing Surveys • Compliance with the Welsh Language (Wales) Measure 2011
Finance and Performance Committee	Amongst the key issues considered by the Committee during 2023-24 were the following: **Financial management and performance**: • Routine monitoring of the financial position of the Health Board through the provision of quarterly financial performance reports and specific focussed reports on efficiency and savings opportunities and delivery. • Focussed updates across a range of themes being considered by the Value and Sustainability Board, including Workforce, Non-Pay, Prevention, CHC, Medicines Management, Digital & Service Redesign. • Received the report for Value Based Healthcare in ABUHB, presenting the key service areas and patient groups benefitting from the use of patient related outcome measures. • Quarterly updates on Efficiency Opportunities. **Organisational performance and management:** Quarterly updates on organisational performance, with exception reporting in identified areas including Planned Care and Stroke. • Update reports relating to: – Radiology Informatics Systems Procurement (RISP) Programme, – IT systems, including the shortfall for funded and part funded digital schemes, and the associated risk with delays in national digital programmes. – Quality of Coding, including a proposed structure for delivery for the improvement of coding services, to enable the clinical coding services deliver a more modern and flexible service for the Health Board. – Outpatient Transformation Programme, describing a number of transformational schemes implemented, their impact, along with the programme plan for 2023/24. – Robotic Process Automation (RPA), – Discharge Programme and Delays, including an update on the progress and impact of the Integrated Discharge Hub, as part of the Six Goals Programme structure
Partnerships, Population	Amongst the key issues considered by the Committee during 2023-24 were the following:

Health and Planning Committee	• Quarterly updates on the work of the Public Service Board, including progress of the 'Building a Fairer Gwent, Gwent Marmot Programme' • Quarterly updates in respect of the business of the Regional Partnership Board, including work on the Area Plan and the development of the Partnership Capital Strategy and Plans • Discussed regional planning work undertaken throughout 2023/24, in regional Ophthalmology, Orthopaedics, Diagnostics services, Cancer services, Vascular services, Stroke services, Thoracic services and Hepato-Biliary and Pancreatic Surgery and the Welsh Sexual Assault Service • Updates on Major Capital programmes, strategic capital projects and estates rationalisation • Endorsed the approach to the development of the IMTP • Updates in relation to health Protection and endorsed the requirement for a permanent Health Protection Team • Update on Decarbonisation, including the Decarbonisation Action Plan 2023/24 and progress against the national programme to deliver the goal of net zero emissions by 2050 • Endorsed the Major Incident Plan for submission to Board • Quarterly updates on the delivery of the Health Boards Clinical Futures Programme, including: – Stroke Services – Homeward Bound Wards – General Internal Medicine – Minor Injury Units – Mental Health Services – Acute Frailty Response Team – Falls Pathway – Welsh Ambulance Service Team – Place Based Care – Primary Care Sustainability – Planned Recovery

Further information is available in the Annual Report for each Committee, published on the Health Board's website via the following link.

Board Development and Briefing

Board members took part in a number of development and briefing sessions through 2023/24. Topics covered at these sessions included:

- Children's Rights Forum
- Annual Plan Priorities 2024/25 including Financial Outlook
- Urgent and Emergency Care
- IMTP 2024-27
- Financial Performance

- Staff Wellbeing and Employee Investigations
- Long Term Strategy
- Safeguarding Training
- Quality Strategy and Quality Assurance Framework
- Safey Flow Model
- Primary Care Sustainability
- Risk Management

Self Assessment and Evaluation

In line with Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups.

The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and to develop and improve leadership and governance. It helps boards identify strengths and development areas to deliver continuous improvement. High performing boards are likely to carry out some form of self-review of their leadership and governance regularly.

In February 2023 the Board was asked to undertake individual 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. This was followed by a Development Session in June 2023 in which the Board identified areas for improvement during 2023/24. This session also took into consideration independent and objective feedback from auditors and inspectors, such as Audit Wales' Structured Assessment which comments on the existence of proper arrangements for the efficient, effective, and economical use of resources within the Health Board. The areas for improvement were presented to the Board in September 2023.

During 2023/24, Committees of the Board undertook a mid-year self-assessment. The findings from each of these self-assessments will be used to inform a comprehensive annual assessment of the Board's effectiveness for 2023/24. In undertaking these assessments, committee members considered their composition, establishment and ways of working, the outcomes of which will inform a detailed review of Committee Terms of Reference in 2024/25.

An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured Assessment, for delivery in 2024/25.

ADVISORY GROUPS AND JOINT COMMITTEES

Advisory Groups

Aneurin Bevan University Health Board's Standing Orders require the Board to establish three advisory groups. These allow the Board to seek advice from and consult with staff and key stakeholders. They are the:

- Stakeholder Reference Group;
- Local Partnership Forum; and
- Healthcare Professionals' Forum.

Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board's website.

Stakeholder Reference Group (SRG)

Aneurin Bevan University Health Board established its Stakeholder Reference Group (SRG) in 2010.

The SRG's role has been to provide independent advice on the Health Board's business, including: Early engagement and involvement in the determination of the Health Board's overall strategic direction; the provision of advice on specific service proposals prior to formal consultation; as well as feedback on the impact of the Health Board's operations on the communities it serves. The SRG should provide a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the Health Board, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the Health Board's decision making.

Since its establishment, the Health Board's engagement arrangements have evolved and continue to develop and mature. In particular, the COVID-19 pandemic required the Health Board to engage with our stakeholders and communities in new and different ways.

In view of these evolving engagement arrangements and given that the Stakeholder Reference Group last met in October 2021, a decision was taken to disband the SRG in its current form in October 2022, whilst the Health Board reviews and redesigns the role and constitution of the Group, ensuring it is fit for purpose and fully effective. A proposal for re-establishment of the SRG has been finalised and will be considered by the Board in 2024.

In the meantime, the Health Board continues to work alongside partners to engage and involve people who others are also seeking to engage. This enables strong partnership working, the sharing of resource and the ability to collaborate regarding joint solutions to challenges shared. Many

organisations have been extremely generous in enabling our participation in their existing activities. The Health Board has previously attended:

- Local Authority Community Talk to Us Sessions, Warm Spaces and Cost of
- Living events;
- Housing Association Resident Complexes and events;
- Health & Wellbeing events and Freshers Fairs at Coleg Gwent Campuses; and
- School Parents evenings, coffee mornings and PTA events.

The Health Board is also represented at Gwent Citizens Panel, Torfaen Access Forum and works with third sector organisations, Gwent Association of Voluntary Organisations and Torfaen Voluntary Alliance.

The Health Board runs a comprehensive community engagement program that ensures communities can speak directly with Health Board staff and share their views on health services. In 2023/24, the Health Board spoke directly with over 6000 residents across 200 venues.

The Health Board is committed to working constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for the population of Gwent. This is delivered in accordance with the Health Board's statutory duties and any specific requirements or directions made by the Welsh Ministers, which includes the development of population assessments and area plans.

Local Partnership Forum (Known as the Trade Union Partnership Forum [TUPF])

The TUPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues. The TUPF is co-chaired by the Chair of Staff Representatives and the Chief Executive of the Health Board. Members are Staff Representatives (including the Independent Member for Trade Unions), the Executive Team and Chief Executive, the Director of Corporate Governance, the Assistant Directors of Workforce and OD and the Head of Workforce Governance. The Forum meets 6 times a year and the Board receives an Annual Report on the work of the Forum.

Healthcare Professionals' Forum (HPF)

The purpose of the HPF is to facilitate engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the Health Board's decision making.

In the latter part of 2023/24, the Board agreed the terms of reference for the establishment of the HPF known as the Clinical Advisory Group with the aim of holding the inaugural meeting in 2024/25. In the absence of this Group, the Board has continued to engage clinical professionals through its professional executive directors (Medical Director, Director of Nursing, Director of Therapies and Health Sciences and Director of Public Health) and existing professional management groups, such as the Clinical Directors Forum and System Leadership Group. The Board also engages with primary care providers through its cluster arrangements.

Joint Committees

As set out within the Health Board's Standing Orders, during 2023/24, the Board was required to establish the following joint Committees:

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

Welsh Health Specialised Services Committee (WHSSC)

The Welsh Health Specialised Services Committee (WHSSC) is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales.

WHSSC was established in 2010 by the Local Health Boards (LHBs) in Wales to ensure that the population of Wales has fair and equitable access to the full range of specialised services. In establishing WHSSC to work on their behalf, the seven LHBs recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

WHSSC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board is represented on the Committee by the Chief Executive and reports of the Joint Committee's activity are regularly reported to the Board.

Further detail in respect of Welsh Health Specialised Services Committee can be found on WHSSC's website

Emergency Ambulance Services Committee (EASC)

Emergency Ambulance Services in Wales are provided the Welsh Ambulance Services NHS Trust (WAST) and commissioning of Ambulance Services in Wales is a collaborative process underpinned by a quality and delivery framework. The framework provides for clear accountability for the provision of emergency ambulance services with the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Services Committee (EASC) acting on behalf of Health Boards and holding WAST to account as the provider of emergency ambulance services. EASC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board

is represented on the Committee by the Chief Executive and reports of the joint committee's activity are regularly reported to the Board.

Further detail in respect of Emergency Ambulance Services Committee can be found on EASC's website.

NHS Wales Joint Commissioning Committee

The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (the Directions) came into force on 7th February 2024 which provide that the Local Health Boards in Wales will work jointly to exercise functions relating to the planning and securing of services specified within the Directions or as identified by the Local Health Boards. Specifically, these are: (a) specialised services for: (i) cancer and blood disorders, (ii) cardiac conditions, (iii) mental health and vulnerable groups, (iv) neurosciences, and (v) women and children; (b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis; (c) emergency medical services; (d) non-emergency patient transport services; (e) emergency medical retrieval and transfer services; (f) NHS 111 services; (g) sexual assault referral centres; and (h) other services as directed by the Welsh Ministers.

For the purpose of jointly exercising those functions set out within the Directions, the Local Health Boards will establish a joint committee to be operational on 1 April 2024, which will supersede the Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee as Joint Committees of Local Health Boards.

Statutory and Strategic Partnerships

Gwent Regional Partnership Board

The Gwent Regional Partnership Board (RPB) is established under Part 9 Social Services and (Wales) Wellbeing Act 2014 and the Partnership Arrangements (Wales) Regulations 2015, within which local authorities and local health boards are required to establish Regional Partnership Boards to manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services, and care and support is in place to best meet the needs of their respective population. The objectives of the Gwent Regional Partnership Board are to ensure the partnership bodies work effectively together to:

- Respond to the population assessment carried out in accordance with section 14 of the Act;
- Develop, publish and implement the Area Plans for each region covered as required under section 14A of the Act;
- Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act; and

❖ Promote the establishment of pooled funds where appropriate.

Welsh Government has distributed a Health and Social Care Regional Integration Fund across Wales to the seven Regional Partnership Boards (RPBs) in Wales. The aim of the fund is to drive and enable integrated working between social services, health, housing and the third sector and independent providers to develop sustainable services.

The Regional Integration Fund (RIF) is hosted by Aneurin Bevan University Health Board on behalf of the Gwent Regional Partnership Board and is a standing agenda item on the Regional Partnership monthly meetings. All matters in relation to the RIF are discussed and approved within the partnership forum. Information is cascaded throughout the partnership structures for transparency. Where needed, the RPB accommodates special meetings to sign off RIF investment plans where meetings schedules do not align with reporting or development timeframes.

Aneurin Bevan University Health Board Members included in the membership of the Regional Partnership Board are:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracy Daszkiewicz, Director for Public Health & Strategic Partnerships
- Hannah Evans, Director of Strategy, Planning & Partnerships
- Phil Robson, Special Advisor to Health Board
- Pippa Britton, Vice Chair

Further detail in respect of the Gwent RPB can be found on the RPB's website.

Gwent Public Services Board

The Gwent Public Services Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Gwent to meet the needs of Gwent citizens present and future. The aim of the group is to improve the economic, social, environmental and cultural well-being of Gwent. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan.

The Health Board contributes to achieving these objectives through the delivery of the Clinical Futures Strategy and the Integrated Medium-Term Plan (IMTP).

Aneurin Bevan University Health Board Members included in the membership of the Public Services Board are:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive

- Tracey Daszkiewicz, Executive Director for Public Health & Strategic Partnerships

Further detail in respect of the Gwent PSB can be found on the PSB's website.

NHS Wales Shared Services Partnership

NHS Wales Shared Services Partnership (NWSSP) was established in November 2010 to deliver economies of scale; efficiencies and consistency of quality and process for the business and professional services that were directly managed and delivered by local NHS bodies.

As a hosted organisation, NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General/CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by Professor Tracy Myhill OBE. The membership is comprised of representatives from each NHS organisation, including Aneurin Bevan University Health Board.

The Partnership Committee is responsible for exercising the Velindre National Health Service Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to Local Health Boards, Special Health Authorities and National Health Service Trusts. Several committees and advisory groups have been established to help support the governance arrangements that underpin how NWSSP operates.

Further detail in respect of NHS Wales Shared Services Partnership can be found on NWSSP's website.

Partnership working with other Health Boards

The Health Board is fully committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability.

The Health Board meets on a regular basis with other Health Boards in South Wales to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

In addition, the Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Velindre University NHS

Trust have agreed to work together on a portfolio of regional opportunities that at the time of writing includes Orthopaedics, Ophthalmology, Diagnostics, Stroke, Cancer and the development / implementation of a single regional clinical strategy for South-East Wales. A Regional Portfolio Oversight Board has been established to oversee the portfolio of work. Each Health Board / Trust is represented on this forum via its Chief Executive, Director of Planning and Chief Operating Officer.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Chief Executive and Accountable Officer, I am responsible for overall risk management and report to the Board on its effectiveness across the Health Board. My advice to the Board has been informed by executive officers and feedback from the Board's Committees, particularly the Audit, Risk, and Assurance Committee and the Patient Quality, Safety, and Outcomes Committee.

Executive Committee meetings provide an opportunity for executive directors to consider, evaluate, and address risk while also actively engaging with and reporting to the Board and its committees on the organisation's risk profile. The Director of Corporate Governance is the Health Board's risk lead, responsible for developing the framework, as well as the systems and processes required for risk management within the organisation. Depending on the nature of the risk, other Directors will take ownership of its management and mitigation. For example, patient safety risks are the responsibility of the Medical Director, the Director of Nursing and Midwifery, and the Director of Therapies and Health Science.

Risk Appetite

In June 2023, the Board commenced developmental work to review and redesign its risk appetite against key business domains or 'themes'. These themes were derived from feedback received from the Board on the most significant risks to the Health Board in achieving its strategic objectives.

The table below summarises the Health Board's position on its appetite for risk and the level of tolerance it is willing to accept. The full Risk Appetite Statement is available here.

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

The Risk Appetite Statement is an important component of the Health Board's risk management arrangements in that it provides guidance and direction in risk prioritisation and resource allocation.

The Health Board's ***Risk Appetite*** represents the overall willingness to accept risk at a strategic level, whereas ***Risk Tolerance*** refers to the level of risk that is acceptable for a specific activity or decision.

Risk appetite guides the Health Board's overall risk approach, whereas tolerance provides a more detailed and measurable framework for assessing and managing risk in specific contexts. This approach has been

the driving force behind the management of strategic and operational risks, and it will be the tool used throughout the Health Board to assign risks to themes and provide a basis for determining risk management.

The Risk Management Framework

In August 2022, the Director of Corporate Governance committed to reviewing the Board Assurance Framework (BAF) to allow for closer alignment and reporting with the Corporate Risk Register (CRR).

In May 2023, the Board reviewed its corporate risk register, which included both strategic and corporate (high-level operational) risks. It was agreed that a risk separation was required to ensure that strategic risks were aligned with the Board's strategic objectives and ministerial priorities, while corporate (high-level operational) risks would be overseen by the executive directors and reported to the Board via the risk and assurance report, allowing for clear risk differentiation and greater transparency of all risks.

This approach resulted in the establishment of a Strategic Risk Register (SRR), formerly known as the BAF, which includes risks that could have an impact on strategic objectives and ministerial priorities, as well as a CRR, which includes any risks escalated from divisions or internal/external intelligence that have the potential to impact service delivery.

The new approach required the Health Board to review its risk management processes and update its Risk Management Framework, making sure that roles and responsibilities, the risk register hierarchy, and the escalation process were all clearly defined. This will allow the Health Board to mature its risk management practices while also providing improved assurance across the internal control system on an operational level.

Furthermore, the Board reviewed its risk appetite statement, as previously stated, to ensure that it was reflective of the current operating environment while also balancing the need to drive improvements and sustainability by increasing its tolerance for specific risk domains to avoid missing opportunities.

The Audit, Risk and Assurance Committee endorsed the revised Risk Management Framework, Policy, and Risk Appetite Statement at its November meeting before submitting it to the Board for formal approval in January 2024.

To support the implementation and embedding of risk management practices across the Health Board a toolkit has been developed to provide staff with the knowledge and tools to actively manage risk. These tools support the Framework, Policy and Appetite Statement and are listed below:-

- NHS 5 X 5 Risk Scoring Matrix – including thresholds for various risk domains
- Strategic / Corporate and Operational Risk Assessment Template (Risk to a Page)
- Risk Management intranet page (under development). This will contain the full Toolkit, FAQs, Bitesize learning, training schedule, etc.

Since the refreshed approach and the establishment of the Strategic Risk Register, it has been determined that a greater emphasis on assurance mapping across the Three Lines of Defence Model to demonstrate assurance sources is required, which will be carried out throughout the first and second quarters of 2024/25. Furthermore, to strengthen the internal control system, a system-wide assurance mapping exercise will be conducted in conjunction with the Quality Assurance and Performance Management Frameworks to provide the Audit, Risk and Assurance Committee (ARAC) with the assurances it requires regarding its delegated responsibilities.

In the fourth quarter of 2024/25, the ARAC will receive the findings of a risk maturity survey, which will provide intelligence on areas where risk management has evolved and is a core competency and enabler for achieving objectives, as well as highlight where resources should be focused to enable change.

The Corporate Governance Directorate has commenced a period of communication and engagement with staff to launch the Risk Management Framework. To coincide with the launch, the Head of Corporate Risk and Assurance will increase visibility across the Health Board, raising awareness and providing staff with the knowledge and skills needed to incorporate risk management into their daily processes. This is being undertaken in a structured way, meeting with departments/directorates and divisions to begin embedding the Health Board's agreed-upon approach to risk management and the escalation process to mature the Health Board's risk management practices.

Risk Management System

The Health Board's electronic risk management system and associated functionality provide a useful mechanism for operational teams to record risks, raise and escalate risks via hierarchical digital risk registers, to which the Head of Corporate Risk and Assurance has full oversight and can review the risk being escalated to ensure it is held on the appropriate risk register for management and oversight. Furthermore, the Health Board's Executive Directors hold assurance meetings with their respective Divisions to discuss management of ongoing risks and provide an additional opportunity to escalate risks. Regular engagement with executive risk owners is conducted to update risks and ensure that scoring is consistent and balanced.

The Legacy Datix module is currently used as the Health Board's risk management system. The Health Board has not yet transitioned to the RLDatix 'Once for Wales' risk management module due to functional issues which are being addressed. A national group is working to ensure the system is fit for purpose and contains all of the functions required for a robust and effective risk management system. The group is optimistic that Datix will make the necessary improvements and that the module will be approved for use throughout Wales.

The Health Board's Risk Profile

The Director of Corporate Governance presents a full strategic risk report to each Board meeting, as well as a report to each Board Committee, which includes detailed risk assessments for the risks for which the Committee has been tasked with seeking assurance.

This report is published in the public domain to ensure transparency and openness regarding the strategic risks identified by the Health Board as potential barriers to achieving the Board's strategic priorities.

As of the end of June 2024, there were **20** strategic risks described in the Strategic Risk Register, representing the most significant risks to the Health Board in terms of potential impact on the delivery of the Board's strategic priorities. These **20** are categorised into risk levels based on their 'likelihood' and 'impact' if the risk occurs as shown below.

Risk Level & Score	Number of Risks	Number of Risks outside of Appetite
Extreme (15 – 25)	**7**	**4**
High (9 – 12)	**10**	**2**
Moderate (5 –8)	**3**	**-**
Low (1 – 4)	**-**	**-**

The highest risk included on the Strategic Risk Register has a score of **20** (L5 x I4) and is owned by the Director of Finance and Procurement (SRR 001G) and is concerned with safeguarding the financial sustainability of the Health Board.

The infographic overleaf depicts the Health Board's current risk exposure to the 20 strategic sub-risks, demonstrating that the majority of the strategic risks are in the upper right quadrant of the risk matrix, indicating a high level of risk exposure. Six of those risks fall outside the Board's agreed-upon appetite level.

Risk Scoring Matrix					
Likelihood	**Impact**				
	1. Negligible	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
5. Almost Certain (91%)				**1 x (Extreme)**	
4. Likely (61-90%)				**3 x (Extreme)**	
3. Possible (41-60%)			**1 x (High)**	**9 x (High)**	**3 x (Extreme)**
2. Unlikely (11-40%)				**3 x (Moderate)**	
1. Rare (1-10%)					

The Table below illustrates **six** of the **20** strategic risks managed by the Health Board fall outside of the risk domain's appetite, as illustrated below.

RISK APPETITE	**Risk Theme**	**Risk Appetite Level**	**Number of Risks outside of Appetite Level**
	Compliance & Safety	**Minimal** Score 8 and below	**5**
	Financial Sustainability	**Cautious** Score 13 and below	**1**

A copy of the latest Strategic Risk Report presented to Board in March 2024 is available here. The risks contained within this have been subject to Executive risk owner scrutiny, challenge, and review. Robust assessments of the Health Board's internal control system were also undertaken, alongside a review of all sources of assurance related to each risk. Work is ongoing to provide enhanced assurance of risks outside of appetite, this will be done by undertaking deep dives of the risks outside of appetite and developing action plans to enhance control and mitigate the likelihood / impact.

Changes to the risk assessment template, as well as the implementation of a dashboard, have allowed the Board to gain a better understanding of risk appetite in relation to the risk profiles for which it is responsible. The revised template for Committees and the Board provides a high-level overview of the risks being managed within the Committee or Board's portfolio and whether they are being managed within the agreed risk

appetite level, and where risks are not managed within agreed limits, that robust plans and objectives are in place to de-escalate.

Recognising that more work needs to be undertaken to improve control and assurances across all risks, an overarching, high-level indication of the level of assurance the Board can derive from this iteration of the strategic risk report is provided below:

Overall Assurance on the Management of Risk		
Nil	Satisfactory	Considerable
	X	

This means that the Board can take a satisfactory level of assurance that the strategic risks on the Strategic Risk Register (at March 2024), which represent significant risks to the IMTP's delivery, are effectively managed. The Board could also be assured that the internal control system in place to manage these risks is considered satisfactory.

The Executive Team reviews strategic and corporate risks on an annual basis, conducting an in-depth review of all risks to ensure they are appropriately articulated, scored, and moderated. This work will be presented to the Board in the second quarter, 2024/25.

Risk & Assurance Related Internal Audit Reviews

The Audit, Risk and Assurance Committee received two risk management audits with a reasonable assurance rating during the 2023/24 financial year. The reviews were designed to give the Board assurance that appropriate risk management arrangements are in place within the Divisions (at the operational level).

The report issued in April 2023 included four recommendations (2 low and 2 medium), with the report issued in April 2024 making one medium recommendation that was not material in nature and will be completed as part of the transition to the Once For Wales Datix Risk Module once it is implemented in the Health Board.

Emergency Planning

In accordance with the statutory duties of the Civil Contingencies Act (2004) and Emergency Planning Guidance issued by Welsh Government the Health Board have in place emergency plans, business continuity arrangements, health protection response plans and supporting documents. The Board agreed a refreshed Major Incident Plan at its meeting in March 2024. The Health Board has also adopted the learning from the 2023 business continuity audit and multi-agency exercises to support organisational preparedness.

THE CONTROL FRAMEWORK

Quality Governance

Patient Safety, Quality and Experience

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

Putting quality and safety above all else is the first NHS Wales core value. This focus has been strengthened through the Health and Social Care (Quality and Engagement) (Wales) Act (2020). Enhancing quality, honesty and transparency, the legislation provides the Health Board with a Duty of Quality, Duty of Candour, and establishes a Citizen Voice - Llais, enriching engagement with our patients, relatives, carers, staff and communities. Llais is an independent body and its free Advocacy service can provide information, advice and support to members of the public.

In 2023 the Health Board published and implemented two Strategies:

- **The Quality Strategy**, which serves as a blueprint for patient safety and quality for the next three years, placing quality and safety at the forefront of all we do, while at the same time recognising that challenges to patient safety and quality change and emerge over time. We will remain agile in responding flexibly to emerging safety and quality issues as they arise. It outlines our improvement objectives for the next three years as well as the frameworks that will support that activity. Our culture values quality, and we are committed to continuous improvement.
- **The Patient Experience and Involvement Strategy** was developed as a direct result of staff, patient, family and carers feedback, telling us what matters to them. Our teams and our staff members have a passion to improve people's experiences within our services and it is important to us that learning from experience is at the heart of the organisation.

These Health Board Strategies have been developed from the experiences of our patients, relatives, carers, staff and communities to focus on improvement, planning and assurance in the right areas. This is aligned with the objectives and aims of the Duty of Quality and in the context of meeting our obligations under the Duty of Candour.

Both Strategies outline our goals and objectives to improve services, clinical effectiveness, safety and people's experiences. It encompasses our intent

to engage patients, families, carers, staff and the wider community, with a commitment to listen to feedback, learn from it, and therefore improve healthcare across all of our services.

Goals and Objectives

The Quality vision of Aneurin Bevan University Hospital Board is to be "widely recognised for delivering the Health and Care Quality Standards". Our first and most important commitment to our patients is to keep them safe. Over the next three years, the Quality Strategy will improve the delivery within these Quality Standards, while continuing to improve patient and staff experience and outcomes.

Our ongoing commitment to quality and safety:

- Aneurin Bevan University Health Board will be a learning organisation where staff members work towards delivering high quality clinical care every day.
- We will strive to better understand our systems of care, build capability through an all teach/all learn philosophy, encourage innovation and engage patients, relatives, carers, staff and communities in improvement endeavours, whilst learning from mistakes.
- We will ensure that quality is embedded throughout the organisation creating a culture of openness and transparency where people are supported to raise concerns.
- Our patients, relatives, carers, staff and communities will be encouraged to work alongside us to achieve this vision.

To date we have achieved a number of milestones, including:

- Implementing the Quality and Engagement Act including the Duty of Candour and Duty of Quality.
- Developing a reporting framework and quality outcomes framework to align with the six domains of quality.
- Reviewing Quality Safety and Patient Experience structures within divisions/directorates, formalising lines of responsibility, accountability, escalation, and assurance.

Ongoing work will continue on:

- Setting out the core evidence that will be considered by each Committee (service/division to sub-committee of board levels) to provide assurance on delivery of Health and Care Standards
- Developing a corporate clinical audit plan to address any gaps in assurance
- Develop an Annual Report for each Health and Care Standard, scheduled for consideration by Patient Quality Safety and Outcomes Committee (PQSOC)
- Strengthened assurance mechanisms for commissioned services
- Standardising resources, role profiles and appraisal arrangements for QPS leads
- Standardised QPS agendas (evidence and risk based)
- Clearly defining the support from corporate teams associated with the quality safety and patient experience agenda and setting the expectation
- Introducing the integrated decision framework with Board development and the identification of priority areas for implementation
- Ensuring that the groups and committees across the Health Board are able to be responsive in promoting quality and patient safety at all levels of the organisation

Learning

The Health Board's commitment to learning and improvement is demonstrated in our Listening and Learning Framework, ensuring effective listening, learning and improving. The Framework brings structure to the way learning from incidents and person-centred feedback is captured. Ensuring learning follows a consistent process across the Health Board. This strengthens our commitment to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety and experience, as well as the experience of our workforce. We are developing a repository for learning which will allow us to review how learning will be identified, stored, triangulated, shared, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce.

We aim to become a true learning organisation to improve patient safety, experience and clinical effectiveness. We will respond to learning and guidance from our Quality Management System, local and national groups, adapting our plans and priorities to ensure we are doing the right things.

Key areas for delivery include:

- Identification of key quality and patient safety priorities and sources of information, to inform the learning and education agenda guided by the views of service users.

- Collaboration between corporate and educational teams to support the development of health professionals around key quality and safety priorities.
- Facilitation of multi professional approaches to education aligned to quality, safety and patient experience.
- Representation of learning and education on key quality and patient safety groups across the organisation.
- To facilitate divisions and directorates to prepare a standardised annual improvement strategy based on information collated from review of complaints, incidents, surveys and audits.
- To build capacity within teams to develop co-produced digital patient stories to support listening and learning Standardisation of training and education and competency records to avoid unwarranted variation in education approaches.
- Introducing a Covid Investigation Team to review cases of nosocomial transmission to identify breaches and ensure learning.

Quality Management System

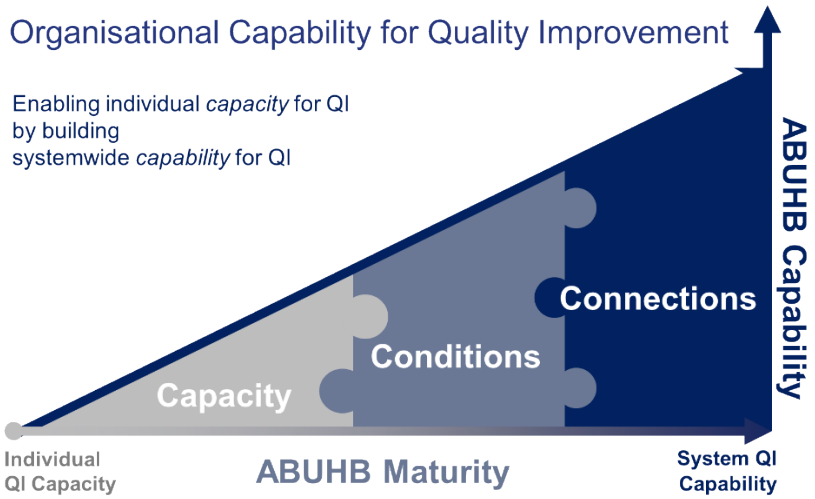
The key to delivery of our plans is to develop a 'Quality Management System' approach to embed a culture of learning: a culture where people listen, think, feel and act 'quality' - promoting openness and learning, continuous improvement and service transformation. This includes work to embed positive cultures of continuous improvement and working together. We will further develop our Quality Management System to routinely set meaningful targets, monitor, measure and report performance to ensure we provide excellent standards of care and set quality goals to continuously improve the services we provide.

Quality Improvement (QI)

"Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement."

Organisational QI Capability is "the organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance".

We will grow and mature our organisational capability for Quality Improvement (QI), by building capacity, conditions and connections which will enable staff to use QI methodology for solving complex problems, and in so doing provide a consistent approach to testing change ideas, learning and informing our decisions.



Data for Quality and Improvement

We will measure our progress and guide our actions towards becoming a learning organisation. Data for Quality and Improvement - both qualitative and quantitative data - are critical in understanding the quality-of-care provision and in evaluating and guiding improvement. Increasing the availability of data and the capability and capacity to analyse, understand and utilise the data will ensure a focus on quality.

Information Governance

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. Information Governance is about setting high standards for handling this information and giving the organisation the tools to achieve those standards.

The Health Board has a range of key roles that have responsibilities in relation to the information that it holds, uses and shares. The Medical Director is the Caldicott Guardian, the Director of Digital is the Senior Information Risk Owner (SIRO) and the Head of Information Governance is the Data Protection Officer (DPO).

During 2023/2024 the Health Board continued to develop the forums for the organisation to consider information governance requirements and to provide a consistent way in which it is managed. These forums allow the facilitation of processes and communications which ensures that all Data Protection obligations are met. Dashboards are produced to provide support and assistance ensuring compliance with training, dealing with complaints, incident and breach management. Annual reports are produced on progress made throughout the year and disseminated to the relevant divisions and boards.

The Health Board continues to be proactive in using the NHS Wales IG Toolkit to ensure consistency of policy, standards and interpretation of the law and regulation across NHS Wales organisations. The Health Board achieved a score of 95% for the last year.

The Wales Accord on the Sharing of Personal Information (WASPI) framework is embedded in the way in which the Health Board shares relevant information with its partner organisations.

During 2023/2024 there was a 6% increase in the number of Subject Access Requests (SARs) compared to the previous year, from 6296 in 2022/23 to 6724 in 2023/24. The largest proportion of requests received continues to be made by solicitors and legal services.

During this year there was a 12% increase in IG incidents reported by staff from the previous year, from 462 incidents in 2022-2023 to 531 incidents in 2023-2024.

There were 11 complaints made to the Information Commissioners Office (ICO) by complainants, with 9 not upheld and 2 awaiting a final outcome at the time of writing.

In 2023/24, there were no serious lapses in data security reported to the ICO by the Health Board

The Corporate Governance Code

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include Self-assessment; Internal and External Audit; and Independent Reviews.

The Board is clear that it is complying with the main principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales. A copy of the current self-assessment against the code is provided as **Attachment Three**.

Planning Arrangements

The Board approved the IMTP at its meeting of 29th March 2023 for submission to Welsh Government. The Plan reflected constructive discussions with Welsh Government ahead of submission informing how the

plan was developed. In approving the Plan at the March 2023 meeting, the Board recognised the significant challenges and risks going forward and in particular the financial context in which the Board were operating in to deliver the plan, with the Duty of Quality and Duty of Candour at the forefront alongside the drive for efficient and effective service delivery. The plan maintained a three year focus given the emphasis on long term sustainability but with a greater level on detail on year one delivery given the scale of challenge and ministerial expectations. Overall, the plan was based on a realistic assessment of delivery for the next three years, it was optimistic in outlook, recognising the need to build on the transformation of services over the last few years, and it focussed on sustainably making change to meet the long term needs of our communities.

On 25th August 2023 the Board received correspondence from Welsh Government noting that as the Board was unable to submit a balanced integrated medium-term plan (IMTP) for 2023-26, in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and in accordance with the NHS Planning Framework, Welsh Government would treat the 2023/4 submission as an Annual Plan.

In December 2024 the NHS Wales Planning Framework was issued by Welsh Government confirming the policy requirements of the 2024/25 planning cycle. As a result, in February 2024 the Health Board issued an Accountable Officer letter to Welsh Government confirming that, due to the ongoing financial challenges, the Health Board would be submitting an Annual Plan for 2024/25 with a three-year intent to balance the immediate system sustainability challenges with the population health and care needs.

In March 2024, the Board received and approved the Annual Plan for 2024/25, which was presented in the context of significant financial and operational challenges. The Annual Plan 2024/25 sets out a three-year intent to recognise the focus required to deliver performance and financial improvements over the next year, the medium-term ambitions to achieve financial and service sustainability and the longer-term ambitions to reduce the health inequalities experienced by our communities.

On 3rd May 2024, Welsh Government confirmed that the Annual Plan 2024/25, as approved by the Board in March 2024, was unsupportable. At the time of writing this report, the Health Board continues to review its Annual Plan 2024/25 in light of Welsh Government's feedback.

MANDATORY DISCLOSURE STATEMENTS

Equality, Diversity & Human Rights

It is a key priority for the Health Board to become a truly inclusive organisation which celebrates its diverse workforce, and where staff feel they are treated equally regardless of their ethnic background, gender, religion, sexual orientation, disability or age.

During the reporting period, extensive engagement and consultation has been carried out to shape our revised Strategic Equality Plan (2024-2028) . The Plan, published in March 2024, sets out our vision, aims and objectives to create a fair, just and equal culture across the Health Board over the next four years. 3 Objectives (what we call the 3Ps of inclusion) will form the basis of our proposed Strategic Equality Plan for 2024 -2028; **Our Patients, Our People and Our Population.**

The Health Board's Annual Equality Report outlines the work that was undertaken from 1 April 2023 to 31 March 2024 to progress the last year of our previous Strategic Equality Objectives. We also have duties to publish information about our workforce and how we use this data and this report includes the Equality Monitoring data based on a snapshot as of 31 March 2023.

Regulations introduced in 2017 require public, private and voluntary sector organisations, with 250 or more employees on a specified 'snapshot date' relevant to their sector, to report annually on their gender pay gap, using six different measures. A snapshot of 31 March 2023, identified a gender pay gap within the Health Board, showing a median pay difference in favour of males of 16.20%, down from 18.72% (31 March 2022).

We will be working in collaboration with Cardiff University during 2024 to undertake the analysis and action required by the 'equal pay duty', to ensure its effectiveness and to make a lasting impact on gender pay disparities in the Health Board.

To demonstrate our anti-racist commitment, the Health Board has committed to voluntarily publishing an annual Ethnicity Pay Gap Report. In the absence of a mandatory framework, we have aligned our reporting framework with the gender pay gap. However, in recognising the complexity of ethnicity pay reporting compared with gender pay reporting, we have made some changes to account for the different data sets.

Analysis of the Ethnicity Pay Gap data will inform the actions of our Equality Objectives to include positive action initiatives. We aim to continue to reduce our gender and ethnicity pay gap year on year, to create greater equality in our pay frameworks.

In addition to our annual reporting cycle, governance arrangements for ED&I ensure the board of directors receive regular assurance that the Health Board is meeting its Public Sector Equality Duty (PSED) requirements.

A review of our current Equality Impact Assessment (EqIA) process, during the reporting period, has identified that a structured program of embedding EQIA practice throughout the organisation is needed and that the practice of completing an EQIA should also be built into strategic and operational plans across directorates.

Governance arrangements have been put in place for scrutinising and approving EQIA's in the form of an EQIA Panel and an auditing process is being developed to better understand our levels of compliance.

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Further detail in this regard is included within the provisions note within the 2023/24 Financial Statements (Note 20).

Carbon Reduction Delivery Plans

The Health Board is unable to confirm compliance with the following statement:

"The organisation has undertaken risk assessment and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with."

As national work progresses with Welsh Government, and through Local Partnerships to develop an Adaptation Toolkit for health and social care organisations in Wales; which when released will allow the Health Board to undertake climate risk assessments using weather projection scenarios. The Health Board will then revisit these reporting requirements when appropriate and are able to comply.

Counter Fraud, anti-corruption and anti-bribery matters.

Aneurin Bevan University Health Board is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care.

The Health Board's Counter Fraud Team undertake proactive/preventative work with the intention of safeguarding the organisation from economic crime. Further information on the valuable work undertaken is available in the Counter Fraud Annual Report 2023/24.

Quality of Data

The Health Board makes every attempt to ensure the quality and robustness of its data and has regular checks in place to assure the accuracy of information relied upon. However, it is recognised that the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement. We have an on-going data quality improvement approach which routinely assesses the quality of our data across key clinical systems. Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

The Board relies upon independent and objective assurances, such as those provided by auditors and inspectors, to comment upon the effectiveness of the Board's assurance system. This assurance system includes reporting on financial performance, operational performance and quality of and associated outcomes.

Ministerial Directions & Welsh Health Circulars

The Welsh Government has previously issued Non-Statutory Instruments and reintroduced Welsh Health Circulars (WHCs) in 2014/15. Details of these and a record of any ministerial directions given is available on the Welsh Government website. A full detail of the WHCs and Ministerial Directions issued to the Health Board in 2023/24 and the Health Board's responding action is included at **Attachment 2**.

There was one Ministerial Direction issued in December 2019, to address the operational challenges arising as a consequence of pension tax arrangements. Further detail in this regard is included in provisions within the 2023/24 Financial Statements (Note 20).

Modern Slavery Act 2015 – Transparency in Supply Chains –

The Health Board is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds.

The code of practice sets out a number of commitments and Procurement Services on behalf of the Health Board has commenced the preparation of an action plan so that it can monitor progress against these. As an example, the Health Board have included the requirement for all suppliers to meet the Act in our standard NHS Terms and Conditions of contract.

Also, following the Transparency in Supply Chains consultation (2019), the UK Government has committed to extend section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales with a budget of £36m or more – This requires organisations to produce annual statements by 30th September of each financial year, that provide details of steps taken to prevent modern slavery in their operations and supply chain. A draft statement is being compiled by Procurement Service and Legal/Risk in readiness for the 30th of September deadline, reflecting the work to date, any further and emerging risks and appropriate mitigations.

The procurement function is a key area for ethical employment in supply chains. This is run by NHS Wales Shared Services Partnership (NWSSP) which is hosted by Velindre University NHS Trust (Velindre). More information can be found on the work done on the Health Board's behalf by NWSSP on the Shared Services Partnership website.

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation.

During 2023/24, the Board's Audit, Risk and Assurance Committee and, Patient Quality, Safety and Outcomes Committee played a key role in monitoring the effectiveness of internal control and the process for risk management. During 2023/24 work was undertaken to strengthen the reporting of risks to the Board and its Committees, with a revised Risk Management Framework approved by the Board in January 2024. Work to fully embed the revised framework will continue in 2024/25. The Board's Quality Strategy, approved in March 2023 and updated in February 2024, will ensure that the work of all regulators, inspectors and assurance bodies is mapped and evidenced in our assurance framework so that the Board is fully aware of this activity and the level of assurance it provides. We will also continue to strengthen arrangements for monitoring and reporting

progress in implementing recommendations arising from the work of auditors.

The Health Board also uses reports from Healthcare Inspectorate Wales, the Welsh Risk Pool and other inspectorates and regulatory bodies to inform the governance and assurance approaches established by the organisation. A tracking mechanism for these recommendations is also in place and progress in delivering these recommendations is overseen by the Patient Quality, Safety and Outcomes Committee via updates in respect of Inspections.

INTERNAL AUDIT

Internal audit provides the Chief Executive/Accountable Officer and the Board, via the Audit, Risk and Assurance Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Risk and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

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

The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

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 2023-24.

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.

Cyber Security (2022 - 2023)
Executive Lead – Chief Executive Officer
The review sought 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.

Unified Breast Unit at Ysbyty Ystrad Fawr (2023-2024)
Executive Lead – Chief Operating Officer
The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit, which was completed in December 2022.

Maternity Services Action Plan (2023-24)
The audit sought to review the governance arrangements in place and examine the tracking and progress of maternity related actions from key recent external reviews.

Early Supported Discharge – Stroke (2023-24)
The overall objective of the audit was to assess whether the arrangements in place for the early supported discharge of stroke patients are operating effectively.

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.

Reports included within the 2022/23 Internal Audit Plan, and reported in the Annual Governance Statement 2022/23, reported to the Audit, Risk and Assurance Committee in 2023/24:

Robotic Process Automation (2022-2023)
The review sought to ensure that the organisation has an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.

IT Strategy (2022-2023)
The review sought to ensure that the organisation has developed an appropriate target operating model to enable to delivery of the Digital Strategy.

Financial Sustainability (2022-2023)
The review sought to review the key financial management controls within Aneurin Bevan University Health Board including the development and monitoring of savings programmes required for financial sustainability.

Risk Management (2022 - 2023)
The review sought to provide an opinion of 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.

Monitoring Action Plans (2022-2023)
The review sought 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).

Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital (2022-2023)
The audit sought to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives i.e. time, cost, and quality.

Infection Prevention and Control (2022-2023)
The review sought to assess adherence to organisational policies and the Health and Care Standards in Wales.

Integrated Wellbeing Networks (2022-2023)
The review sought to provide an opinion on the Health Board's plan to further develop Integrated Wellbeing Networks across the region.

Dementia Services (2022-2023)
The review sought to ensure that Aneurin Bevan University Health Board has an appropriate process for Dementia Services.

Contract Management (2022-2023)
The audit sought to provide a review of the effectiveness of the management of operational contracts entered into by Aneurin Bevan University Health Board.

Mental Health Transformation (2022-2023)
The audit sought to provide a review of the controls in place for the projects that support the transformation of mental health services within Aneurin Bevan University Health Board.

Royal Gwent Hospital – Redevelopment & Expansion of Endoscopy Services (2022-2023)
The audit sought to review the delivery and management arrangements in place to progress the Royal Gwent Hospital Endoscopy Redevelopment & Expansion of Endoscopy Services project, and the performance to date against its key delivery objectives i.e., time, cost, and quality.

Bank Office and Temporary Workers (2022-2023)
The review sought to provide an opinion over the Bank Office and Temporary Workers process. As well as undertook a follow-up audit work on the process for contract and off-contract agency nursing.

Reports included within the 2023/24 Internal Audit Plan:

IMPT (2023-2024)
The review sought to provide an opinion over the controls to ensure the delivery of the IMTP / strategic objectives.

Safeguarding (2023-2024)
The audit sought to review the arrangements in place to ensure that the Health Board discharges its statutory responsibilities Safeguarding.

Clinical Coding (2023-2024)
The review sought to provide an opinion over the timely recording of Finished Consultant Episodes (FCE), in accordance with clinical coding standards.

Business Continuity Planning (2023-2024)
The review sought to review the arrangements that the Health Board has in place to maintain business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been Considered.

Integrated Performance Dashboard – Data Quality (2023-2024)
The review sought to assess the accuracy of data utilised within Integrated Performance Report (IPR) dashboard. In particular, focused on the accuracy of a sample of data used within the reporting of key metrics within the IPR dashboard i.e. that the source data utilised was consistent with the figures within the dashboard.

Stakeholder Engagement on IT Projects (2023-2024)
The audit sought to review the framework in place for stakeholder engagement on key IT projects.

Asset Management (2023-2024)
This review provided an opinion on the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets. The review focused on the roll-out of Radio Frequency (RFID) tagging.

Risk Management & Assurance (2023-24)
This review sought to assess the effectiveness of the risk management and assurance arrangements in place within the Health Board, to ensure that strategic objectives are achieved. This review focused on the management of risks within the Digital Services Directorate

Long Term Sickness Absence Management (2023-24)
The review sought to determine compliance with the NHS Wales Managing Absence at Work Policy and whether the Health Board is acting promptly and managing the interests of all parties within the process of managing long term sickness absence.

Medical Equipment & Devices (Ultrasound) (2023-24)
This review sought to provide an opinion over the management and tracking of ultrasound devices throughout the Health Board.

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.

The Management response and action plan to respond to the issues and weaknesses identified, which form part of the final reports, are considered by the Audit, Risk and Assurance Committee. The Committee monitor progress in line with agreed timescales via the Audit Recommendations Tracker.

In addition for all limited assurance rated reports, executive leads attend the Audit, Risk and Assurance Committee to provide assurance on the actions identified.

Reports included within the 2022/23 Internal Audit Plan, and reported in the Annual Governance Statement 2022/23, reported to the Audit, Risk and Assurance Committee in 2023/24:

Discharge Planning *(2022/23)*
This audit was undertaken to provide an opinion on the discharge planning process of the Health Board. It has focussed on the management and delivery of planned discharges and has included sample testing of patients admitted during April and May 2022.

The review 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 the sample testing.
In addition, Internal Audit 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.

An Action Plan is in place to address the recommendations. Collaboration with local authority colleagues has been established to allow the Health Board to

begin formally reporting the new Welsh Government data set that was required in relation to delayed discharge; however, the data required validation with LA colleagues.

Tredegar Health & Wellbeing Centre *(2022-23)*
The audit sought to review the management and governance arrangements in place to progress the Bevan Health & Wellbeing Centre.

An action plan to respond to the recommendations has been implemented, and the Centre opened to patients in January 2024.

Reports included in the 2023/24 Internal Audit Plan:

Facilities (2023-2024)
The review sought to provide assurance over whether appropriate stock processes are in place and whether applicable controls within the process for allocating/approving bank shifts are effective.

The main areas of concern raised during the audit related to the management of stock process. A Management Plan was in place and the team are committed to ensuring completion within the agreed timescales.

Estates Condition (2023-2024)
The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overall limited assurance was determined, notably due to the concerns that identified estate risks cannot be managed within existing funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

A management action plan is in place to respond to the recommendations, with work ongoing to develop clearer future plans and to determine areas of prioritisation.

Bevan Health and Wellbeing Centre (2023-24)
The audit sought to review the delivery and management arrangements in place to progress the Bevan Health & Wellbeing Centre.

The audit recognised the significant delays to the delivery of the project (currently circa 49.6 weeks) which are attributed to the Supply Chain Partner (SCP) and the corresponding delay in achieving the anticipated business case objectives.

The project faces significant challenges going forward as the contractor is likely to be operating at a loss – accordingly, maintaining reasonable performance from

the SCP through existing project management tools will be essential through to completion and handover

A management action plan is in place to respond to the recommendations.

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.

Reports included within the 2022/23 Internal Audit Plan, and reported in the Annual Governance Statement 2022/23, reported to the Audit, Risk and Assurance Committee in 2023/24:

Clinical Futures - Care Closer to Home (2022-2023)
The review sought to provide Aneurin Bevan University Health Board with a consolidated summary of audit work reported as part of the 2022/23 Internal Audit Plan that covers the area of Clinical Futures – Care Closer to Home. Whether the Health Board is on track to implement its overall objective of Care Closer to Home.

Reports included in the 2023/24 Internal Audit Plan:

Putting Things Right (2023-2024)
To review sought to determine if there are alternative processes or approaches that can be adopted by the Health Board to improve the overall management of Putting Things Right.

Follow-up of High Priority Recommendations (2023-2024)
The review sought to assess whether high-level internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Committee via the Audit Recommendation Tracking Tool (the 'Tracker')

Monitoring and Implementation of Audit Recommendations

The Audit, Risk and Assurance Committee monitors the implementation of audit recommendations. In April 2022, the Committee adopted a standard operating procedure (SOP) outlining the internal and external recommendation tracking process. This SOP provided rationale for how tracking recommendations benefits the organisation.

Since adopting the SOP, the Committee has received a report on audit recommendations at each meeting. The Committee has retained a focus on all outstanding recommendations, especially those predating the 2022/23 reporting year. Recognising progress, the Committee agreed in February

2024 to transition to quarterly reporting if all long-term recommendations were either completed or had a robust action plan for completion.

To provide assurance to the Committee and the Board, Internal Audit conducts an annual review of how audit recommendations have been implemented, specifically high priority recommendations to ensure they are addressed in an appropriate and timely manner. The review assesses the risk to the Health Board if the implementation of high-priority recommendations is delayed.

Rather than an assurance rating, the review provides an "opinion" summarising the status of actions completed and recommendations that remain open. The 2023/24 opinion found that management was closing actions appropriately and that there was sufficient evidence to support the closure of recommendations. It found that there were more recommendations closed in 2023/24 (13 actions) than in 2022/23 (seven actions), indicating that there has been a greater emphasis on implementing recommendations.

The outcome of the review assured the Audit, Risk and Assurance Committee that current controls over monitoring recommendations were sufficient and effective, and that, ongoing oversight has helped advance implementation efforts to strengthen operations and risk management.

Head of Internal Audit's Opinion for 2023/24

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

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2023/24 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

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

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

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

EXTERNAL AUDIT: AUDIT WALES STRUCTURED ASSESSMENT

The Audit Wales 2023 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.

Overall, the Audit Wales report stated:

"Overall, we found that while the Health Board governance arrangements are reasonably effective there is scope to provide clarity on both the impacts of actions set out in plans and actions taken to improve performance.'

The report went on to say that:

- **Board transparency, effectiveness, and cohesion** – the Health Board's Board and Committee arrangements are reasonably effective; however, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.

- **Corporate systems of assurance** – the Health Board is making good progress in developing and refining its systems of assurance. However, it will need to effectively embed new arrangements across the organisation to manage the finance, performance, and quality risks it faces.

- **Corporate approach to planning** – the Health Board is developing a new long-term strategy that provides an opportunity to plan more sustainable services. There are reasonably effective arrangements for developing corporate plans; however, progress reports do not provide enough detail to demonstrate delivery is on track.

- **Corporate approach to managing financial resources -** The Health Board is facing significant financial challenges. Whilst there are reasonably effective financial planning and financial management arrangements, the Health Board needs to establish control over savings delivery to prevent the financial position from deteriorating.

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

CONCLUSION

As Accountable Officer for Aneurin Bevan University Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board and its Executive Directors are alert to their accountabilities in respect of internal control and the Board has had in place during the year a system of providing assurance aligned to corporate objectives to assist with identification and management of risk.

During 2023/24, the Health Board proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Work will continue in 2024/25 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will also continue in 2024/25 to further embed risk management and assurance arrangements at a corporate and operational level. Implementation of further improvements identified by the Board through its self-assessment process, will see a further strengthening of the Board's effectiveness and the system of internal control in 2024/25.

This Annual Governance Statement confirms that Aneurin Bevan University Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board and the Executive Team has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board, I will continue to drive improvements and will seek to provide assurance for our citizens and stakeholders that the

services we provide are efficient, effective and appropriate, and are designed to meet patient needs and expectations.

It is disappointing that in 2023/24, Aneurin Bevan University Health Board was moved into 'Targeted Intervention' for planning and finance and 'Enhanced Monitoring' for performance and outcomes related to urgent and emergency care pathways as a result of extended waits for patients in ambulances and emergency department clinical assessment at the Grange University Hospital. Alongside the targeted action the Health Board is taking to deliver in-year improvements is the clear and emerging priorities for the strategic and tactical planning and reconfigurations required for services and estates to achieve sustainable services and financial balance by 2026/27. The Health Board maintains a relentless focus on recovering its position of being in routine performance monitoring.

It is widely known that the demands on the health and care system remain significantly pressured, increasing health inequalities, and sustained economic and cost of living challenges. The Health Board will therefore need to continually reflect and respond to the demands and challenges it faces in 2024/25 and beyond. I will ensure our Governance Framework considers and responds to this need.

Signed:

Nicola Prygodzicz
Chief Executive
Dated: XX 2024

Attachment One

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil Champion roles where they act as ambassadors for these matters.

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Independent Members					
Ann Lloyd	Chair		Chair of the Board	6 out of 6	
			Chair, Remuneration and Terms of Service Committee	3 out of 3	
			Chair, Partnerships, Population Health and Planning Committee	4 out of 4	
Pippa Britton	Vice Chair	(interim prior to 3rd May)	Member of the Board	5 out of 6	Mental Health
			Chair, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Chair, Mental Health Act Monitoring Committee	4 out of 4	
			Vice Chair, Remuneration and Terms of Service Committee	3 out of 3	
Shelley Bosson	Independent Member (Community)		Member of the Board	6 out of 6	Infection Prevention and Control
			Member, Audit, Risk and Assurance Committee	6 out of 6	
			Member, Finance and Performance Committee	3 out of 4	
Louise Wright	Independent Member (Trade Union)		Member of the Board	4 out of 6	Children and Young People
			Vice Chair, Patient Quality, Safety and Outcomes Committee	5 out of 6	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Chair, People and Culture Committee	3 out of 3	
			Member, Remuneration and Terms of Service Committee	3 out of 3	
			Vice Chair, Charitable Funds Committee	4 out of 4	
Richard G Clarke	Independent Member (Local Authority)		Member of the Board	3 out of 6	
			Vice Chair, Audit, Risk and Assurance Committee	5 out of 6	
			Chair, Finance and Performance Committee	4 out of 4	
			Member, Partnerships, Population Health and Planning Committee	3 out of 4	
Professor Helen Sweetland	Independent Member (University)		Member of the Board	6 out of 6	
			Member, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Member, People and Culture Committee	2 out of 3	
Paul Deneen	Independent Member (Community)		Member of the Board	6 out of 6	Equality
			Member, Audit, Risk and Assurance Committee (until August 2023)	3 out of 3	
			Member, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Vice Chair, People and Culture Committee	3 out of 3	
			Member, Mental Health Act Monitoring Committee	4 out of 4	
			Chair, Charitable Funds Committee	4 out of 4	
Iwan Jones			Member of the Board	6 out of 6	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
	Independent Member (Finance)		Chair, Audit, Risk and Assurance Committee	6 out of 6	
			Vice Chair, Finance and Performance Committee	3 out of 4	
			Member, Remuneration and Terms of Service Committee	3 out of 3	
			Member, Charitable Funds Committee	4 out of 4	
Dafydd Vaughan	Independent Member (Digital)		Member of the Board	6 out of 6	
			Member, People and Culture Committee	3 out of 3	
			Member, Finance and Performance Committee	4 out of 4	
			Member, Partnerships, Population Health and Planning Committee	4 out of 4	
Martin Blakebrough	Independent Member (Third Sector)	From 03/05/2023			
Penny Jones	Independent Member (Community)	From 15/01/2024	Member of the Board	1 out of 1	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Executive Directors					
Nicola Prygodzicz	Chief Executive		Member of the Board	6 out of 6	
			Member, Charitable Funds Committee	4 out of 4	
			Attendee as requested at all Board Committees		
Rob Holcombe	Director of Finance and Procurement		Member of the Board	6 out of 6	
			Member, Charitable Funds Committee	4 out of 4	
			Required Attendee: Audit, Finance and Risk Committee		
			Attendee as requested at all Board Committees		
Dr James Calvert	Medical Director/Deputy Chief Executive	From 24/09/2023	Member of the Board	4 out of 6	Caldicott
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Sarah Simmonds	Director of Workforce and OD		Member of the Board	6 out of 6	Raising Concerns Welsh Language
			Required attendee: People and Culture Committee		
			Attendee as requested at all Board Committees		
Hannah Evans	Director of Strategy, Planning and Partnerships		Member of the Board	6 out of 6	Emergency Planning
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Jennifer Winslade	Director of Nursing		Member of the Board	6 out of 6	
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Peter Carr	Director of Therapies and Health Sciences		Member of the Board	6 out of 6	Fire Safety Violence and Aggression
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Tracy Daszkiewicz	Director of Public Health		Member of the Board	5 out of 6	
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		
Leanne Watkins	Chief Operating Officer	From 1/05/2023	Member of the Board	5 out of 6	
			Required attendee: Mental Health Act Monitoring Committee		
			Attendee as requested at all Board Committees		
Directors in Attendance					
Paul Solloway	Director of Digital	From 28/06/2023	Attendee at the Board	5 out of 5	
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Director of Corporate Governance					
Rani Dash	Director of Corporate Governance		Attendee at the Board	6 out of 6	
			Attendee as requested at all Board Committees		

Quoracy of Meetings

Quorate	Non-Quorate

Board	**24 May 2023**	**19 July 2023**	**27 September 2023**	**22 November 2023**	**24 January 2024**	**27 March 2024**
Patient Quality, Safety and Outcomes Committee	**25 April 2023**	**20 June 2023**	**26 July 2023**	**11 October 2023**	**13 December 2023**	**23 February 2024**
Audit, Risk and Assurance Committee	**18 April 2023**	**23 May 2023**	**18 July 2023**	**12 September 2023**	**28 November 2023**	**6 February 2024**
Charitable Funds Committee	**28 June 2023**	**9 November 2023**	**22 January 2024**	**7 March 2024**		
Partnerships, Population Health and Planning Committee	**17 May 2023**	**12 July 2023**	**1 November 2023**	**31 January 2024**		
Mental Health Act Monitoring Committee	**19 June 2023**	**5 September 2023**	**6 December 2023**	**21 February 2024**		
Finance and Performance Committee	**21 June 2023**	**7 September 2023**	**21 December 2023**	**14 March 2024**		
People and Culture Committee	**13 June 2023**	**19 October 2023**	**22 February 2024**			
Remuneration and Terms of Service Committee	**26 April 2023**	**5 October 2023**	**17 January 2024**			

Attachment Two

Welsh Health Circulars

Date Issued	Name & No. of WHC	Progress	Rating
06/04/2023	**WHC/2023/009** COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group	Implemented as required locally - Currently a national issue with DHCW who are yet to identify eligible patients	**In Progress**
27/04/2023	**WHC/2023/11** Guidance on Self-harm: assessment, management and preventing recurrence	All GP practices in ABUHB made aware of the NICE guidance. The key recommendations associated with safeguarding, consent and confidentiality are part of the wider contractual Clinical Governance Toolkit and revalidation requirements of practitioners. All departments within MH&LD are aware of the NICE Guidelines, with information distributed for awareness through different methods within each department.	**In Progress**
09/06/2023	**WHC/2023/019** In support of prevention of suicide and self harm: GMC and NICE Guidance on Information disclosure for the protection of patients and others	This was issued via the All Wales Alert system on 9th June 2023 and cascaded to: GP Practice Managers, GP OOHs, Sessional GPs, HB Primary Care Managers, Medial Committees, Independent Hospitals / Hospices / Prisons	**Complete**
25/09/2023	**WHC/2023/008** SaBTO FAIR III recommendations to tissue and cell donation process	The tissue donation consent process is handled by NHSBT. The referral forms used by ABUHB do not ask any questions relating to consent that are impacted by the FAIR III recommendations. The ABUHB forms are predominantly an initial screening referral tool that then allows NHSBT to contact patient's families and proceed with the formal consent process.	**Complete**
03/11/2023	**WHC/2023/035** Update of guidance on clearance and management of healthcare workers living with a bloodborne virus (BBV) and a reminder of health clearance for tuberculosis		**In Progress**
09/11/2023	**WHC/2023/040** The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)	Relevant staff have attended webinar Lead staff identified to support and take forward Review of ABUHB guideline to incorporate standards New digital system flags NIPE check within 72 hours	**In Progress**
27/11/2023	**WHC/2023/039** Independent Authorisation of Blood Component Transfusion (IABT)	The WHC has been discussed by the Hospital Transfusion Committee (HTC). The Health Board's current policy and standard operating procedures for prescribing blood are to be reviewed in light of the WHC. The Health Board employs several non-medic BCT Authorisers who have undertaken the appropriate Wales training and compliance assessment. Each BCT Authoriser has a Consultant mentor, retains a portfolio	**In Progress**

Date Issued	Name & No. of WHC	Progress	Rating
		of practice and is regularly assessed to ensure that their practice is up to date and meets the correct standards.	
09/11/2023	**WHC/2023/038** Healthy Start eLearning Course	Course live on ESR	**Complete**
11/12/2023	**WHC/2023/044** Influenza (flu) Vaccination Programme deployment 'mop up' 2023-2024	Implemented in January 2024 as required. Borough pop-up clinics targeted 25% of GP practices with lowest flu vaccine uptake.	**Complete**
13/12/2023	**WHC/2023/046** All-Wales Control Framework for Flexible Workforce Capacity	Actions in place for phase 1 and reported to WG	**Complete**
14/12/2023	**WHC/2023/043** Vaccination of Healthcare Staff to Protect Against Measles	A task and finish group was set up on 15/12/23 in response to the WHC published on 14/12/23. The health board assessed and agreed staff high risk areas and staff MMR immunisation status was obtained via OH records and by request via WIS with staff consent. All staff who have not received a full 2 doses of MMR have been invited for an immunisation via text, email and targeted communications. Clinics have been mobilised at various locations for easy access and occupational health continue to provide weekly drop in sessions. The WHC was reinforced with primary care providers detailing steps to be taken to ensure that staff who are not fully vaccinated should make an appointment for their MMR.	**In progress**
21/12/2023	**WHC/2023/047** Influenza vaccines and eligible cohorts for the 2024 to 2025 season	Incorporated into plan development for 2024/25 season. Vaccine stock ordered in accordance with eligible cohorts and vaccine advice as per JCV	**In progress**
08/01/2024	**WHC/2023/048** Health Board allocations for 2024 to 2025	Implemented	**Complete**
11/01/2024	**WHC/2023/041** Refresh of the rare disease action plan 2022 to 2026	The Health Board recognises the actions required and has identified there are 5 specific actions that involve the Health Board and which have been acted upon.	**In progress**
20/02/2024	**WHC/2023/045** Recording dementia read codes	Dementia alerts are promoted on WPAS, so that we can see how patients with dementia are in the hospital at any given time. Dementia alerts is separate to dementia read code. These alerts will help us to improve our identification and awareness, hence we can incorporate dementia	**In progress**

Date Issued	Name & No. of WHC	Progress	Rating
		care plans as well. This will also help us with the National Audit of Dementia, which recommend us to identify those are at risk of harm in the hospital like inpatient fall but more importantly involve patient in the discharge process	
10/01/2024	**WHC/2024/001** Changes to the way individuals who are at highest risk from Covid-19 access lateral flow tests	Implemented as planned. Citizens being advised during antiviral triage on how to obtain tests from local pharmacies. Information also disseminated via ABUHB Social Media channels. Care homes informed of change to access – can still be used to expedite access to antiviral treatment. Local pharmacies participating in scheme supported by PCCS Pharmacy Advisor.	**Complete**
01/02/2024	**WHC/2024/005** Private obesity surgery and the Welsh NHS	The WHC is unclear and there remain concerns about rejection of ABUHB patients to Tier 4. Swansea Bay UHB is commissioned Tier 4 in Wales. A referral pathway has been developed for referral to SBUHB and has been provided to SBUHB for comment / agreement. The Pathway has been issued to AMD's, CD's. The Pathway and instructions have been issued to primary care. Also reviewing process and criteria at national level.	**In progress**
02/02/2024	**WHC/2024/008** Vaccination against measles - urgent action	Working group established with school nursing, vaccination service and public health. Schools identified with <90% uptake, and in-school vaccination MMR clinics planned for secondary school; community vaccine service offer for primary schools. Significant area of work to ensure data validity and rigour. Ongoing work to develop a vaccination outbreak response plan, pathways in place for rapid testing of suspected measles cases, and robust protocols in place for isolation arrangements for suspected measles cases.	**In progress**
12/02/2024	**WHC/2024/004** Assurance of aseptic preparation of medicines in NHS Wales (Sterile preparation of medicine)	Implemented as required	**Complete**
08/02/2024	**WHC/2024/009** Covid 19 spring booster vaccination programme 2024	Blended model of delivery with Primary Care and community pop-up clinics. Commenced on 2nd April in line with WHC and JCVI requirements.	**In progress**
27/02/2024	**WHC/2024/10** Welsh Sustainability Conference and Awards - New dates	Implemented as required	**Complete**

Date Issued	Name & No. of WHC	Progress	Rating
05/03/2024	**WHC/2024/02** Standards for Competency Assurance of Non-Medical Prescribers in Wales	In progress and on track	**In progress**
06/03/2024	**WHC/2024/011** Changes to dietary advice on feeding young children		**In progress**
19/03/2024	**WHC/2024/012** Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement	Preceptorship programme reviewed and refreshed, will be delivered centrally to ensure standardisation, equity and a prudent approach. On track with timescales for meeting submission of implementation plan to WG by 1st July. Several actions undertaken within the implementation plan to date.	**In progress**
22/03/2024	**WHC/2024/006** National Clinical Guidance for Stroke, for the UK and Ireland	Work to be presented to Stroke Delivery Group (5th June) and then to PQSOC (2nd July).	**In progress**
28/03/2024	**WHC/2024/017** Implementation of the Non-pay elements of the 2022-24 Collective Agreement	First phase response complete 31st May 2024. WHC to be added as standing agenda item to TUPF from June 2024	**In progress**

Ministerial Directives

Ministerial Directive	Date Issued	Action to demonstrate implementation/response	Rating
The Duty of Candour statutory guidance 2023	01/04/2023	Currently implementing this guidance as part of the delivery of the Health Board Strategy	In Progress
The NHS (General Medical Services Contracts) (Wales) Regulations 2023: integrated impact assessment	11/05/2023	The Unified Contract came into effect on 1st October 2023. Health Boards are currently awaiting WG to issue a template variation notice and GMS regulations template:	In Progress
The Primary Care (E-Prescribing pilot scheme) Directions 2023	01/06/2023	The first use of the Electronic Prescription Service (EPS) in Wales is on track to take place this autumn in Rhyl, North Wales. There will be several weeks of testing in Rhyl before EPS is rolled out across Wales in a phased approach in 2024. ABHB will support this as required alongside the Digital Medicines Transformation Portfolio.	In Progress
NHS (General Medical Services contracts) (Wales) Regulations 2023	17/07/2023	Health Boards received the confirmed copy and CVN relating to the 2006 contract on 10th December 2023. Meeting held 6th February 2024 with HBs, WG and Legal representatives to discuss. Identified that not all contracts had received a CVNs in 2006, therefore WG/Legal agreed to provide the necessary documents for this. The HB received the documents on 7th March 2024 from WG. The HB will be issuing bilateral agreements for all contracts, which also requires a 14 day notification period. All contracts must be issued by 18th March to meet this deadline. 20 x bilateral agreements/conformed copy have been prepared (18 that had the 2006 variation and 2 that had had new contracts since 2006). As of March 2024, x 44 agreements need to be prepared - 4 will require the new version of the contract – which has not yet been issued. The HB will endeavour to meet this deadline, however it will be very challenging.	In Progress
The National Health Service (Wales Eye Care services)(Wales) Directions 2023	26/10/2023	Implemented and payments reflected	Complete
The Low Vision Service Committee (Wales) Directions 2016 (with consolidated amendments)	26/10/2023	Implemented and payments reflected	Complete
The Eye Health Examination Service Committee (Wales) Directions 2016 (with consolidated amendments)	26/10/2023	Implemented	Complete

Ministerial Directive	Date Issued	Action to demonstrate implementation/response	Rating
Statement of general ophthalmic service remuneration and fee Directions.	24/11/2023	Implemented with relevant fees applied. Indicative budget allocation will need continuous review to ensure appropriate level of funding is available for each service. Some services to be implemented.	**In progress**
Death Certification reform	14/12/2023	Issued	**Complete**
The Medical Examiners (Wales) Regulations 2024	14/12/2023	Primarily affects the function of the Medical Examiner; the HB is considered a stakeholder.	**Complete**
The Eye Health Examination Service Committee (Wales) Directions 2016 (with consolidated amendments)	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board. Some aspects ongoing including WGOS 3 mobile providers and students.	**In Progress**
Wales Eye Care Services (Administrative List) (Wales) Directions 2024	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	**Complete**
The Low Vision Service Committee (Wales) Directions 2016 (with consolidated amendments)	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	**Complete**
The National Health Service (Wales Eye Care Services) (Wales)(No. 2) Directions 2024	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	**Complete**
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024	14/02/2024	Actioned automatically by SSP - confirmation has been sought from all independent GMS contractors that 5% uplift has been applied	**Complete**
The National Health Service Joint Commissioning Committee (Wales) Directions 2024	29/02/2024	Implemented	**Complete**

Attachment Three

Corporate governance in central government departments: code of good practice 2017

Aneurin Bevan University Health Board Assessment 2023/24

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.1 2.2	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust.	The Board meets in public on a bi-monthly basis. A forward work programme of Board Business is in place and approved on an annual basis. The work of the Board is guided and determined by its Standing Orders, Standing Financial Instructions and Schemes of Delegation. This provides the framework for delegation and decision making within the Health Board. The Board receives, as standing items to each meeting, finance, performance and corporate risk reports.	Comply	Board and Committee Minutes – demonstrate Scrutiny and support Audit Wales Structured Assessment 2023
2.3	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance	The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. The Board seeks an open culture and high standards in the ways in which its work is conducted. Board Members share corporate responsibility for all decisions and undertake a key role in monitoring the performance of the organisation. Progress against the Health Board Integrated Medium Term Plan 2022-2025, which adopts a life course approach, is presented to the Board on a quarterly basis. The Health Board's Standing Orders and Standing Financial Instructions are designed to translate the statutory requirements into day to day operating practice, and, together with the adoption of a Schedule	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2023 IMTP Value and Behaviours Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there.	of Decisions reserved to the Board of Directors; a Scheme of Decisions to Officers and Others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Board's Values and Behaviour Framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.		
2.4 3.10	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information	The Board meets at least six times a year and in addition holds an Annual General Meeting. Discussions, actions and decisions of all meetings of the Board and its Committees are formally recorded as minutes or action notes. The Board's role, as set out in its Standing Orders, is to: • Set the strategic direction for the organisation • Hold the organisation to account for performance and delivery • Set the tone and culture of the Board and the organisation The Board's business is therefore structured in this way and encompasses the five main areas set out in point 2.4.	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2023 Board and Committee Agenda and Meeting Papers
2.7	The Board also supports the accounting officer in the discharge of obligations set out in Managing Public Money for the proper conduct of business and maintenance of ethical standards.	The Board approves the Accountability Report, following scrutiny by the Audit, Risk and Assurance Committee, on an annual basis which includes the Statement by the Accountable Officer assuring the Board on the System of Internal Control.	Comply	Accountability Report

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.12	Where Board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes.	Any concerns raised at Board and Committee meetings are formally recorded in the minutes. The role of the Director of Corporate Governance is responsible for ensuring these matters are effectively managed, recorded and resolved where possible.	Comply	Board and Committee Agenda and Papers Role of the Director of Corporate Governance
3.1 3.11 3.12 3.13	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size.	Constitution is set out in the Health Board's Establishment Orders and the Health Board abides by this composition. The Health Board's Standing Orders also outlines the composition of the Board. The Board has a range of skills and expertise. Individuals are appointed to Independent Member or Executive roles based on their particular backgrounds and specialist knowledge. All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. The appointment panels for all Executive appointments, although organisation appointments, will have external independent assessors and Welsh Government representation. All Executive Directors are appointed to permanent NHS contracts. Independent Members are appointed for up to four years at any one time and can be re-appointed up to a maximum of eight years in the organisation. This is controlled by Welsh Government as they are Ministerial appointments.	Comply	Health Board Establishment Orders Standing Orders Board Member Induction checklist

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		The Board is provided with a range of information including performance information at Board and Committee Meetings. The format and content of these is informed by national standards and requirements and also locally requested information. Independent Member membership on Board Committees are rotated at appropriate times to ensure there is mix and balance of experience across all meetings		
3.2	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework.	The Board is constituted in accordance with the Health Board's Establishment Orders and Standing Orders	Comply	Health Board Establishment Orders Standing Orders
3.3	The Finance Director should be professionally qualified.	The Director of Finance and Procurement is professional qualified	Comply	Recruitment and appointment documentation for the Director of Finance and Procurement
3.5	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive	The Structured Assessment 2023 highlights that • *Independent Members participate fully in meetings, providing reasonably effective scrutiny on the information presented.* • *The Health Board has effective local induction arrangements for Executive Directors and Independent Members. These include meetings with other Board*	Comply	Audit Wales Structured Assessment 2023 Independent Member Induction Pack

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		• *Members and stakeholders alongside detailed training materials. Independent members indicated they feel supported in their ongoing learning and development*. There is a national programme of induction, in which all members are asked to participate. This is organised by Academi Wales and Welsh Government. Tailored programmes of induction is in place new Independent Members, and work continues to build a comprehensive programme for future use. There is also a programme of Board Development Sessions and Board Briefings and other training made available to the Board.		
3.15	The Board should agree and document in its board operating framework a *de minimis* threshold and mechanisms for board advice on the operation and delivery of policy proposals.	A forward work programme of Board Business is in place and approved on an annual basis. The Terms of Reference Operating Arrangements for the Board Committees articulate their remit. A forward work programme for each Committee is in place and approved on an annual basis.	Comply	Board Forward Work Programme Committee Forward Work Programmes Committee Terms of Reference
4.1	The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date	All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. All Executive appointments, although internal appointments have external independent assessors on the panels and also Welsh Government representation. The Director of Corporate Governance monitors the terms of office of Independent Members to ensure	Comply	Terms of Reference and Operating Arrangements for Board and Committees Board and Committee Forward Work Programmes

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the departmental family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience	succession planning is timely and managed in conjunction with the public appointments unit. Agenda Setting meetings are held with the Chair, Chief Executive and Director of Corporate Governance to plan the agenda and ensure sufficient time is allocated to the right things at Board meetings. Board Induction programme in place (as previously referenced), supplemented by ongoing Board Briefing and Board Development sessions. The Chair undertakes regular one to ones and annual Personal Appraisal and Development Reviews with all Independent Members. Agenda and papers for Board meetings are published one week prior to the meeting. Report templates have been revised to ensure to support the provision of appropriate and relevant information. Revised Corporate Governance Structure implemented during 2023. Head of Board Business appointed and Improving Board Business Plan in place to develop processes to improve the effectiveness and efficiency of the Board. The Board's Quality Strategy and Quality Assurance Framework ensure learning as a key pillar of quality, embedded across the organisation. The Board undertakes an assessment of its effectiveness using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for		

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		Leadership and Governance Developmental Reviews. During 2023/24, Committees undertook a mid-year self-assessment of their effectiveness to inform the Board's end of year assessment.		
4.5	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance	The Terms of Reference and operating arrangements are based on the model Standing Orders and ensure that roles and responsibilities of Board Committees capture scrutiny and assurance roles. The Chair reviews the membership of Committees on an annual basis to ensure the appropriate balance of skills and expertise and support succession planning.	Comply	Terms of Reference for Board Committees Standing Orders
4.6	The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate.	The Annual Governance Statement provides details on the membership of the Board and Committee and the attendance record of individuals at these meetings.	Comply	Annual Governance Statement
4.10	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate.	Independent Members of the Board have direct access to members of the executive team in order to seek further information or clarification on issues as and when they arise. Regular Board Development sessions and Board briefings are also held to ensure that Board members are kept up to date on the breadth of issues. The Director of Corporate Governance acts as an independent voice within the organisation to advise and support the Board on governance matters and its	Comply	Board Secretary role profile

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		approach to openness and transparency. The Director of Corporate Governance is responsible for developing the programmes of work for the Board and Committees of the organisation. Ensuring that agenda and papers are developed and reviewed prior to publication to ensure the quality or reports and maximum transparency and openness in the way in which the organisation conducts its business.		
4.11	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include: – developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention – ensuring good information flows within the board and its committees and between senior management and non-executive board members, including: – challenging and ensuring the quality of board papers and board information – ensuring board papers are received by board members according to a timetable agreed by the board – providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements – ensuring the board follows due process – providing assurance to the board that the department: – complies with government policy, as set out in the code	The Director of Corporate Governance undertakes these roles as Board Secretary for the Health Board	Comply	Board Secretary role description Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	– adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts) – acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up – arranging induction and professional development of board members (including ministers)			
4.14	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties).	Individual annual assessment of Board Executive Directors is undertaken by the Chief Executive and Independent Members by the Chair, with the former reported to the Remuneration and Terms of Service Committee.	Comply	Appraisal documentation and process
4.15	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed.	Board Members complete annual Declarations of Interest and this register is available on the Health Board's website. Declarations of Interest in relation to items on the agenda are also sought at each Board and Committee meeting and are formally recorded within the minutes. Standards of Business Conduct for Employees in place and details responsibilities for declarations of interests.	Comply	Declarations of Interest Register Standards of Business Conduct for Employees Policy

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
5.1 5.8	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: – an audit and risk assurance committee, chaired by a suitably experienced non-executive board member – an internal audit service operating to Public Sector Internal Audit Standards1 – sponsor teams of the department's key ALBs	The Health Board has established an Audit, Risk and Assurance Committee, chaired by the Independent Member Finance lead. NWSSP Internal Audit Services are appointed as the Health Boards Internal Auditors The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.	Comply	Terms of Reference and Operating Arrangements for the Audit, Risk and Assurance Committee Accountability Report Audit Wales Structured Assessment
5.2 5.13	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year. The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board.	The Audit, Risk and Assurance Committee is responsible for reviewing the system of governance and assurance established within the Health Board and the arrangements for internal control, including risk management for the organisation and, in particular, advises on the Annual Governance Statement signed by the Chief Executive. The Governance Statement is included within the Accountability Report which is considered by the Audit, Risk and Assurance Committee prior to approval by the Board.	Comply	Accountability Report
5.3 5.10	The board's regular agenda should include scrutinising and advising on risk management.	The Health Board approve the Risk Management Strategy and Board Assurance Framework. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.	Comply	Board and Committee Agendas and papers Risk Management Strategy

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		A Corporate Risk Register is maintained and considered at each Board Meeting, and by the Audit, Risk and Assurance Committee. Each Committee monitors risks associated with its portfolio and provides assurance reports on these to the Board.		Board Assurance Framework Corporate Risk Register
5.4 5.9 5.11 5.12 5.14 5.15	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook.* The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities	An Audit, Risk and Assurance Committee is established. The Terms of Reference and Operating Arrangements for the ARA Committee are clear in relation to authority and delegated responsibilities. These Terms of Reference are published on the Health Board's website. Full secretariat support is provided by the Corporate Governance Team. 5 Independent Members comprise the Audit, Risk and Assurance Committee. The Board Assurance Framework is scrutinised by the Audit, Risk and Assurance Committee.	Comply	Terms of Reference and Operating Arrangements for Audit, Risk and Assurance Committee Board Assurance Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.			
5.5	The head of internal audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs.	The role of Head of Internal Audit is clearly set out in the Health Board's Standing Orders. The Head of Internal Audit attends all meetings of the Audit, Risk and Assurance Committee. Audit Wales and Internal Audit have a routine invite to all Board and Committee meetings.	Comply	Standing Orders Terms of Reference for the Audit, Risk and Assurance Committee
5.6 5.7 5.10	The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently. The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams	The Health Board has an agreed Risk Management Strategy. Development work continues to review and refine the Risk Management Strategy, with a Board Development session held in March 2022 focused on strategic risk management and assurance arrangements, including risk appetite and tolerance which will be a key element of the updated Risk Management Strategy. The Risk Management Strategy articulates a clear risk escalation pathway. A Risk Management Community of Practice is in place, led by the Head of Corporate Services, Risk and Assurance.	Comply	Risk Management Strategy Corporate Risk Register

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role.			

Remuneration and Staff Report 2023/24

The Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared by NHS bodies providing information under the headings in SI 2008 No 410, made to the extent that they are relevant. The Remuneration Report contains information about senior managers remuneration. The definition of 'Senior Manager' is: "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and Terms of Service for Executive Directors and the Chief Executive are agreed, and kept under review, by the Board's Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Directors (the latter with the advice of the Chief Executive). In 2023/24, the Remuneration and Terms of Service Committee was chaired by the Health Board's Chair, Ann Lloyd CBE, and the membership included the following Members:

- Pippa Britton, Vice Chair of the Board;
- Iwan Jones, Chair of Audit, Risk and Assurance Committee
- Louise Wright, Independent Member (Trade Union).

Meetings are minuted and decisions fully recorded.

Independent Member Remuneration

Remuneration for Independent Members is determined by the Welsh Government, along with the tenure of appointments. Details of Independent Members' remuneration for the 2023/24 financial year, together with comparators are given in Tables below.

Directors' Remuneration

Details of Directors' remuneration for the 2023/24 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2023/24, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Remuneration and Terms of Service Committee also reviews objectives set for Executive Directors and assesses performance against those objectives when considering recommendations in respect of annual pay uplifts. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month notice period. Conditions are in line with those set by Welsh Government as part of the NHS Reform Programme of 2009.

The Remuneration and Terms of Service Committee considers issues of equality and diversity when evaluating and setting remuneration for Directors', particularly in relation to gender and ethnicity in pay levels, in line with Welsh Government's Framework.

Salary and Pension Disclosure Table: Salaries and Allowances

Name	Title	2023-24 Full Year Equivalent Salary (bands of £5,000) £000	2023-24 Salary (bands of £5,000) £000	2023-24 Benefits in kind (to nearest £100) £00	2023-24 Pension Benefits £000	2023-24 Total (bands of £5,000) £000	2022-23 Full Year Equivalent Salary (bands of £5,000) £000	2022-23 Salary (bands of £5,000) £000	2022-23 Benefits in kind (to nearest £100) £00	2022-23 Pension Benefits £000	2022-23 Total (bands of £5,000) £000
Executive Directors											
Glyn Jones	Deputy Chief Executive (From 05.09.22 Until 23.09.22)						205 - 210	100 - 105	0	32	135 - 140
	Interim Chief Executive (From 01.11.21 Until 04.09.22)										
Nicola Prygodzicz	Chief Executive (From 05.09.22)	225 - 230	205 - 210	12	62	270 - 275	215 - 220	165 - 170	12	282	450 - 455
	Director of Planning, Performance, Digital & IT / Interim Deputy Chief Executive (Until 04.09.22)						125 - 130				
Dr James Calvert	Medical Director / Deputy Chief Executive (From 24.09.22)	215 - 220	215 - 220	0	57	275 - 280	190 - 195	195 - 200	0	66	260 - 265
	Medical Director (Until 23.09.22)						185 - 190				
Robert Holcombe	Director of Finance and Procurement (From 14.11.22)	160 - 165	160 - 165	0	0	160 - 165	150 - 155	155 - 160	0	200	355 - 360
	Interim Director of Finance, Procurement and Value Based Healthcare (Until 13.11.22)						150 - 155				
Chris Dawson-Morris	Interim Director of Planning and Performance (From 05.09.22 Until 02.04.23)	125 - 130	0 - 5	0	0	0 - 5	125 - 130	75 - 80	0	15	90 - 95
Hannah Evans	Director of Strategy, Planning and Partnerships (From 01.04.23)	145 - 150	145 - 150	0	82	230 - 235					
Jennifer Winslade	Director of Nursing (From 08.08.22)	145 - 150	145 - 150	7	0	150 - 155	135 - 140	90 - 95	0	59	150 - 155
Linda Alexander	Director of Nursing (From 25.06.22 Until 14.08.22)							15 - 20	0	10	25 - 30
Rhiannon Jones	Director of Nursing (Until 05.07.22)							35 - 40	0	7	40 - 45
Sarah Simmonds	Director of Workforce and Organisational Development	145 - 150	150 - 155	15	51	200 - 205	140 - 145	140 - 145	15	72	215 - 220
Dr Sarah Aitken	Director of Public Health and Strategic Partnerships (Until 05.01.23)						130 - 135	95 - 100	0	0	95 - 100
Peter Carr	Director of Therapies and Health Sciences	125 - 130	120 - 125	0	0	120 125	110 - 115	110 - 115	25	16	130 - 135
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (Until 30.04.23)	135 - 140	10 - 15	0	0	10 - 15	145 - 150	145 - 150	0	212	360 - 365
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships (From 01.04.23)	140 - 145	140 - 145	0	35	175 - 180					
Chief Operating Officer											
Leanne Watkins	Chief Operating Officer (From 01.05.23)	145 - 150	150 - 155	17	121	270 - 275					
	Director of Operations (From 17.03.22 Until 30.04.23)						120 - 125	120 - 125	17	32	155 - 160
Other Directors											
Rani Dash	Director of Corporate Governance	120 - 125	125 - 130	45	64	195 - 200	110 - 115	110 - 115	56	41	155 - 160
Paul Solloway	Director of Digital (From 28.06.23)	125 - 130	90 - 95	6	214	305 - 310					

Special Advisor to the Board

Philip Robson	Special Advisor to the Board	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20

Independent Members

Ann Lloyd CBE	Chair	65 - 70	65 - 70	0	0	65 - 70	65 - 70	65 - 70	0	0	65 - 70
Pippa Britton	Vice Chair (Interim Until 02.05.23)	55 - 60	55 - 60	0	0	55 - 60	55 - 60	55 - 60	0	0	55 - 60
Katija Dew	Independent Member (Third/Voluntary Sector) (Until 31.03.23)						15 - 20	15 - 20	0	0	15 - 20
Martin Blakebrough	Independent Member (Third Sector) (From 03.05.23)	15 - 20	10 - 15	0	0	10 - 15					
Prof. Helen Sweetland	Independent Member (University)	0	0	0	0	0	0	0	0	0	0
Richard Clark	Independent Member (Local Authority)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Paul Deneen	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Shelley Bosson	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Penny Jones	Independent Member (Community) (From 15.01.24)	15 - 20	15 - 20	0	0	15 - 20					
Dafydd Vaughan	Independent Member (Digital) (From 09.05.22)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	10 - 15	0	0	10 - 15
Iwan Jones	Independent Member (Finance) (From 04.04.22)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Louise Wright	Independent Member (Trade Union)	0	0	0	0	0	0	0	0	0	0
Keith Sutcliffe	Associate Independent Member (Chair of Stakeholder Group) (Until 30.11.22)						0	0	0	0	0

	2023-24	
	Pay	Ratio
Band of Highest paid Director's Total Remuneration £000	225 - 230	
25th percentile pay £	28,581	8.0
Median pay £	35,922	6.3
75th percentile pay £	46,686	4.9

2022-23	
Pay	Ratio
215 - 220	
26,282	8.3
33,428	6.5
43,078	5.0

Salary has been reported as gross pay, which is before the deduction of any salary sacrifice schemes. During 2023-24 the following salary was sacrificed.

	Lease Car Scheme	Home Electronics Scheme
	£'000	£'000
Nicola Prygodzicz	7	
Jennifer Winslade	6	
Sarah Simmonds	8	
Leanne Watkins	11	<1
Rani Dash	7	
Paul Solloway	6	

The post of Special Advisor to the Board has been disclosed as it has been deemed to have an influence over board decisions.
The amount of pension benefits for the year which contributes to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes and is based on information received from NHS BSA Pensions Agency.

The value of pension benefits is calculated as follows:
(real increase in pension* x20) + (real increase in any lump sum) – (contributions made by member)
*excluding increases due to inflation or any increase of decrease due to a transfer of pension rights

This is not an amount which has been paid to an individual by the Health Board during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a persons salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Robert Holcombe, Jennifer Winslade, Peter Carr and Dr Chris O'Connor are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Due to the deadline for requests of pension entitlements issued by NHS Business Services Authority the reported pension benefits exclude the affect of the revised salary applied in March 2024.

During 2023-24 the Health Board has paid two former chief executives who were on secondment to Welsh Government. Andrew Goodall has been seconded since 8th June 2014 and Judith Paget had been seconded since 1st November 2021 until 30th November 2023. The details of the remuneration received by these individuals is disclosed in the accounts of the Welsh Government, and the Health Board was reimbursed for the employment costs incurred. The salary for Andrew Goodall was between £230,000 to £235,000 (£215,000 to £220,000 2022-23) and for Judith Paget between £155,000 to £160,000 (£215,000 to £220,000 2022-23).

Salary and Pension entitlements of Senior Managers Pension Benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Nicola Prygodzicz	Chief Executive	0.0 - 2.5	47.5 - 50.0	70 - 75	195 - 200	1650	1175	328	0
Dr James Calvert	Medical Director / Deputy Chief Executive	0.0 - 2.5	45.0 - 47.5	85 - 90	235 - 240	2114	1589	337	0
Robert Holcombe	Director of Finance and Procurement	(2.5) - 0.0	32.5 - 35.0	55 - 60	145 - 150	1290	965	206	0
Chris Dawson-Morris	Interim Director of Planning and Performance (Until 02.04.23)	0.0 - 2.5	0.0	10 - 15	0	133	78	0	0
Hannah Evans	Director of Strategy, Planning and Partnerships (From 01.04.23)	2.5 - 5.0	42.5 - 45.0	40 - 45	105 - 110	846	527	246	0
Jennifer Winslade	Director of Nursing	(7.5) - (5.0)	25.0 - 27.5	55 - 60	150 - 155	1316	1088	98	0
Sarah Simmonds	Director of Workforce and Organisational Development	0.0 - 2.5	30.0 - 32.5	35 - 40	90 - 95	736	479	190	0
Peter Carr	Director of Therapies and Health Sciences	(7.5) - (5.0)	17.5 - 20.0	40 - 45	110 - 115	937	753	91	0
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (Until 30.04.23)	(2.5) - 0.0	0.0 - 2.5	45 - 50	115 - 120	993	909	(2)	0
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships (From 01.04.23)	2.5 - 5.0	0.0	15 - 20	0	224	166	22	0
Leanne Watkins	Chief Operating Officer (From 01.05.23) / Director of Operations (Until 30.04.23)	2.5 - 5.0	45.0 - 47.5	50 - 55	135 - 140	1061	671	304	0
Rani Dash	Director of Corporate Governance	0.0 - 2.5	30.0 - 32.5	25 - 30	70 - 75	517	299	172	0
Paul Solloway	Director of Digital (From 28.06.23)	10.0 - 12.5	25.0 - 27.5	35 - 40	100 - 105	809	471	209	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Due to the deadline for requests of pension entitlements issued by NHS Business Services Authority the reported pension entitlements exclude the affect of the revised pay applied in March 2024.

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

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

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

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

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

The Health Board have included a Scheme Pay provision of £604,453 (as notified by Welsh Government) within these accounts.

Remuneration Relationship

9.6 Fair Pay disclosures								
9.6.1 Remuneration Relationship								
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.								
		2023-24	**2023-24**	**2023-24**		2022-23	2022-23	2022-23
		£000	**£000**	**£000**		£000	£000	£000
Total pay and benefits		**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
	25th percentile pay ratio	**225 - 230**	**29**	**8.0**		215 - 220	26	8.3
	Median pay	**225 - 230**	**36**	**6.3**		215 - 220	33	6.5
	75th percentile pay ratio	**225 - 230**	**47**	**4.9**		215 - 220	43	5.0
Salary component of total pay and benefits								
	25th percentile pay ratio	**225 - 230**	**29**			215 - 220	26	
	Median pay	**225 - 230**	**36**			215 - 220	33	
	75th percentile pay ratio	**225 - 230**	**47**			215 - 220	43	
Total pay and benefits		**Highest Paid Director**	**Employee**	**Ratio**		Highest Paid Director	Employee	Ratio
	25th percentile pay ratio	**225 - 230**	**29**	**8.0**		215 - 220	26	8.3
	Median pay	**225 - 230**	**36**	**6.3**		215 - 220	33	6.5
	75th percentile pay ratio	**225 - 230**	**47**	**4.9**		215 - 220	43	5.0
Salary component of total pay and benefits								
	25th percentile pay ratio	**225 - 230**	**29**			215 - 220	26	
	Median pay	**225 - 230**	**36**			215 - 220	33	
	75th percentile pay ratio	**225 - 230**	**47**			215 - 220	43	

In 2023-24, 10 (2022-23, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £15k to £383k (2022-23, £14k to £416k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

There has been a decrease in the pay ratio which attributable to the increase in the chief executive / highest paid director salary being less than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	2022-23 to 2023-24	2021-22 to 2022-23
% Change from previous financial year in respect of Chief Executive	%	%
Salary and allowances	5	7
Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	5	7
Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	7	5
Performance pay and bonuses	0	0

STAFF REPORT

Staff Numbers

9.2 Average number of employees	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2022-23
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and boarc	2,743	12	6	0	0	0	2,761	2,727
Medical and dental	839	8	73	404	0	14	1,338	1,259
Nursing, midwifery registered	3,815	1	196	0	0	0	4,012	3,991
Professional, Scientific, and tech	449	0	3	0	0	0	452	462
Additional Clinical Services	2,804	0	37	0	0	0	2,841	2,877
Allied Health Professions	857	0	19	0	0	0	876	829
Healthcare Scientists	242	0	5	0	0	0	247	245
Estates and Ancilliary	995	0	98	0	0	0	1,093	1,146
Students	9	0	0	0	0	0	9	10
Total	12,753	21	437	404	0	14	13,629	13,546

The data above represents an average over 52 weeks of the year and includes agency workers and specialist trainees. There has been a small increase in staff in post overall. The strategic work to reduce agency over the past 12 months has been successful along with increases in most clinical roles.

Turnover has reduced from the previous year to the pre-pandemic rates of 9.1%.

In the last 12 months staff in post has increased by 3.3%. The increases have been within Additional Clinical Services (9.74%) because of a targeted recruitment campaign that has taken place over the last 18 months to fill Healthcare Support Worker vacancies and reduce agency usage. Registered Nursing numbers have increased by 3% through an International Recruitment Campaign. Through a Retention Programme we have supported turnover figures returning to pre-covid levels of 9%, a reduction of circa 2%.

In terms of administration increases, there has been an overall increase in administration resources by 65 WTE (2%). These increases are broadly

distributed across divisions. A number are associated with increases for specific programme delivery e.g. medical e- systems, recruitment, digital/ data/ technology and informatics and Public Health wellbeing. Other increases have been due to regional programmes such as hosting of the Regional Ophthalmology Booking function as well as other local service developments such as opening of the Breast Unit, Musculo Skeletal and therapy initiatives, and local restructures.

Staff Composition

The table below provides the breakdown of staff numbers per discipline and professional group within the Health Board.

The gender breakdown for all staff groups as at 31 March 2024 is provided below:

	2023-2024			2022-2023			2021-2022		
	Directors	**WTE**		**Directors**	**WTE**	**%**	**Directors**	**WTE**	**%**
Female	8	10,413	79.60%	5	10,127	80.06%	4.78	9722.1	79.27%
Male	4	2669	20.40%	6	2521.5	19.94%	6	2543.1	20.73%
Total	**12**	**13,082.00**		**11**	**12,648.50**		**10.78**	**12,265.20**	

The total number of staff per discipline will differ from the staff numbers shown in the gender breakdown table as the gender figures are based on a point in time as of 31 March 2024 whereas the staff per discipline numbers represent the average over a 52 week period of staff in post.

Sickness Absence Data

The Health Board's sickness absence rate for 2023/2024 is 6.10%, a decrease in sickness related absence from 6.74% in 2022/2023 which was a reduction in the previous year of 6.30% in 2021/2022. Sickness absence remained above 6% from August 2023 to February 2024 reducing to 5.9%, in March 2024. January 2024 recorded the highest sickness absence at 6.79%.

The table below provides the sickness absence trend data for the Health Board over the last nine years.

Sickness Absence	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Days Lost (Short Term <28 days)	61261	53097	60406	54759	68229	60411	79761	98573	85948
Days Lost (Long Term >28 days)	144562	147711	153345	162684	194289	188778	203781	205131	207218
Total Days Lost	205823	200808	213751	217443	262518	249189	283542	303704	293166
Total Staff Years	902	880	937	954	1156	1093	1249	1350	1308
Average Working Days Lost	14.7	14.2	15.2	15.2	15.2	16	17.2	18	17.5
Total staff employed in period (headcount)	14020	14155	10412	14334	14835	15528	15863	16245	16735
Total staff employed with no absence (headcount)	4919	5803	4848	5016	5402	6055	5710	5035	5188
Percentage staff with no sick	40%	41%	37%	35%	36%	39%	36%	31%	31%

Over the past 9 years, the average working days lost per individual has increased slightly year on year, however in 2023/24 average sickness days lost has reduced to 17.5 days per individual employee.

Staff Policies

Aneurin Bevan University Health Board has a robust framework of Policies and Procedures to enable appropriate action in order to discharge its statutory requirements and appropriate accountability for:

- Giving full and fair consideration to applications for employment made by disabled persons or other protected characteristics, having regard to their particular aptitudes and abilities;
- Continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- Otherwise for the training, career development and promotion of staff with protected characteristics persons employed by the Health Board.

Staff policies applied during the reporting period 1 April 2023 to 31 March 2024 include:

- Employment of Disabled People
- Equality and Diversity Policy
- NHS Wales Managing Attendance at Work Policy
- NHS Wales Respect and Resolution Policy
- Speaking Up Safely Framework

All policies are developed in partnership with staff and trade union colleagues and are assessed via an Equality Impact Assessment to ensure that every policy is fair and does not present barriers to participation or disadvantage any protected groups from participation.

Employee Relations Matters

Details of the number of disciplinary cases between 1 April 2023 to 31 March 2024 is provided below:

Disciplinary Cases	Dismissals	Appeals	Employment Tribunals	Upholding Professional Standards in Wales
63	2	2	3	9

The above activity demonstrates a 72% reduction in disciplinary cases since launching the avoidable employee harm work programme in 2021/22. The purpose of the avoidable employee harm programme is to find other mechanisms to consider allegations of minor misconduct or unintended errors made by the workforce (e.g. reflective practice, training).

Payment to Past Directors

No payments have been made to any person who was not a director at the time the payment was made, but who had been a director of the Health Board previously.

Expenditure on Consultancy

Sum of GL Balance Txn Name/Pay WTE	C Level	Description	Total
ATTAIN HEALTH MANAGEMENT SERVICES LTD	CPLN: Director of Planning	RPB - Strategic Capital Consultancy review of Services	101,935
CGI IT UK LTD	CDDS: Digital, Data & Technology	G CLOUD Consultancy - Workstream Business Case consultation for new Clinical Portal	93,767
DALTON CONSULTING	CCEO: Chief Exec/Non Execs	Advisory Support to Exec Team	4,150
ERNST & YOUNG LLP	CFIN: Finance Director	VAT Consultancy & Advisory Services	102,466
HUGH IRWIN ASSOCIATES LTD	CPLN: Director of Planning	RPB - Strategic Capital Consultancy review of Services	1,600
OXFORD BROOKES ENTERPRISES LTD	CPLN: Director of Planning	RPB - Strategic Capital Consultancy review of Services	14,110
SIRIUS PARTNERS	CPLN: Director of Planning	RPB - Strategic Capital Consultancy review of Services	16,338
SUPPORTIVE CARE UK LTD	CLPC: Primary Care & Community Services	Consultant Support to the Specialist Palliative Care Service	76,050
SYNBIOTIX SOLUTIONS LTD	CNON: Estates and Facilities Division	VAT reclaim from Catering Consultancy Invoice from 22/23	-131
Grand Total			410,285

Tax Assurance for Off-payroll Engagements

Table 1 : For all off-Payroll engagements as of 31 March 2024, for more than £245 per day

No. of exisiting Engagements as of 31 March 2024	3
Of which, the number that have existed:	
for less than one year at time of reporting	1
for between one and two years at time of reporting	0
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	2

Annex 1 (Continued)Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2024, earning £245 per day or greater

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	
Number of individuals that have been deemed " board members, and/or, senior officials with significant financial responsibility" , during the financial year. This figure should include both off-payroll and on-payroll engagements.	10

Exit Packages and Severance Payments

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2023-24 Number of compulsory redundancies	2023-24 Number of other departures	2023-24 Total number of exit packages	2023-24 Number of departures where special payments have been made	2022-23 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	1	0
£25,000 to £50,000	0	0	0	0	1
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	1	1

Exit packages cost band (including any special payment element)	2023-24 Cost of compulsory redundancies	2023-24 Cost of other departures	2023-24 Total cost of exit packages	2023-24 Cost of special element included in exit packages	2022-23 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	24,254	0
£25,000 to £50,000	0	0	0	0	32,197
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	24,254	32,197

Exit costs paid in year of departure	Total paid in year 2023-24	Total paid in year 2022-23
	£	£
Exit costs paid in year	24,254	0
Total	24,254	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Health Board has not approved any VERS in 2023-24.

Additional requirement as per FReM
£0.00 exit costs were paid in 2023-24, relating to 2022-23 (the year of departure).

Senedd Cymru / Welsh Parliamentary Accountability and Audit Report 2023/24

Regularity of Expenditure
Regularity of Expenditure Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the

legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

Aneurin Bevan University Health Board ensures that the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Health Board's Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
- prepare them on a going concern basis on the presumption that the services of the Health Board will continue in operation.

Fees and charges

Where the Health Board undertakes activities that are not funded directly by the Welsh Government the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 (page XX) of the Annual Accounts 2023/24. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

The Health Board incurred costs amounting to £0.455m for the provision of the statutory audit by the Wales Audit Office.

Managing public money

This is the required Statement for Public Sector Information Holders as referenced in the Directors' Report. In line with other Welsh NHS bodies, the Health Board has adopted standing financial instructions which enforce the principles outlined in HM Treasury guidance 'Managing Public Money' which sets out the main principles for dealing with resources in the UK public sector. As a result, the Health Board should have complied with the cost allocation and charging requirements of this guidance. The Health Board has not been made aware of any instances where this has not been done.

Remote Contingent Liabilities
This disclosure was introduced for the first time in 2015-16. It shows those contingent liabilities that are deemed to be extremely remote and have not been previously disclosed within the normal contingent liability note within the accounts.

The remote contingent liabilities cost consists of 3 medical negligence cases and 1 GP Indemnity case in 2023-24 (11 medical negligence cases in 2022-23). Should these cases progress the majority of the costs incurred, in excess of £25k per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

Nicola Prygodzicz
Chief Executive **Date: XX July 2024**

THE CERTIFICATE AND INDEPENDENT AUDITOR'S REPORT OF THE AUDITOR GENERAL FOR WALES TO THE SENEDD

REPORT OF THE AUDITOR GENERAL TO THE SENEDD

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Aneurin Bevan University Health Board Final Accounts for 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mark Ross, Assistant Director of Finance (Financial Systems and Services)

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

Ar Gyfer Penderfyniad/For Decision

To give assurance to the Committee along with the Head of Internal Audit Opinion and the Audit Wales audit of annual accounts report, to enable the Committee to recommend that the Board approve the ABUHB 2023/24 accounts.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The accounts for 2023/24 are attached to this paper.

The following changes have been actioned from the draft accounts that affect the performance of the Health Boards duties reported to the Committee on the 21st of May.

- A journal has been actioned for £11,845.57 to reflect an underpayment made to one of the independent members during 2023/24.
- The remuneration report has also been amended to reflect this change.
- The related party note has also been amended to show the declaration for this independent member.

The impact on the Health Boards reported position is a change from an overspend of £49.754m in the draft accounts to £49.766m in the final audited accounts.

Although this adjustment was not material to the main accounts it was material to the remuneration report, so the adjustment was actioned for the audited submission.

There have been no other changes from the draft accounts that affect the performance of any other of the Health Boards's duties reported to the Committee on the 21st of May.

Audit Wales have confirmed they intend to give an unqualified opinion on the Aneurin Bevan University Health Board 2023/24 Financial Statements. They will qualify the regularity opinion as the Health Board has not achieved its statutory target to break even over a three-year period. The final position as at 31 March 2024 shows a year end deficit of £49.766m and combined with the outcomes for 2021-22 and 2022-23, a three-year deficit of £86.359m.

A number of classification type adjustments have been made during the audit. These are included in Appendix 1 attached.

The Committee are asked to note that the accounts have been satisfactorily completed, and along with the audit of annual accounts report from Audit Wales and the Head of Internal Audit Opinion, recommend approval of the Accounts by the Board at the meeting on 11th July.

At the time of writing this report there are still some minor audit queries outstanding, with Audit Wales also conducting a final review of the audit. A further update on the outstanding queries will be presented at the meeting.

Cefndir / Background

See above.

Asesiad / Assessment

This report provides the Committee with details of amendments actioned from the draft accounts to the final accounts on completion of the Audit, with one adjustment detailed above impacting the 2023/24 reported position of the Health Board.

At the time of writing, Audit Wales are following up a number of minor queries - an update will be provided at the Committee.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to endorse the Aneurin Bevan University Health Board accounts for 2023/24 for approval by the Board on 11th July 2024.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	**Appendix** SoFP – Statement of Financial Position IMTP – Integrated Medium Term Financial Plan SIFT – Medical Service Incremental Teaching Funding PILON – Payment in lieu of notice MFA – Manual for Accounts PPE – Property, Plant & Equipment PFI – Private Finance Initiative IFRS – International Financial reporting Standards WG – Welsh Government FYE – Full year equivalent

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
	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/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Choose an item.

2023/24 ANNUAL ACCOUNTS – Appendix 1

Adjustments Actioned from Draft to Final 2023/24 Annual Accounts

Note No.	Issue	Impact On Fin. Target
	Adjustments Actioned – impact on financial target.	**£12K**
	Martin Blakebrough underpaid by £11,845.57 in 2023/24 accrual actioned in 2023/24.	
3.3	Directors' costs changed from £2,206K to £2,218K	
9.1	Permanent Staff changed from £603,287K to £603,299K	
18	Non-NHS Payables changed from £56,646K to £56,658K	
LFR3	Chairman & Non-Exec Members changed from £276K to £288K	
2.3	**Adjustments Actioned – No impact on financial target** Removal of the word 'approved' as ABUHB do not have an approved IMTP	None
3.4	Amendment to narrative note to amend figure quoted from £563,791 to £563,291	None
4	Training and Education income re SIFT £2.004m received from WG re-mapped from WG income in the draft accounts to training and education income in the final accounts in line with the MFA.	None
9.1	Payment in Lieu of notice £29K omitted from note 9.1. Salary and Wages for permanent staff changed from £603,287K to £603,316K with sub totals amended accordingly. (See further adjustment above)	None
9.3	Heading for 2022/23 amended in final as incorrectly stated as 2022-24 in draft accounts.	None
9.5	Termination payment incorrectly classified as Payment in lieu of notice (PILON). Note 9.5 amended to read 1 case under special payments and £24,254 added to value section under special payments and cash transactions in the year.	None
11.3	Additional row added to Maturity analysis by WG to take off finance charges allocated to future period to reconcile to note 24. Revised totals now read Land £11K, Buildings £9.078K and Other £7,248K.	None
13	Abandonment in the course of construction re intangible assets shown under PPE in draft accounts in error. £438K moved from PPE to Intangible Assets.	None
20	No of redress cases in narrative note as the bottom of note 20 is incorrect – amended from 52 to 33 in line with note 3.4	None

21.1	Number of new phase 8 claims incorrectly stated as 14 in the draft accounts, amended to 13 in the final audited accounts.	None
25.2	Additional column added to final pro-forma re PFI SoFP by WG to eliminate validation issue. Incorrect figure included in note re Nevill Hall Hospital Day Surgery. Amended from £45K to £48K.	None None
27	Impact of IFRS16 on SoFP PFI contracts incorrectly shown in draft accounts - £1.514m shown as movement in capital creditors – moved to 'other' in final audited accounts.	None
30	Debtor and Creditor with WG was omitted from the draft submission. Final audited submission amended to reflect £22K debtor, £2,246K creditor. Declaration omitted from draft accounts for Martin Blakebrough, now added to final audited accounts with the following declaration in relation to his role as Chief Executive of Kaleidoscope. Expenditure £50K, Income £413K, Creditor £26K, Debtor 51K	None
33	Duplicate line 5 & 8 – line 5 deleted	None
	LFRs amended to account for the adjustments within the main accounts	None
	REMUNERATION REPORT & PENSIONS BENEFITS	
	Martin Blakebrough salary understated in draft accounts as he had not been paid his full salary during 2023/24. Accrual actioned to correct this identified above. Salary Band changed from 0-5 to 10-15 in final audited accounts. Also removed the narrative at the bottom of the note which read the following in the draft accounts - Martin Blakebrough commenced with the Health Board on 3rd May 2023 but has yet to formally take up Board duties.	None
	Peter Carr's FYE Salary changed to £125k-£130k from £115k-£120k. There was a Staff Change Form completed 28th March 24 to increase his pay band, Finance unaware of change request.	None
	James Calvert FYE Equivalent Salary should be changed to £215k-£220k from £210-£215k to include Deputy Chief Exec payemnt of £10k per annum.	None

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1st October 2009 following the merger of Gwent Healthcare NHS Trust and the following Local Health Boards.
Blaenau Gwent Local Health Board
Caerphilly Local Health Board
Monmouthshire Local Health Board
Newport Local Health Board
Torfaen Local Health Board

The Health Board covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen with a population of approximately 600,000 people. The Health Board has an annual budget from the Welsh Government of just over £1.6 billion per year from which we plan and deliver services for the population of the Health Board area. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being Act and the Well Being of Future Generations Act.

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2021-22. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	2023-24 £000	2022-23 £000
Expenditure on Primary Healthcare Services	3.1	**325,276**	307,116
Expenditure on healthcare from other providers	3.2	**508,398**	474,153
Expenditure on Hospital and Community Health Services	3.3	**1,105,268**	1,004,067
		1,938,942	1,785,336
Less: Miscellaneous Income	4	**(121,956)**	(109,566)
LHB net operating costs before interest and other gains and losses		**1,816,986**	1,675,770
Investment Revenue	5	**(17)**	(18)
Other (Gains) / Losses	6	**331**	(530)
Finance costs	7	**1,168**	1,060
Net operating costs for the financial year		**1,818,468**	**1,676,282**

See note 2 on page 28 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 75 form part of these accounts.

Other Comprehensive Net Expenditure

	2023-24 £000	2022-23 £000
Net (gain) / loss on revaluation of property, plant and equipment	**(19,417)**	(47,165)
Net (gain)/loss on revaluation of right of use assets	**0**	(17)
Net (gain) / loss on revaluation of intangibles	**(114)**	0
(Gain) / loss on other reserves	**0**	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	**0**	0
Net (gain)/loss on revaluation of financial assets held for sale	**0**	0
Impairment and reversals	**0**	0
Transfers between reserves	**0**	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Other comprehensive net expenditure for the year	**(19,531)**	(47,182)
Total comprehensive net expenditure for the year	**1,798,937**	1,629,100

The notes on pages 8 to 75 form part of these accounts.

Statement of Financial Position as at 31 March 2024

	Notes	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Property, plant and equipment	11	**892,817**	869,541
Right of Use Assets	11.3	**17,370**	23,867
Intangible assets	12	**4,685**	5,091
Trade and other receivables	15	**144,066**	77,466
Other financial assets	16	**667**	726
Total non-current assets		**1,059,605**	976,691
Current assets			
Inventories	14	**9,844**	9,576
Trade and other receivables	15	**136,573**	152,162
Other financial assets	16	**59**	58
Cash and cash equivalents	17	**4,145**	4,704
		150,621	166,500
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**150,621**	166,500
Total assets		**1,210,226**	1,143,191
Current liabilities			
Trade and other payables	18	**(202,162)**	(222,124)
Other financial liabilities	19	**0**	0
Provisions	20	**(71,827)**	(87,280)
Total current liabilities		**(273,989)**	(309,404)
Net current assets/ (liabilities)		**(123,368)**	(142,904)
Non-current liabilities			
Trade and other payables	18	**(15,888)**	(20,692)
Other financial liabilities	19	**0**	0
Provisions	20	**(149,647)**	(81,186)
Total non-current liabilities		**(165,535)**	(101,878)
Total assets employed		**770,702**	731,909
Financed by :			
Taxpayers' equity			
General Fund		**581,378**	552,847
Revaluation reserve		**189,324**	179,062
Total taxpayers' equity		**770,702**	731,909

The financial statements on pages 2 to 7 were approved by the Board on 11 July 2024 and signed on its behalf by:

Chief Executive and Accountable Officer …….. Date: 11 July 2024

The notes on pages 8 to 75 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2024

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2023-24			
Balance as at 31 March 2023	552,847	179,062	**731,909**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment	0	0	**0**
Impact of IFRS 16 on PPP/PFI Liability	(1,543)	0	**(1,543)**
Balance at 1 April 2023	551,304	179,062	**730,366**
Net operating cost for the year	(1,818,468)		**(1,818,468)**
Net gain/(loss) on revaluation of property, plant and equipment	0	19,417	**19,417**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	114	**114**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other Reserve Movement	0	0	**0**
Transfers between reserves	9,269	(9,269)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2023-24	(1,809,199)	10,262	**(1,798,937)**
Net Welsh Government funding	1,807,206		**1,807,206**
Notional Welsh Government Funding	32,067		**32,067**
Balance at 31 March 2024	581,378	189,324	**770,702**

Notional Welsh Government funding line includes the 6.3% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

Notional Welsh Government funding split;
Notional 6.3% staff employer pension £32,065,000
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £2,000

The notes on pages 8 to 75 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2023

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2022-23			
Balance at 31 March 2022	530,429	133,026	**663,455**
NHS Wales Transfer	1,106	0	**1,106**
RoU Asset Transitioning Adjustment	820	0	**820**
Balance at 1 April 2022	532,355	133,026	**665,381**
Net operating cost for the year	(1,676,282)		**(1,676,282)**
Net gain/(loss) on revaluation of property, plant and equipment	0	47,165	**47,165**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other reserve movement	0	0	**0**
Transfers between reserves	1,129	(1,129)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2022-23	(1,675,153)	46,036	**(1,629,117)**
Net Welsh Government funding	1,667,210		**1,667,210**
Notional Welsh Government Funding	28,435		**28,435**
Balance at 31 March 2023	552,847	179,062	**731,909**

Notional Welsh Government funding line includes the 6.3% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

Notional Welsh Government funding split*;*
Notional 6.3% staff employer pension £28,427,000
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £8.270.

The notes on pages 8 to 75 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2024

	Notes	2023-24 £000	2022-23 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(1,818,468)**	(1,676,282)
Movements in Working Capital	27	**(69,062)**	26,776
Other cash flow adjustments	28	**175,424**	46,683
Provisions utilised	20	**(30,160)**	(15,442)
Net cash outflow from operating activities		**(1,742,266)**	(1,618,265)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(58,252)**	(39,158)
Proceeds from disposal of property, plant and equipment		**215**	591
Purchase of intangible assets		**(1,778)**	(1,932)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(59,815)**	(40,499)
Net cash inflow/(outflow) before financing		**(1,802,081)**	(1,658,764)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,807,206**	1,667,210
Capital receipts surrendered		**0**	0
Capital grants received		**0**	62
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**0**	0
Capital element of payments in respect of on-SoFP PFI		**(1,585)**	(947)
Capital element of payments in respect of Right of Use Assets		**(4,099)**	(4,577)
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**1,801,522**	1,661,748
Net increase/(decrease) in cash and cash equivalents		**(559)**	2,984
Cash and cash equivalents (and bank overdrafts) at 1 April 2023		**4,704**	1,720
Cash and cash equivalents (and bank overdrafts) at 31 March 2024		**4,145**	4,704

The notes on pages 8 to 75 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2023-24 Manual for Accounts. The accounting policies contained in that manual follow the 2023-24 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-20 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, in Wales the additional 6.3% being funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency).

However, NHS Wales' organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated. For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

● the technical feasibility of completing the intangible asset so that it will be available for use.

● the intention to complete the intangible asset and use it.

● the ability to use the intangible asset.

● how the intangible asset will generate probable future economic benefits.

● the availability of adequate technical, financial and other resources to complete the intangible asset and use it.

● the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale,within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application rhe LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.
Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.
There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The LHB will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.7 instead.

On componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The LHB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The LHB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 The LHB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The entity employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the LHB applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 The LHB as lessor (where relevant)

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of [the entity] net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the the LHB net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Wales organisation has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Wales organisation has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2023-24 and 2022-23. The WRP is hosted by Velindre NHS University Trust.

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in Nore 31 to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the NHS Wales organisation not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budget

The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in Note 32 - the Pooled budget Note.

The pooled budget is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

Monmouthshire County Council - Monnow Vale Health and Social Care Unit
Funds are pooled for the provision of health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. The financial operation of the pool is governed by a pooled budget agreement between the Local Health Board and Monmouthshire County Council. The income from Monmouthshire County Council is recorded as Local Authority Income in these accounts.

Expenditure for services provided under the arrangement is recorded under the appropriate expense headings in these accounts.

The property in which the unit is housed has been provided by a Private Finance Partner; the contract with the PFI partner is for 30 years and is categorised as an on balance sheet PFI scheme with the HB recognising **72%** of the property - see Note 32 of these accounts for further details.

The five Local Authorities in Gwent - Gwent Wide Integrated Community Equipment Service
Funds are pooled for the provision of an efficient and effective GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partner localities. The pool is hosted by Torfaen County Borough Council. The Health Board makes a financial contribution to the scheme but does not account for the schemes expenditure or assets/liabilities generated by this expenditure.

The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Torfaen County Borough Council, are accounted for as expenditure within these accounts.

Monmouthshire County Council - Mardy Park Rehabilitation Centre
Funds are pooled for the provision of care to individuals who have rehabilitation needs. The LHB has entered into a pooled budget with Monmouthshire County Council. The pool is hosted by Monmouthshire County Council.

The five Local Authorities in Gwent - Gwent Frailty Programme
Funds are pooled for the purpose of establishing a consistent service across Gwent. The pool is hosted by Caerphilly County Borough Council, as lead commissioner. The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Caerphilly County Borough Council, are accounted for as expenditure within these accounts. Additional information is provided in Note 32.

The five Local Authorities in Gwent and ABUHB – A pooled Fund for Care Home Accommodation functions for Older People
Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The overarching strategic aim of this Agreement is: -
• To ensure coordinated arrangements for ensuring an integrated approach across the Partnership to the commissioning and arranging for Care Home Accommodation for Older People.
• To ensure provision of high quality, cost effective Care Home Accommodation which meets local health and social care needs, through the establishment of a pooled fund
• To develop a managed market approach to the supply of quality provision to meets the needs of Older People Care Home Accommodation.

Funds are pooled for the provision and commissioning of specified services for older people (>65 years of age) in a care home setting in Gwent. The pool has been hosted by Torfaen County Borough Council since August 2018.

The Health Board makes a financial contribution to the scheme equivalent to actual expenditure incurred in commissioning related placements in homes during the year, but in addition does incur minimal costs associated with a share of the services provided by the host organisation and these are accounted for as expenditure within these accounts.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1 April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

1.24.1. Provisions

The LHB provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
	Contingent Liability for all other estimated expenditure.	
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

* *Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of minus 0.25%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

The Health Board has provided for some £213m (£162m 2022/23) within note 20 in respect of potential clinical negligence and personal injury claims and associated defence fees. These provisions have been arrived at on the advice of NHS Wales Shared Services Partnership - Legal & Risk Services. Given the nature of such claims this figure could be subject to significant change in future periods. However, the potential financial effect of such uncertainty is mitigated by the fact that the LHB's ultimate liability in respect of individual cases is capped at £0.025m, with amounts above this excess level being reimbursed by the Welsh Risk Pool.

The Health Board has estimated a liability of £0.393m (£0.427m 2022/23) in respect of retrospective claims for Continuing Health Care funding. The estimated provision is based upon an assessment of the likelihood of claims meeting criteria for continuing health care and the actual costs incurred by individuals in care homes. The provision is based on information made available to the Health Board at the time of these accounts and could be subject to significant change as outcomes are determined.

Aneurin Bevan University Local Health Board has reviewed its portfolio of outstanding claims for continuing healthcare and made an assessment of likely financial liability based on an estimated success factor, eligibility factor and expected weekly average costs of claims. The assumptions have been derived by reviewing a sample of claims.

Primary care expenditure includes estimates for areas which are paid in arrears and not finalised at the time of producing the accounts. These estimates relate to GMS Quality Assurance and Improvement Framework, GMS Enhanced Services, and pharmacy estimates, which are based on an assessment of likely final performance.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

Within the Provisions Note (note 20) the amount relating to Early Retirements and Permanent Injury benefits has been discounted using the PES (2021) Post Employment Benefits Liabilities Real Rate in Excess of CPI of 2.45%.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the NHS Wales organisation's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.2. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.3. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Wales organisation's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.4. Assets contributed by the NHS Wales organisation to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHBs SoFP.

1.26.5. Other assets contributed by the NHS Wales organisation to the operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

Other PFI arrangements off Statement of Financial Position
The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Nevill Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Joint PFI contract
The LHB has entered into an agreement to share a facility, provided by a Private Finance Partner, with Monmouthshire County Council to match the agreement with the Private Finance Partner. The arrangement is treated as a PFI arrangement and the total obligation is included as a liability of the LHB. The contribution towards the unitary charge committed by Monmouthshire County Council is treated as a financial asset. The future contribution was measured initially at the same amount as the fair value of the share of the PFI asset and is subsequently measured as a finance lease.

1.26.6 Impact of IFRS 16 on on-balance sheet PFI/PPP Schemes

On-balance sheet PPP arrangements should be based on IFRS 16 accounting principles from 2023/24.

When measuring the liability for on-balance sheet PPP contracts containing capital payments linked to a price index IFRS 16 requires that 'a lessee shall remeasure the lease liability where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments. The lessee shall remeasure the lease liability to reflect those revised lease payments only when there is a change in the cash flows.

Initial remeasurement -the future PPP liability will need to be remeasured at 1 April 2023 to include the actual indexation-linked changes to payments for the capital/infrastructure element which have taken effect in the cash flows since the PPP agreement commenced. This should use a cumulative catch-up approach, where the cumulative effect is recognised as an adjustment to the opening balance of retained earnings.

Subsequent measurement - The PPP liability will continue to require remeasurements whenever cash payments change in response to indexation movements as set out in the individual PPP contract. The double entry for the subsequent liability remeasurement should be Debit Finance Cost, Credit PPP liability.

The liability does not include estimated future indexation linked increases.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2023, Standard is not yet adopted by the FReM which is expected to be from April 2025: early adoption is not permitted.

1.30. Accounting standards issued that have been adopted early

During 2023-24 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the Aneurin Bevan University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Aneurin Bevan University LHB NHS Charitable Fund as a subsidiary and therefore is required to consolidate the results of the Aneurin Bevan University LHB NHS Charitable Fund within the statutory accounts of the LHB.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Aneurin Bevan University LHB NHS Charitable Fund or its independence in its management of charitable funds.

However, the LHB organisation has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts.

Details of the transactions with the charity are included in the related parties' notes - note 30.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2021-22	2022-23	2023-24	**Total**
	£000	£000	£000	**£000**
Net operating costs for the year	1,598,803	1,676,282	1,818,468	**5,093,553**
Less general ophthalmic services expenditure and other non-cash limited expenditure	(58)	148	599	**689**
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	29	**29**
Total operating expenses	1,598,745	1,676,430	1,819,096	**5,094,271**
Revenue Resource Allocation	1,598,994	1,639,588	1,769,330	**5,007,912**
Under /(over) spend against Allocation	249	(36,842)	(49,766)	**(86,359)**

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24.
The Health Board will, in dialogue with Welsh Government, confirm the implications for reporting this deficit as part of the 2024/25 IMTP.
The health board received £49.9m of strategic cash support in 2023/24.

2.2 Capital Resource Performance

	2021-22	2022-23	2023-24	**Total**
	£000	£000	£000	**£000**
Gross capital expenditure	52,167	41,028	62,681	**155,876**
Add: Losses on disposal of donated assets	0	2	1	**3**
Less NBV of property, plant and equipment, right of use and intangible assets	(3,115)	(61)	(5,845)	**(9,021)**
Less capital grants received	(22)	(62)	0	**(84)**
Less donations received	(166)	(227)	(136)	**(529)**
Less IFRS16 Peppercorn income	0	0	0	**0**
Less **initial recognition** of RoU Asset Dilapidations	0	0	0	**0**
Charge against Capital Resource Allocation	48,864	40,680	56,701	**146,245**
Capital Resource Allocation	48,914	40,723	56,742	**146,379**
(Over) / Underspend against Capital Resource Allocation	50	43	41	**134**

Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2021-22 to 2023-24.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2022-2025 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB was unable to submit a balanced Integrated Medium Term Plan for the period 2023-2026 in accordance with NHS Wales Planning Framework. The Health Board submitted an Annual Plan for 2023-24: Three Year Intent 2024/25 and were placed in targeted intervention with a requirement for the Health Board to deliver the commitments set out in the annual plan.

The Minister for Health and Social Services extant approval

Status

Date

The LHB has therefore not met its statutory duty to have an approved Integrated Medium Term plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2023-24	2022-23
Total number of non-NHS bills paid	**327,881**	371,943
Total number of non-NHS bills paid within target	**319,291**	354,020
Percentage of non-NHS bills paid within target	97.4%	95.2%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2023-24 Total £000	2022-23 Total £000
General Medical Services	122,671		122,671	116,217
Pharmaceutical Services	33,813	(8,057)	25,756	25,273
General Dental Services	39,870		39,870	39,817
General Ophthalmic Services	3,201	7,458	10,659	8,866
Other Primary Health Care expenditure	4,373		4,373	2,612
Prescribed drugs and appliances	121,947		121,947	114,331
Total	**325,875**	**(599)**	**325,276**	307,116

Note 3.1 - Expenditure on Primary Healthcare Services
The General Medical Services expenditure includes £18,793k (2022/23 £16,406k) in relation to staff salaries, the General Dental Services expenditure includes £4,070k (2022/23 £3,032k) in relation to staff salaries, the Prescribed Drugs & Appliance expenditure includes £348k (2022/23 £329k) in relation to staff salaries, and the General Ophthalmic Services includes £37k (2022/23 £8k) in relation to staff salaries.

3.2 Expenditure on healthcare from other providers

	2023-24 £000	2022-23 £000
Goods and services from other NHS Wales Health Boards	**69,753**	63,968
Goods and services from other NHS Wales Trusts	**47,460**	43,527
Goods and services from Welsh Special Health Authorities	**0**	0
Goods and services from other non Welsh NHS bodies	**12,041**	10,092
Goods and services from WHSSC / EASC	**208,640**	198,320
Local Authorities	**41,143**	47,685
Voluntary organisations	**9,408**	9,260
NHS Funded Nursing Care	**11,260**	9,681
Continuing Care	**99,136**	86,006
Private providers	**9,110**	5,392
Specific projects funded by the Welsh Government	**0**	0
Other	**447**	222
Total	**508,398**	474,153

Local Authorities expenditure relates to the following bodies:	**£'000**	£'000
Blaenau Gwenty County Borough Council	**3,462**	4,331
Caerphilly County Borough Council	**17,706**	17,867
Monmouthshire County Council	**4,759**	8,334
Newport City Council	**8,289**	10,252
Torfaen County Borough Council	**6,874**	6,790
Gloucestershire County Council	**52**	111
Swansea Council	**1**	0
Swindon Borough Council	**0**	0
	41,143	47,685

3.3 Expenditure on Hospital and Community Health Services

	2023-24	2022-23
	£000	£000
Directors' costs	2,218	2,374
Operational Staff costs	786,497	729,603
Single lead employer Staff Trainee Cost	32,482	30,104
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	130,717	120,657
Supplies and services - general	20,384	20,123
Consultancy Services	410	327
Establishment	7,251	6,928
Transport	1,441	1,942
Premises	43,954	48,310
External Contractors	0	0
Depreciation	43,001	42,936
Depreciation Right of Use assets (RoU)	4,474	4,479
Amortisation	2,349	2,859
Fixed asset impairments and reversals (Property, plant & equipment)	9,732	(19,470)
Fixed asset impairments and reversals (RoU Assets)	0	0
Fixed asset impairments and reversals (Intangible assets)	438	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	455	421
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	3,217	1,526
Research and Development	0	0
Expense related to short-term leases	713	552
Expense related to low-value asset leases (excluding short-term leases)	936	858
Other operating expenses	14,599	9,538
Total	**1,105,268**	1,004,067

The Health Board spent £2.9m (£2.7m 2022/23) on Research and Development. The majority of this spend relates to staff £2.3m (£2.2m 2022/23) which along with the non-staff spend is reflected under the various headings within note 3.3. During 2023-24 Research and Development income received was £2.7m (£2.6m 2022/23).

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

	2023-24	2022-23
Increase/(decrease) in provision for future payments:	**£000**	£000
Clinical negligence;		
Secondary care	**72,303**	(3,578)
Primary care	**817**	38
Redress Secondary Care	**221**	478
Redress Primary Care	**0**	0
Personal injury	**734**	193
All other losses and special payments	**821**	34
Defence legal fees and other administrative costs	**1,308**	1,184
Gross increase/(decrease) in provision for future payments	**76,204**	**(1,651)**
Contribution to Welsh Risk Pool	**0**	0
Premium for other insurance arrangements	**0**	0
Irrecoverable debts	**198**	(104)
Less: income received/due from Welsh Risk Pool	**(72,845)**	3,281
Total	**3,557**	1,526

	2023-24	2022-23
	£	£
Permanent injury included within personal injury £:	**(613,210)**	(285,049)

Note 3.4 includes £563,291 (£615,848 2022/23) relating to Redress cases which represents 81 (81 2022/23) cases where payments were made in year totalling £293,446 (£275,664 2022/23) including defence fees. An additional provision has been created for a further 33 (50 2022/23) cases where an offer has been made or causation and breach have been proven with estimated costs of £269,845 (£340,184 2022/23).

During 2023/24 ABUHB incurred a loss of £756,007.34 as a result of flood damage. £416,135.83 related to revenue items with £339,871.50 relating to capital items. This has resulted in a variance between Note 3.3 and Note 3.4 as the Capital loss of £339,891.50 is reflected within the SoCNE page 2 row 18 - Other (Gains)/Losses.

4. Miscellaneous Income

	2023-24 £000	2022-23 £000
Local Health Boards	**22,054**	20,509
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	**13,948**	11,521
NHS Wales trusts	**11,418**	10,652
Welsh Special Health Authorities	**15,800**	13,782
Foundation Trusts	**38**	22
Other NHS England bodies	**1,472**	1,469
Other NHS Bodies	**56**	58
Local authorities	**20,351**	19,078
Welsh Government	**4,788**	4,622
Welsh Government Hosted bodies	**0**	0
Non NHS:		
Prescription charge income	**0**	0
Dental fee income	**5,160**	4,848
Private patient income	**0**	27
Overseas patients (non-reciprocal)	**157**	42
Injury Costs Recovery (ICR) Scheme	**1,140**	1,022
Other income from activities	**1,083**	837
Patient transport services	**0**	0
Education, training and research	**2,034**	2,043
Charitable and other contributions to expenditure	**1,259**	1,048
Receipt of NWSSP Covid centrally purchased assets	**0**	0
Receipt of Covid centrally purchased assets from other organisations	**0**	0
Receipt of donated assets	**136**	210
Receipt of Government granted assets	**0**	62
Right of Use Grant (Peppercorn Lease)	**0**	17
Non-patient care income generation schemes	**131**	100
NHS Wales Shared Services Partnership (NWSSP)	**0**	0
Deferred income released to revenue	**0**	0
Right of Use Asset Sub-leasing rental income	**0**	0
Contingent rental income from finance leases	**0**	0
Rental income from operating leases	**343**	226
Other income:		
Provision of laundry, pathology, payroll services	**131**	102
Accommodation and catering charges	**3,519**	3,103
Mortuary fees	**364**	375
Staff payments for use of cars	**625**	617
Business Unit	**0**	0
Scheme Pays Reimbursement Notional	**463**	(615)
Other	**15,486**	13,789
Total	**121,956**	109,566

Other income Includes;		
Salary Sacrifice Schemes & Fleet Vehicles	**5,954**	4,265
VAT recoveries re Business Activities and Contracted Out Services	**2,249**	1,523
Integrated Care Fund	**3,678**	4,894
Other	**3,605**	3,107
	0	0
	0	0
	0	0
Total	**15,486**	13,789

Injury Cost Recovery (ICR) Scheme income

	2023-24 %	2022-23 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.07	24.86

5. Investment Revenue

	2023-24	2022-23
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	**0**	0
contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue :		
Bank accounts	**0**	0
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**17**	18
Total	**17**	18

6. Other gains and losses

	2023-24	2022-23
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**(345)**	530
Gain/(loss) on disposal other than by sale of right of use assets assets	**14**	0
Gain/(loss) on disposal of intangible assets	**0**	0
Gain/(loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on disposal of financial assets	**0**	0
Change on foreign exchange	**0**	0
Change in fair value of financial assets at fair value through SoCNE	**0**	0
Change in fair value of financial liabilities at fair value through SoCNE	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**(331)**	530

7. Finance costs

	2023-24	2022-23
	£000	£000
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under Right of Use Leases	**274**	232
Interest on obligations under PFI contracts;		
main finance cost	**231**	239
contingent finance cost	**0**	471
Impact of IFRS 16 on PPP/PFI contracts	**521**	0
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**1,026**	942
Provisions unwinding of discount	**142**	118
Other finance costs	**0**	0
Total	**1,168**	1,060

8. Future change to SoCNE/Operating Leases

LHB as lessee

As at 31st March 2024 the LHB had 2 operating leases agreements in place for the lease of premises, 510 arrangements in respect of equipment and 242 in respect of vehicles with 3 property, 195 equipment and 70 vehicle leases having expired in year.

	2023-24 Low Value & Short Term	2023-24 Other	2023-24 Total	2022-23 Total
Payments recognised as an expense				
	£000	**£000**	**£000**	£000
Minimum lease payments	**1,670**	**0**	**1,670**	1,487
Contingent rents	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	0
Total	**1,670**	**0**	**1,670**	1,487

Total future minimum lease payments				
Payable	**£000**	**£000**	**£000**	£000
Not later than one year	**1,079**	**0**	**1,079**	864
Between one and five years	**862**	**0**	**862**	612
After 5 years	**0**	**0**	**0**	0
Total	**1,941**	**0**	**1,941**	1,476

LHB as lessor

	2023-24	2022-23
Rental revenue	**£000**	£000
Rent	**343**	226
Contingent rents	**0**	0
Total revenue rental	**343**	226

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**289**	252
Between one and five years	**1,033**	964
After 5 years	**1,031**	1,236
Total	**2,353**	2,452

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2022-23
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	603,328	1,504	39,562	25,864	0	2,766	673,024	627,009
Social security costs	63,758	0	0	3,133	0	0	66,891	62,249
Employer contributions to NHS Pension Scheme	101,724	0	0	3,485	0	0	105,209	93,244
Other pension costs	298	0	0	0	0	0	298	365
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	769,108	1,504	39,562	32,482	0	2,766	845,422	782,867

Charged to capital	977	1,011
Charged to revenue	844,445	781,856
	845,422	782,867
Net movement in accrued employee benefits (untaken staff leave)	(167)	(12)

The staff under the 'Other' heading relate to Agency Medical Staff who are paid via a direct engagement scheme which commenced in January 2020.

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2022-23
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,743	12	6	0	0	0	2,761	2,727
Medical and dental	839	8	73	404	0	14	1,338	1,259
Nursing, midwifery registered	3,815	1	196	0	0	0	4,012	3,991
Professional, Scientific, and technical staff	449	0	3	0	0	0	452	462
Additional Clinical Services	2,804	0	37	0	0	0	2,841	2,877
Allied Health Professions	857	0	19	0	0	0	876	829
Healthcare Scientists	242	0	5	0	0	0	247	245
Estates and Ancilliary	995	0	98	0	0	0	1,093	1,146
Students	9	0	0	0	0	0	9	10
Total	12,753	21	437	404	0	14	13,629	13,546

9.3. Retirements due to ill-health

	2023-24	2022-23
Number	15	14
Estimated additional pension costs £	1,462,604	606,310

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

9.4 Employee benefits

The Health Board does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2023-24 Number of compulsory redundancies	2023-24 Number of other departures	2023-24 Total number of exit packages	2023-24 Number of departures where special payments have been made	2022-23 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	**0**	**0**	**0**	**0**	0
£10,000 to £25,000	**0**	**0**	**0**	**1**	0
£25,000 to £50,000	**0**	**0**	**0**	**0**	1
£50,000 to £100,000	**0**	**0**	**0**	**0**	0
£100,000 to £150,000	**0**	**0**	**0**	**0**	0
£150,000 to £200,000	**0**	**0**	**0**	**0**	0
more than £200,000	**0**	**0**	**0**	**0**	0
Total	**0**	**0**	**0**	**1**	1

Exit packages cost band (including any special payment element)	2023-24 Cost of compulsory redundancies	2023-24 Cost of other departures	2023-24 Total cost of exit packages	2023-24 Cost of special element included in exit packages	2022-23 Total cost of exit packages
	£	£	£	£	£
less than £10,000	**0**	**0**	**0**	**0**	0
£10,000 to £25,000	**0**	**0**	**0**	**24,254**	0
£25,000 to £50,000	**0**	**0**	**0**	**0**	32,197
£50,000 to £100,000	**0**	**0**	**0**	**0**	0
£100,000 to £150,000	**0**	**0**	**0**	**0**	0
£150,000 to £200,000	**0**	**0**	**0**	**0**	0
more than £200,000	**0**	**0**	**0**	**0**	0
Total	**0**	**0**	**0**	**24,254**	32,197

Exit costs paid in year of departure	Total paid in year 2023-24	Total paid in year 2022-23
	£	£
Exit costs paid in year	**24,254**	0
Total	**24,254**	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Health Board has not approved any VERS in 2023-24.

Additional requirement as per FReM
£0.00 exit costs were paid in 2023-24, relating to 2022-23 (the year of departure).

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

	2023-24	**2023-24**	**2023-24**	2022-23	2022-23	2022-23
	£000	**£000**	**£000**	£000	£000	£000
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**225 - 230**	**29**	**8.0**	215 - 220	26	8.3
Median pay	**225 - 230**	**36**	**6.3**	215 - 220	33	6.5
75th percentile pay ratio	**225 - 230**	**47**	**4.9**	215 - 220	43	5.0
Salary component of total pay and benefits						
25th percentile pay ratio	**225 - 230**	**29**		215 - 220	26	
Median pay	**225 - 230**	**36**		215 - 220	33	
75th percentile pay ratio	**225 - 230**	**47**		215 - 220	43	

Total pay and benefits	**Highest Paid Director**	**Employee**	**Ratio**	Highest Paid Director	Employee	Ratio
25th percentile pay ratio	**225 - 230**	**29**	**8.0**	215 - 220	26	8.3
Median pay	**225 - 230**	**36**	**6.3**	215 - 220	33	6.5
75th percentile pay ratio	**225 - 230**	**47**	**4.9**	215 - 220	43	5.0
Salary component of total pay and benefits						
25th percentile pay ratio	**225 - 230**	**29**		215 - 220	26	
Median pay	**225 - 230**	**36**		215 - 220	33	
75th percentile pay ratio	**225 - 230**	**47**		215 - 220	43	

In 2023-24, 10 (2022-23, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £15k to £383k (2022-23, £14k to £416k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

There has been an decrease in the pay ratio which attributable to the increase in the chief exectuive / highest paid director salary being less than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	**2022-23 to 2023-24**	2021-22 to 2022-23
% Change from previous financial year in respect of Chief Executive	**%**	**%**
Salary and allowances	**5**	7
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**5**	7
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**7**	5
Performance pay and bonuses	**0**	0

9.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2023-24 tax year (2022-23 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2023-24	**2023-24**	2022-23	2022-23
NHS	**Number**	**£000**	Number	£000
Total bills paid	4,932	402,257	4,740	380,000
Total bills paid within target	4,364	381,217	4,198	360,894
Percentage of bills paid within target	**88.5%**	**94.8%**	88.6%	95.0%
Non-NHS				
Total bills paid	327,881	709,739	371,943	651,605
Total bills paid within target	319,291	688,084	354,020	624,146
Percentage of bills paid within target	**97.4%**	**96.9%**	95.2%	95.8%
Total				
Total bills paid	**332,813**	**1,111,996**	376,683	1,031,605
Total bills paid within target	**323,655**	**1,069,301**	358,218	985,040
Percentage of bills paid within target	**97.2%**	**96.2%**	95.1%	95.5%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2023-24	2022-23
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**542**	413
Total	**542**	**413**

11.1 Property, plant and equipment

2023-24

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	77,508	696,196	2,237	36,936	118,190	546	43,310	4,162	979,085
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2023	**77,508**	**696,196**	**2,237**	**36,936**	**118,190**	**546**	**43,310**	**4,162**	**979,085**
Indexation	**(2,000)**	**21,643**	**33**	**0**	**0**	**0**	**0**	**0**	**19,676**
Additions									
- purchased	**0**	**2,574**	**19**	**46,443**	**5,806**	**0**	**2,471**	**243**	**57,556**
- donated	**0**	**0**	**0**	**0**	**136**	**0**	**0**	**0**	**136**
- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer from/into other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**42,054**	**0**	**(42,602)**	**124**	**0**	**250**	**(410)**	**(584)**
Revaluations	**0**	**(22)**	**0**	**0**	**0**	**0**	**0**	**0**	**(22)**
Reversal of impairments	**0**	**19,893**	**101**	**0**	**0**	**0**	**0**	**0**	**19,994**
Impairments	**(397)**	**(31,439)**	**0**	**0**	**0**	**0**	**0**	**0**	**(31,836)**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**(7,193)**	**(265)**	**(6,573)**	**(42)**	**(14,073)**
At 31 March 2024	**75,111**	**750,899**	**2,390**	**40,777**	**117,063**	**281**	**39,458**	**3,953**	**1,029,932**
Depreciation at 31 March bf	0	22,122	294	0	60,999	502	24,324	1,303	**109,544**
NHS Wales Transfers	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2023	**0**	**22,122**	**294**	**0**	**60,999**	**502**	**24,324**	**1,303**	**109,544**
Indexation	**0**	**879**	**15**	**0**	**0**	**0**	**0**	**0**	**894**
Transfer from/into other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**(2)**	**0**	**79**	**(112)**	**(35)**
Revaluations	**0**	**(657)**	**0**	**0**	**0**	**0**	**0**	**0**	**(657)**
Reversal of impairments	**0**	**439**	**3**	**0**	**0**	**0**	**0**	**0**	**442**
Impairments	**0**	**(2,552)**	**0**	**0**	**0**	**0**	**0**	**0**	**(2,552)**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**(6,642)**	**(265)**	**(6,573)**	**(42)**	**(13,522)**
Provided during the year	**0**	**22,912**	**83**	**0**	**12,921**	**32**	**6,678**	**375**	**43,001**
At 31 March 2024	**0**	**43,143**	**395**	**0**	**67,276**	**269**	**24,508**	**1,524**	**137,115**
Net book value at 1 April 2023	**77,508**	**674,074**	**1,943**	**36,936**	**57,191**	**44**	**18,986**	**2,859**	**869,541**
Net book value at 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**
Net book value at 31 March 2024 comprises :									
Purchased	**72,053**	**705,809**	**1,995**	**40,777**	**49,031**	**12**	**14,879**	**2,393**	**886,949**
Donated	**3,058**	**1,745**	**0**	**0**	**560**	**0**	**71**	**36**	**5,470**
Government Granted	**0**	**202**	**0**	**0**	**196**	**0**	**0**	**0**	**398**
At 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**
Asset financing :									
Owned	**75,111**	**703,130**	**1,995**	**40,777**	**49,759**	**12**	**14,950**	**2,429**	**888,163**
On-SoFP MIMS Funded PPP contracts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-SoFP PFI contracts	**0**	**4,626**	**0**	**0**	**28**	**0**	**0**	**0**	**4,654**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**

The net book value of land, buildings and dwellings at 31 March 2024 comprises :

	£000
Freehold	**780,060**
Long Leasehold	**4,783**
Short Leasehold	**19**
	784,862

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. **0**

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation h as been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an a rms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

2022-23	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	78,456	691,679	3,030	23,203	130,298	546	39,785	4,184	971,181
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	(32)	(392)	0	0	0	0	(517)	0	(941)
Cost or valuation at 1 April 2022	78,424	691,287	3,030	23,203	130,298	546	39,268	4,184	970,240
Indexation	(2,002)	16,637	22	0	0	0	0	0	14,657
Additions									
- purchased	0	4,259	53	22,262	4,961	0	4,937	112	36,584
- donated	0	0	0	0	109	0	63	38	210
- government granted	0	44	0	0	18	0	0	0	62
Transfer from/into other NHS bodies	0	0	0	0	1,106	0	0	0	1,106
Reclassifications	0	6,811	0	(8,529)	(56)	0	46	10	(1,718)
Revaluations	3,694	(26,767)	(715)	0	0	0	0	0	(23,788)
Reversal of impairments	0	8,529	(153)	0	0	0	0	0	8,376
Impairments	(2,608)	(4,604)	0	0	0	0	0	0	(7,212)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(18,246)	0	(1,004)	(182)	(19,432)
At 31 March 2023	77,508	696,196	2,237	36,936	118,190	546	43,310	4,162	979,085
Depreciation at 31 March bf	0	74,177	415	0	66,042	470	18,529	1,069	**160,702**
NHS Wales Transfers	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	(108)	0	0	0	0	(13)	0	**(121)**
Depreciation at 1 April 2022	0	74,069	415	0	66,042	470	18,516	1,069	160,581
Indexation	0	53	0	0	0	0	0	0	53
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(10)	0	7	3	0
Revaluations	0	(56,103)	(246)	0	0	0	0	0	(56,349)
Reversal of impairments	0	(17,935)	(168)	0	0	0	0	0	(18,103)
Impairments	0	(203)	0	0	0	0	0	0	(203)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(18,185)	0	(1,004)	(182)	(19,371)
Provided during the year	0	22,241	293	0	13,152	32	6,805	413	42,936
At 31 March 2023	0	22,122	294	0	60,999	502	24,324	1,303	109,544
Net book value at 1 April 2022	78,424	617,218	2,615	23,203	64,256	76	20,752	3,115	809,659
Net book value at 31 March 2023	77,508	674,074	1,943	36,936	57,191	44	18,986	2,859	869,541
Net book value at 31 March 2023 comprises :									
Purchased	74,353	672,131	1,943	36,936	56,328	44	18,905	2,809	863,449
Donated	3,155	1,746	0	0	608	0	81	50	5,640
Government Granted	0	197	0	0	255	0	0	0	452
At 31 March 2023	77,508	674,074	1,943	36,936	57,191	44	18,986	2,859	869,541
Asset financing :									
Owned	77,508	668,777	1,943	36,936	57,049	44	18,986	2,859	864,102
On-SoFP PFI contracts	0	5,297	0	0	142	0	0	0	5,439
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2023	77,508	674,074	1,943	36,936	57,191	44	18,986	2,859	869,541

The net book value of land, buildings and dwellings at 31 March 2023 comprises :

	£000
Freehold	748,040
Long Leasehold	5,410
Short Leasehold	75
	753,525

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:
i) Donated Assets
Assets totalling £136k were purchased via Charitable funds donations during the year.

ii) Valuations
The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

In 2023-24, indexation has been applied to land and buildings based on indices received from the Valuation Office Agency and as agreed in the Technical Update Note 002 issued by Welsh Government on 27th October 2023. No indexation has been applied to equipment.

In addition, in 2023-24 there have been separate revaluations for six assets under construction coming into use. These include Tredegar Health and Well-being Centre, the centralised Breast Unit at Ysbyty Ystrad Fawr, the new endoscopy unit and lift upgrades at the Royal Gwent Hospital and the Staff well-being centre at Grange House in Llanfrechfa. An impairment of £3.199m is included as a result of the discovery of reinforced autoclaved aerated concrete (RAAC) in some parts of Nevill Hall Hospital.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation
There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
There have not been write downs.

vi) The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.
There are no assets held for sale or sold in the period.

IFRS 13 Fair value measurement
There are no assets requiring Fair Value measurement under IFRS 13.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2023	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2024	0	0	0	0	0	**0**
Balance brought forward 1 April 2022	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2023	0	0	0	0	0	**0**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, five are significant in their own right:
- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2024 £1,341k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2024 £2,317k
- Ty Gwent held under Land & Buildings NBV at 31 March 2024 £1,213k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2024 £2,441k
- NHH Energy scheme (previously classified as an off balance sheet PFI scheme) held under Plant & Machinery NBV at 31 March 2024 £2,180k

2023-24	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March	813	16,854	0	0	8,473	559	1,660	0	**28,359**
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Cost or valuation at 1 April	**813**	**16,854**	**0**	**0**	**8,473**	**559**	**1,660**	**0**	**28,359**
Additions	0	1,768	0	0	585	533	385	0	**3,271**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	-6,442	0	0	0	-232	0	0	**-6,674**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
At 31 March	**813**	**12,180**	**0**	**0**	**9,058**	**860**	**2,045**	**0**	**24,956**
Depreciation at 31 March	98	2,118	0	0	1,519	269	488	0	**4,492**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April	**98**	**2,118**	**0**	**0**	**1,519**	**269**	**488**	**0**	**4,492**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	-1,169	0	0	0	-211	0	0	**-1,380**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	98	2,019	0	0	1,619	281	457	0	**4,474**
At 31 March	**196**	**2,968**	**0**	**0**	**3,138**	**339**	**945**	**0**	**7,586**
Net book value at 1 April	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**
Net book value at 31 March	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	606	296	0	0	0	0	0	0	**902**
Other Public Sector Market Value Leases	11	1,153	0	0	0	0	0	0	**1,164**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	7,763	0	0	5,920	521	1,100	0	**15,304**
Total	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insigni ficant, however, six are significant in their own right:
- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2023 £1,468k
- Brynmawr Medical Centre held under Land & Buildings NBV at 31 March 2023 £2,839k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2023 £2,732k
- Blaenavon Primary Care Resource Centre (managed GP practice lease) held under Land & Buildings NBV at 31 March 2023 £1,242k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2023 £2,709k

2022-23	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March	0	0	0	0	0	0	0	0	**0**
Lease prepayments in relation to RoU Assets	0	266	0	0	157	18	0	0	**441**
Transfer of Finance Leases from PPE Note	0	424	0	0	0	0	517	0	**941**
Operating Leases Transitioning	813	15,071	0	0	6,853	342	1,143	0	**24,222**
Cost or valuation at 1 April	**813**	**15,761**	**0**	**0**	**7,010**	**360**	**1,660**	**0**	**25,604**
Additions	0	1,471	0	0	1,463	199	0	0	**3,133**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	-91	0	0	0	0	0	0	**-91**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	-287	0	0	0	0	0	0	**-287**
At 31 March	**813**	**16,854**	**0**	**0**	**8,473**	**559**	**1,660**	**0**	**28,359**
Depreciation at 31 March	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases from PPE Note	0	108	0	0	0	0	13	0	**121**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April	**0**	**108**	**0**	**0**	**0**	**0**	**13**	**0**	**121**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	-108	0	0	0	0	0	0	**-108**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	98	2,118	0	0	1,519	269	475	0	**4,479**
At 31 March	**98**	**2,118**	**0**	**0**	**1,519**	**269**	**488**	**0**	**4,492**
Net book value at 1 April	**813**	**15,653**	**0**	**0**	**7,010**	**360**	**1,647**	**0**	**25,483**
Net book value at 31 March	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	704	314	0	0	0	0	0	0	**1,018**
Other Public Sector Market Value Leases	11	1,875	0	0	0	0	0	0	**1,886**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	12,547	0	0	6,954	290	1,172	0	**20,963**
Total	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**

11.3 Right of Use Assets continued

Quantitative disclosures

	2023-24	2023-24	2023-24	2023-24	2022-23
Maturity analysis	**LAND**	**BUILDINGS**	**OTHER**	**TOTAL**	
Contractual undiscounted cash flows relating to lease liabilities	**£000**	**£000**	**£000**	**£000**	**£000**
Less than 1 year	0	1,531	2,179	3,710	4,234
2-5 years	2	3,641	3,907	7,550	10,489
> 5 years	11	4,668	1,478	6,157	8,949
Less finance charges allocated to future periods	-2	-762	-316	-1,080	-1,200
Total	**11**	**9,078**	**7,248**	**16,337**	**22,472**

Lease Liabilities (net of irrecoverable VAT)	**2023-24**	2022-23
Current	3,445	4,008
Non-Current	12,892	18,464
Total	**16,337**	**22,472**

Amounts Recognised in Statement of Comprehensive Net Expenditure	**2023-24**	2022-23
Depreciation	4,474	4,479
Impairment	0	0
Variable lease payments not included in lease liabilities - Interest expense	274	232
Sub-leasing income	-2	-2
Expense related to short-term leases	713	552
Expense related to low-value asset leases (excluding short-term leases)	936	858

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)		
Interest expense	-274	-232
Repayments of principal on leases	-4,099	-4,577
Total	**-4,373**	**-4,809**

12. Intangible non-current assets

2023-24

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2023	3,547	0	7,772	0	0	0	11,319
Revaluation	0	0	0	0	0	0	0
Reclassifications	35	0	0	0	0	548	583
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	(438)	(438)
Additions- purchased	50	0	716	0	0	953	1,719
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(101)	0	(5,564)	0	0	0	(5,665)
Gross cost at 31 March 2024	3,531	0	2,924	0	0	1,063	7,518
Amortisation at 1 April 2023	1,129	0	5,099	0	0	0	6,228
Revaluation	0	0	(114)	0	0	0	(114)
Reclassifications	35	0	0	0	0	0	35
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	737	0	1,612	0	0	0	2,349
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(101)	0	(5,564)	0	0	0	(5,665)
Amortisation at 31 March 2024	1,800	0	1,033	0	0	0	2,833
Net book value at 1 April 2023	2,418	0	2,673	0	0	0	5,091
Net book value at 31 March 2024	1,731	0	1,891	0	0	1,063	4,685
NBV at 31 March 2024							
Purchased	1,731	0	1,891	0	0	1,063	4,685
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2024	1,731	0	1,891	0	0	1,063	4,685

12. Intangible non-current assets
2022-23

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	**Total**
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2022	**1,838**	**0**	**7,535**	**0**	**0**	**0**	**9,373**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	1,718	0	0	0	0	0	**1,718**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	66	0	955	0	0	0	**1,021**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	(75)	0	(718)	0	0	0	**(793)**
Gross cost at 31 March 2023	**3,547**	**0**	**7,772**	**0**	**0**	**0**	**11,319**
Amortisation at 31 March bf	**714**	**0**	**3,448**	**0**	**0**	**0**	**4,162**
NHS Wales Transfers	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	**0**
Amortisation at 1 April 2022	**714**	**0**	**3,448**	**0**	**0**	**0**	**4,162**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	490	0	2,369	0	0	0	**2,859**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	(75)	0	(718)	0	0	0	**(793)**
Amortisation at 31 March 2023	**1,129**	**0**	**5,099**	**0**	**0**	**0**	**6,228**
Net book value at 1 April 2022	**1,124**	**0**	**4,087**	**0**	**0**	**0**	**5,211**
Net book value at 31 March 2023	**2,418**	**0**	**2,673**	**0**	**0**	**0**	**5,091**
NBV at 31 March 2023							
Purchased	2,418	0	2,673	0	0	0	**5,091**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2023	**2,418**	**0**	**2,673**	**0**	**0**	**0**	**5,091**

Additional Disclosures re Intangible Assets

Disclosures:

i) Donated Assets

Aneurin Bevan University LHB has not received any donated intangible assets during the year.

ii) Recognition

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives

The useful economic life of Intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL and the UEL of internally generated software is based on the professional judgement of LHB professionals and Finance staff.

iv) Additions during the period

Intangible assets acquired during the period amounted to £1.719m; this was primarily on software licence renewals and new purchases.

v) Disposals during the period

Fully amortised software and licences with a GBV of £5.665m were disposed of as no longer in use, during the year.

13 . Impairments

	2023-24 Property, plant & equipment £000	2023-24 Right of Use Assets £000	2023-24 Intangible assets £000	2022-23 Property, plant & equipment £000	2022-23 Right of Use Assets £000	2022-23 Intangible assets £000
Impairments arising from :						
Loss or damage from normal operations	**0**	**0**	**0**	0	0	0
Abandonment in the course of construction	**0**	**0**	**438**	0	0	0
Over specification of assets (Gold Plating)	**0**	**0**	**0**	0	0	0
Loss as a result of a catastrophe	**0**	**0**	**0**	0	0	0
Unforeseen obsolescence	**0**	**0**	**0**	0	0	0
Changes in market price	**0**	**0**	**0**	0	0	0
Others (specify)	**31,284**	**0**	**0**	10,557	0	0
Reversal of Impairments	**(19,552)**	**0**	**0**	(26,479)	0	0
Total of all impairments	**11,732**	**0**	**438**	(15,922)	0	0
Analysis of impairments charged to reserves in year :						
Charged to the Statement of Comprehensive Net Expenditure	**9,732**	**0**	**438**	(19,470)	0	0
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	**2,000**	**0**	**0**	3,548	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	**0**	**0**	**0**	0	0	0
Total	**11,732**	**0**	**438**	(15,922)	0	0

2023-24	Impairment amount £000	Reason for impairment £000	Nature of Asset £000	Valuation basis £000	Charge to SoCNE £000	Charge to reserve £000
Indexation - Land	2,397	Indexation loss	Operational	Existing Use	397	2,000
Tredegar HWBC (Bevan Health Centr	13,403	Assets Valued on Coming Into Use	Operational	Fair Value	13,403	0
Endoscopy Redevelopment, RGH	5,978	Assets Valued on Coming Into Use	Operational	Fair Value	5,978	0
YYF Unified Breast Unit	5,796	Assets Valued on Coming Into Use	Operational	Fair Value	5,796	0
RAAC at NHH	3,199	Economic Loss / Assets Valued on Coming Into Use	Operational	Fair Value	3,199	0
Grange House Wellbeing Centre, LGH	511	Assets Valued on Coming Into Use	Operational	Fair Value	511	0
WCCIS Phase 2 - abandonment of AL	438	Abandoned development	Intangible AUC	Fair Value	438	0
Total Impairment	31722				29722	2000
Reversal of Impairments						
Grange University Hospital	(16,154)	Indexation - reversal of impairment in previous years	Operational	Indexation	(16,154)	
Ysbyty Aneurin Bevan	(2,318)		Operational	Indexation	(2,318)	
Neville Hall	(536)		Operational	Indexation	(536)	
Royal Gwent	(200)		Operational	Indexation	(200)	
St Cadocs	(153)		Operational	Indexation	(153)	
Llanfrechfa Grange	(135)		Operational	Indexation	(135)	
Various Community Sites	(56)		Operational	Indexation	(56)	
Total Reversal of Impairments	-19552				-19552	0
Net credit to SoCNE	12170				10170	2000

14.1 Inventories

	31 March 2024	31 March 2023
	£000	£000
Drugs	**3,095**	2,819
Consumables	**6,482**	6,471
Energy	**267**	286
Work in progress	**0**	0
Other	**0**	0
Total	**9,844**	9,576
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2024	31 March 2023
	£000	£000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

15. Trade and other Receivables

Current	**31 March 2024 £000**	31 March 2023 £000
Welsh Government	**2,246**	1,517
WHSSC / EASC	**2,911**	1,019
Welsh Health Boards	**3,971**	3,175
Welsh NHS Trusts	**5,901**	4,309
Welsh Special Health Authorities	**1,044**	1,010
Non - Welsh Trusts	**24**	66
Other NHS	**267**	213
2019-20 Scheme Pays - Welsh Government Reimbursement	**604**	141
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	**93,727**	109,290
NHS Wales Primary Sector FLS Reimbursement	**920**	111
NHS Wales Redress	**502**	587
Other	**791**	0
Local Authorities	**5,468**	9,756
Capital receivables - Tangible	**0**	0
Capital receivables - Intangible	**0**	0
Other receivables	**12,766**	16,714
Provision for irrecoverable debts	**(1,942)**	(1,763)
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**7,373**	6,017
Other accrued income	**0**	0
Sub total	**136,573**	152,162
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	**142,085**	76,333
NHS Wales Primary Sector FLS Reimbursement	**0**	2
NHS Wales Redress	**0**	0
Other	**744**	0
Local Authorities	**0**	0
Capital receivables - Tangible	**0**	0
Capital receivables - Intangible	**0**	0
Other receivables	**1,237**	1,131
Provision for irrecoverable debts	**0**	0
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**0**	0
Other accrued income	**0**	0
Sub total	**144,066**	77,466
Total	**280,639**	229,628

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2024 £000	31 March 2023 £000
By up to three months	**1,922**	2,415
By three to six months	**383**	360
By more than six months	**1,570**	1,331
	3,875	4,106

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	**(1,763)**	(1,870)
Transfer to other NHS Wales body	**0**	0
Amount written off during the year	**20**	0
Amount recovered during the year	**0**	3
(Increase) / decrease in receivables impaired	**(176)**	119
Bad debts recovered during year	**(22)**	(15)
Balance at 31 March	**(1,942)**	(1,763)

In determining whether a debt is impaired, consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

Receivables VAT

Trade receivables	**2,091**	1,899
Other	**195**	92
Total	**2,286**	1,991

16. Other Financial Assets

	Current		Non-current	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**35**	34	**452**	487
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	**24**	24	**215**	239
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**59**	**58**	**667**	**726**

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	**2023-24**	**2022-23**
RoU Sub-leasing income	**-2**	-2

17. Cash and cash equivalents

	2023-24	2022-23
	£000	£000
Balance at 1 April	**4,704**	1,720
Net change in cash and cash equivalent balances	**(559)**	2,984
Balance at 31 March	**4,145**	4,704
Made up of:		
Cash held at GBS	**4,122**	4,681
Commercial banks	**0**	0
Cash in hand	**23**	23
Cash and cash equivalents as in Statement of Financial Position	**4,145**	4,704
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**4,145**	4,704

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities (ROUA) -£6.135m
Lease Liabilities (short-term and low value leases) £0.465m
PFI liabilities: £0.478m

The movement relates to cash, no comparative information is required by IAS 7 in 2023-24.

18. Trade and other payables

Current	**31 March 2024**	31 March 2023
	£000	£000
Welsh Government	**22**	44
WHSSC / EASC	**4,681**	3,125
Welsh Health Boards	**5,964**	3,461
Welsh NHS Trusts	**5,416**	6,088
Welsh Special Health Authorities	**39**	80
Other NHS	**7,477**	4,559
Taxation and social security payable / refunds	**16,072**	17,761
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**56,658**	58,923
Local Authorities	**19,638**	27,191
Capital payables- Tangible	**6,493**	7,189
Capital payables- Intangible	**147**	206
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**3,445**	4,008
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**638**	1,036
Impact of IFRS 16 on SoFP PFI contracts	**108**	0
Pensions: staff	**10,718**	9,797
Non NHS Accruals	**74,734**	88,638
Deferred Income:		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**(10,088)**	(9,982)
Sub Total	**202,162**	222,124
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**0**	0
Local Authorities	**0**	0
Capital payables- Tangible	**0**	0
Capital payables- Intangible	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**12,892**	18,464
Obligations under finance leases, HP contracts		0
Imputed finance lease element of on SoFP PFI contracts	**1,590**	2,228
Impact of IFRS 16 on SoFP PFI contracts	**1,406**	0
Pensions: staff	**0**	0
Non NHS Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**15,888**	20,692
Total	**218,050**	242,816

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The Capital Payables - Tangible figure includes balances that have been agreed with Welsh NHS Trusts, as part of the Agreement of Balances process, totalling £53k.

In 2023/24, the PFI Contract liabilities have been adjusted due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligations. The liability is now split out over 4 lines.

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	**31 March 2024 £000**	31 March 2023 £000
Between one and two years	**3,182**	4,352
Between two and five years	**4,810**	6,585
In five years or more	**7,896**	9,755
Sub-total	**15,888**	20,692

19. Other financial liabilities

	Current		**Non-current**	
Financial liabilities	**31 March 2024 £000**	31 March 2023 £000	**31 March 2024 £000**	31 March 2023 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2023	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2024
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	80,878	(10,810)	4,456	652	33,576	(25,049)	(19,563)	0	64,140
Primary care	79	0	0	0	820	(105)	(3)	0	791
Redress Secondary care	331	0	(1)	0	363	(288)	(142)	0	263
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	479	0	0	0	436	(631)	(247)	0	37
All other losses and special payments	0	0	0	0	821	(821)	0	0	0
Defence legal fees and other administration	2,306	0	0	181	1,402	(1,314)	(621)		1,954
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	385			41	401	(401)	(103)	74	397
2019-20 Scheme Pays - Reimbursement	6			0	1	0	0	0	7
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	449			0	1,278	0	0	0	1,727
Other	2,367		0	0	1,429	(3)	(1,282)		2,511
Total	87,280	(10,810)	4,455	874	40,527	(28,612)	(21,961)	74	71,827
Non Current									
Clinical negligence:-									
Secondary care	74,527	0	0	(652)	76,834	(948)	(7,734)	0	142,027
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	2,770	0	0	0	545	(356)	0	68	3,027
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	775	0	0	(181)	587	(104)	(60)		1,017
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,627			(41)	0	0	0	0	2,586
2019-20 Scheme Pays - Reimbursement	136			0	461	0	0	0	597
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	351		0	0	272	(140)	(90)		393
Total	81,186	0	0	(874)	78,699	(1,548)	(7,884)	68	149,647
TOTAL									
Clinical negligence:-									
Secondary care	155,405	(10,810)	4,456	0	110,410	(25,997)	(27,297)	0	206,167
Primary care	79	0	0	0	820	(105)	(3)	0	791
Redress Secondary care	331	0	(1)	0	363	(288)	(142)	0	263
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,249	0	0	0	981	(987)	(247)	68	3,064
All other losses and special payments	0	0	0	0	821	(821)	0	0	0
Defence legal fees and other administration	3,081	0	0	0	1,989	(1,418)	(681)		2,971
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	3,012			0	401	(401)	(103)	74	2,983
2019-20 Scheme Pays - Reimbursement	142			0	462	0	0	0	604
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	449			0	1,278	0	0	0	1,727
Other	2,718		0	0	1,701	(143)	(1,372)		2,904
Total	168,466	(10,810)	4,455	0	119,226	(30,160)	(29,845)	142	221,474

Expected timing of cash flows:

	In year to 31 March 2025	Between 1 April 2025 31 March 2029	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	64,140	142,027	0	206,167
Primary care	791	0	0	791
Redress Secondary care	263	0	0	263
Redress Primary care	0	0	0	0
Personal injury	37	3,026	0	3,063
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	1,954	1,018	0	2,972
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	397	2,586	0	2,983
2019-20 Scheme Pays - Reimbursement	7	35	562	604
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	1,727	0	0	1,727
Other	2,511	393	0	2,904
Total	71,827	149,085	562	221,474

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2024/25 it will receive £65,272K and in 2025/26 and beyond £142,829K from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £393K. The estimation method used to calculate the provision for 2023/24 is consistent with the methodology used in 2022/23. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.
Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.
The total Health Board provision also includes an amount of £270K which relates to 33 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

20. Provisions (continued)

	At 1 April 2022	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	56,805	(16,033)	(8,975)	52,699	42,660	(11,816)	(34,462)	0	**80,878**
Primary care	41	0	0	0	40	(2)	0	0	**79**
Redress Secondary care	126	0	(117)	0	516	(148)	(46)	0	**331**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	599	0	0	0	786	(598)	(308)	0	**479**
All other losses and special payments	0	0	0	0	34	(34)	0	0	**0**
Defence legal fees and other administration	2,239	0	0	327	1,953	(1,334)	(879)		**2,306**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	395			684	50	(392)	(415)	63	**385**
2019-20 Scheme Pays - Reimbursement	11			0	0	(5)	0	0	**6**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	0			0	449	0	0	0	**449**
Other	3,067		0	0	(13)	(5)	(682)		**2,367**
Total	**63,283**	**(16,033)**	**(9,092)**	**53,710**	**46,475**	**(14,334)**	**(36,792)**	**63**	**87,280**
Non Current									
Clinical negligence:-									
Secondary care	123,659	0	0	(52,699)	5,380	(696)	(1,117)	0	**74,527**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,262	0	0	0	36	(262)	(321)	55	**2,770**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	1,042	0	0	(327)	144	(50)	(34)		**775**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	3,311			(684)	0	0	0	0	**2,627**
2019-20 Scheme Pays - Reimbursement	745			0	0	(3)	(606)	0	**136**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	0			0	0	0	0	0	**0**
Other	405		0	0	137	(97)	(94)		**351**
Total	**132,424**	**0**	**0**	**(53,710)**	**5,697**	**(1,108)**	**(2,172)**	**55**	**81,186**
TOTAL									
Clinical negligence:-									
Secondary care	180,464	(16,033)	(8,975)	0	48,040	(12,512)	(35,579)	0	**155,405**
Primary care	41	0	0	0	40	(2)	0	0	**79**
Redress Secondary care	126	0	(117)	0	516	(148)	(46)	0	**331**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,861	0	0	0	822	(860)	(629)	55	**3,249**
All other losses and special payments	0	0	0	0	34	(34)	0	0	**0**
Defence legal fees and other administration	3,281	0	0	0	2,097	(1,384)	(913)		**3,081**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	3,706			0	50	(392)	(415)	63	**3,012**
2019-20 Scheme Pays - Reimbursement	756			0	0	(8)	(606)	0	**142**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	0			0	449	0	0	0	**449**
Other	3,472		0	0	124	(102)	(776)		**2,718**
Total	**195,707**	**(16,033)**	**(9,092)**	**0**	**52,172**	**(15,442)**	**(38,964)**	**118**	**168,466**

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2023/24 it will receive £82,013,376 and in 2024/25 and beyond £74,980,511 from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £426,553. The estimation method used to calculate the provision for 2022/23 is consistent with the methodology used in 2021/22. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.
Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.
The total Health Board provision also includes an amount of £340,184 which relates to 50 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

Provision (Continued)

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

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

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

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

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

The Health Board have included a Scheme Pay provsion of £604,453 (as notified by Welsh Government) within these accounts.

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2023-24 £'000**	2022-23 £'000
Legal claims for alleged medical or employer negligence:-		
Secondary care	**271,446**	337,156
Primary care	**547**	1,251
Redress Secondary care	**3**	0
Redress Primary care	**0**	3
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**4,244**	4,625
Continuing Health Care costs	**1,483**	1,379
Other	**0**	0
Total value of disputed claims	**277,723**	344,414
Amounts (recovered) in the event of claims being successful	**(272,258)**	(339,412)
Net contingent liability	**5,465**	5,002

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them. The value of legal claims has decreased by £66m from the value of legal claims in 2022-23, while the number of claims has increased from 224 in 2022-23 to 236 in 2023-24.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Continuing Healthcare Cost uncertainties
The Health Board continues to review claims for reimbursement of retrospective care payments (IRPs). As a consequence there has been a movement in the level of provision and uncertainty including in these Accounts.

Note 20 sets out the £0.393m provision made for probable continuing care costs relating to 69 outstanding phase 3 to 8 claims received by 31st March 2024. This compares with the 2022/23 provision of £0.427m and 52 outstanding phase 1 to 8 claims.

Note 21.1 also sets out the £1.483m contingent liability for possible additional continuing care costs relating to those claims if they are all settled and in full, comparing adversely with the £1.379m reported for 2022/23.

There are still 13 new (Phase 8) claims, which have been received whereby the assessment process remains incomplete, as we are still awaiting full details to support the claims. The assessment process is highly complex and involves a multi-disciplinary teams and for those reasons can take many months. At this stage, the HB does not have enough information to make a judgement on the likely success or otherwise of these claims, however, they may result in additional costs to the HB, which cannot be quantified at this time.

The Health Board are also aware of an incident from 2019 that has been investigated by the Health and Safety Executive. The HSE have yet to make an enforcement decision and as such can not be quantified at this time.

21.2 Remote Contingent liabilities

	2023-24	2022-23
	£000	£000
Guarantees	**0**	0
Indemnities	**24,064**	33,808
Letters of Comfort	**0**	0
Total	**24,064**	**33,808**

The remote contingent liabilities cost consists of 3 medical negligence cases and 1 GP Indemnity case in 2023-24 (11 medical medical negligence cases in 2022-23). Should these cases progress the majority of the costs incurred, in excess of £25K per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

21.3 Contingent assets

	2023-24	2022-23
	£000	£000
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2023-24	2022-23
	£000	£000
Property, plant and equipment	**25,569**	54,039
Right of Use Assets	**0**	0
Intangible assets	**173**	689
Total	**25,742**	54,728

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note are prepared on a cash basis.

Gross loss to the Exchequer

23.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2024	
	Number	**£**
Clinical negligence	339	27,570,923
Personal injury	122	1,227,151
All other losses and special payments	162	840,374
Total	623	29,638,448

23.2 Analysis of number of cases and associated amounts paid out during the financial year

	Case Type	In year claims in excess of £300,000		Cumulative amount
		Case Number	**£**	**£**
Cases in excess of £300,000:				
	Medical Negligence	MN/107/3636	307,970	317,891
	Medical Negligence	MN/107/3228	335,100	345,200
	Medical Negligence	MN/107/3721	603,501	699,738
	Medical Negligence	MN/107/0905	2,927,075	3,348,998
	Medical Negligence	MN/107/2957	874,191	1,039,724
	Medical Negligence	MN/107/2754	4,239,790	4,685,760
	Medical Negligence	MN/107/2012	329,270	958,516
	Medical Negligence	MN/107/3477	839,436	885,840
	Medical Negligence	MN/107/3253	995,303	1,032,161
	Medical Negligence	MN/107/3309	3,407,775	3,994,620
	Medical Negligence	MN/107/2594	4,653,438	4,806,234
	Personal Injury	PI/107/3465	371,116	374,896
	Other Losses		756,007	756,007
		No of cases	**£**	**£**
Sub-total		**13**	**20,639,972**	**23,245,585**
All other cases paid in year		610	8,998,476	30,351,538
Total cases paid in year		**623**	**29,638,448**	**53,597,123**

24. Right of Use / Finance leases obligations

24.1 Obligations (as lessee)

Amounts payable under right of use asset leases:

2023-24

	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2024	31 March 2024	31 March 2024	31 March 2024
Minimum lease payments	**£000**	**£000**	**£000**	**£000**
Within one year	0	1,531	2,179	**3,710**
Between one and five years	2	3,641	3,907	**7,550**
After five years	11	4,668	1,478	**6,157**
Less finance charges allocated to future periods	-2	-762	-316	**-1,080**
Minimum lease payments	**11**	**9,078**	**7,248**	**16,337**
Included in:				
Current borrowings	0	1,402	2,043	**3,445**
Non-current borrowings	11	7,676	5,205	**12,892**
	11	9078	7248	**16337**
Present value of minimum lease payments				
Within one year	0	1,402	2,043	**3,445**
Between one and five years	1	3,250	3,755	**7,006**
After five years	10	4,426	1,450	**5,886**
Present value of minimum lease payments	**11**	**9,078**	**7,248**	**16,337**
Included in:				
Current borrowings	0	1,402	2,043	**3,445**
Non-current borrowings	11	7,676	5,205	**12,892**
	11	9078	7248	**16337**

2022-23	LAND	BUILDINGS	OTHER	TOTAL
	31 March 2023	31 March 2023	31 March 2023	31 March 2023
Minimum lease payments	**£000**	**£000**	**£000**	**£000**
Within one year	0	2,209	2,025	4,234
Between one and five years	1	6,076	4,412	10,489
After five years	12	7,156	1,781	8,949
Less finance charges allocated to future periods	-2	-954	-243	-1,199
Minimum lease payments	11	14,487	7,975	22,473
Included in:				
Current borrowings	0	2,053	1,955	**4,008**
Non-current borrowings	11	12,434	6,020	**18,465**
	11	14487	7975	**22473**
Present value of minimum lease payments				
Within one year	0	2,053	1,955	4,008
Between one and five years	1	5,631	4,281	9,913
After five years	10	6,803	1,739	8,552
Present value of minimum lease payments	11	14,487	7,975	22,473
Included in:				
Current borrowings	0	2,053	1,955	**4,008**
Non-current borrowings	11	12,434	6,020	**18,465**
	11	14487	7975	**22473**

24.2 Right of Use Assets / Finance lease receivables (as lessor)

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under right of use assets / finance leases:	**2023-24**	2022-23
	31 March	31 March
	2024	2023
Gross Investment in leases	**£000**	£000
Within one year	**26**	26
Between one and five years	**106**	106
After five years	**118**	144
Less finance charges allocated to future periods	**(11)**	(13)
Minimum lease payments	**239**	263
Included in:		
Current financial assets	**24**	24
Non-current financial assets	**215**	239
	239	263
Present value of minimum lease payments		
Within one year	**24**	24
Between one and five years	**99**	98
After five years	**116**	141
Less finance charges allocated to future periods	**0**	0
Present value of minimum lease payments	**239**	263
Included in:		
Current financial assets	**24**	24
Non-current financial assets	**215**	239
	239	263

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Nevill Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2024	31 March 2023
	£000	£000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	**£000**
	626
Contract start date:	Feb-00
Contract end date:	Feb-25

Chepstow Community Hospital - a new community hospital including the provision of ancillary support services. This scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from February 2000. The obligation for the scheme is £468k.

	£000
Capital value of scheme included in Fixed Assets Note 11	**3,932**
Contract start date:	Mar-04
Contract end date:	Mar-36

Monnow Vale Health and Social Care Facility - a new health and social care facility. This scheme commenced in 2006 with unitary charge payments being made for a period of 30 years from 2006. The obligation for the scheme is £3,226k. In 2023/24, the liability for the scheme was increased by £1,618k due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligation.

	£000
Capital value of scheme included in Fixed Assets Note 11	**96**
Contract start date:	Sep-99
Contract end date:	Jun-24

Nevill Hall Hospital Day Surgery - a purpose built day unit including the provision of medical equipment for the unit. The PFI partner has responsibility for maintaining the building and replacing the equipment used with the unit. The scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from 1999. The obligation for the scheme is £48k. In 2023/24, the liability for the scheme was increased by £444k due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligation.

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI	**On SoFP PFI**	**On SoFP PFI**	**On SoFP PFI**
		IFRS 16 impact on PFI		
	Capital element	**Finance Charge**	**Imputed interest**	**Service charges**
	31 March 2024	**31 March 2024**	**31 March 2024**	**31 March 2024**
		£000	**£000**	**£000**
Total payments due within one year	**638**	**108**	**80**	**2,888**
Total payments due between 1 and 5 years	**523**	**462**	**338**	**2,856**
Total payments due thereafter	**1,067**	**944**	**222**	**5,080**
Total future payments in relation to PFI contracts	**2,228**	**1,514**	**640**	**10,824**

	On SoFP PFI	On SoFP PFI	On SoFP PFI	On SoFP PFI
		IFRS 16 impact on PFI		
	Capital element	Finance Charge	Imputed interest	Service charges
	31 March 2023	31 March 2023	31 March 2023	31 March 2023
		£000	£000	£000
Total payments due within one year	1,036	0	166	3,235
Total payments due between 1 and 5 years	1,025	0	209	5,592
Total payments due thereafter	1,203	0	157	6,553
Total future payments in relation to PFI contracts	3,264	0	532	15,380

	31/03/2024
	£000
Total present value of obligations for on-SoFP PFI contracts	**15,206**

25.3 Charges to expenditure	2023-24	2022-23
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	2,394	2,346
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	2,394	2,346

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	1,953	0
Later than one year, not later than five years	0	1,950
Later than five years	726	671
Total	2,679	2,621

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	3	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

25.5 The LHB has no Public Private Partnerships

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The LHB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The LHB has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the LHB in undertaking its activities.

Currency risk

The LHB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. The LHB therefore has low exposure to currency rate fluctuations.

Interest rate risk

LHBs are not permitted to borrow. The LHB therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the LHB's funding derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

The LHB is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The LHB is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2023-24 £000	2022-23 £000
(Increase)/decrease in inventories	**(268)**	(850)
(Increase)/decrease in trade and other receivables - non-current	**(66,541)**	48,026
(Increase)/decrease in trade and other receivables - current	**15,588**	(18,413)
Increase/(decrease) in trade and other payables - non-current	**(4,804)**	16,983
Increase/(decrease) in trade and other payables - current	**(19,962)**	(1,166)
Total	**(75,987)**	44,580
Adjustment for accrual movements in fixed assets - creditors	**1,791**	3,423
Adjustment for accrual movements in fixed assets - debtors	**(34)**	0
Adjustment for accrual movements in right of use assets - creditors	**6,135**	0
Adjustment for accrual movements in right of use assets - debtors	**(24)**	0
Other adjustments	**(943)**	(21,227)
	(69,062)	26,776

28. Other cash flow adjustments

	2023-24 £000	2022-23 £000
Depreciation	**47,475**	47,415
Amortisation	**2,349**	2,859
(Gains)/Loss on Disposal	**331**	(530)
Impairments and reversals	**10,170**	(19,470)
Release of PFI deferred credits	**0**	0
NWSSP Covid assets issued debited to expenditure but non-cash	**0**	0
Covid assets received credited to revenue but non-cash	**0**	0
Donated assets received credited to revenue but non-cash	**(136)**	(210)
Government Grant assets received credited to revenue but non-cash	**0**	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	**0**	(17)
Non-cash movements in right of use assets	**0**	0
Non-cash movements in provisions	**83,168**	(11,799)
Other movements	**32,067**	28,435
Total	**175,424**	46,683

Other movements are Notional funding received for the

- LHB notional 6.3% Staff Employer Pension Contributions and
- 2019/20 Pensions Annual Allowance Charge Compensation Scheme

funded directly to the NHSBA Pensions Division by Welsh Government.

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 11th July 2024; post the date the financial statements were certified by the Auditor General for Wales.

30. Related Party Transactions

The Welsh Government is regarded as a related party. During the year the LHB have had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely

	2023-24		As at 31st March 2024	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Welsh Government	65	6,993	22	2,246
Betsi Cadwaladr University Health Board	1,474	138	293	13
Cardiff & Vale University Health Board	44,303	3,199	2,454	1,181
Cwm Taf University Health Board	22,114	2,657	1,704	1,088
Hywel Dda University Health Board	1,253	346	544	41
Powys Teaching Health Board	373	14,658	62	1,316
Swansea Bay University Health Board	3,762	1,154	906	332
Velindre NHS Trust	85,357	11,055	3,289	5,218
Welsh Ambulance Services NHS Trust	10,305	257	1,803	27
Public Health Wales NHS Trust	1,588	4,253	377	654
Welsh Health Specialised Services Committee	208,689	13,948	4,681	2,911
Health Education and Improvement Wales (HEIW)	40	14,596	7	901
Digital Health and Care Wales (DHCW)	7,549	1,307	32	143

In addition the LHB has had significant number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions are with the following:-

	2023-24		As at 31st March 2024	
Government Body	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Blaenau Gwent County Borough Council	4,476	1,360	2,952	378
Caerphilly County Borough Council	19,212	13,413	5,524	3,395
Monmouthshire County Council	7,453	1,955	2,421	780
Newport City Council	11,673	2,096	5,328	436
Torfaen County Borough Council	10,684	1,557	3,052	264

The LHB has also had significant material transactions with the following:

Aneurin Bevan Local Health Board Charitable Fund	39	1,257	8	378

A number of the LHB's Board members have interests in related parties as follows:

			2023-24		As at 31st March 2024	
Member	Related Organisation	Relationship with Related Party	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Nicola Prygodzicz	Velindre NHS Trust	Sister is a Senior Nurse in the Corporate Nursing Team	85,357	11,055	3,289	5,218
Robert Holcombe	JW Bowkett (Electrical Installation) Ltd	Son was an employee until June 2023	536	0	169	0
	Torfaen County Borough Council	Member of Torfaen CBC Land Access Forum	10,684	1,557	3,052	264
Peter Carr	Digital Health & Care Wales	Chair of National Laboratory Information Management Systems 2.0 Programme Board	7,549	1,307	32	143
Philip Robson	Hospice of Valleys	Trustee	475	0	4	0
Richard Clark	Torfaen Voluntary Alliance	Company Secretary and Trustee	142	0	0	0
	Torfaen County Borough Council	Elected Member, Deputy Leader and Executive Member for Children, Families and Education	10,684	1,557	3,052	264
Penny Jones	Monmouthshire County Council	Councillor	7,453	1,955	2,421	780
Martin Blakebrough	Kaleidoscope	Chief Executive	50	413	26	51

31. Third Party assets

The LHB held £32,719.58 cash at bank and in hand at 31 March 2024 (31st March 2023, £23,655.85) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £0 at 31st March 2024 (31st March 2023, £0). This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

In addition the LHB had located on its premises a significant quantity of consignment stock. This stock remains the property of the supplier until it is used. The value of consignment stock at 31 March 2024 amounted to £3.5m (£2.5m as at 31st March 2023).

32. Pooled budgets

The Health Board has five pooled budgets. The specific accounting treatment of each pooled budget is covered within Accounting Policies note 1.22.

Monnow Vale Health and Social Care Unit
The Health Board has entered into a pooled budget with Monmouthshire County Council. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 to provide health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs and a memorandum note to the accounts provides details of the joint income and expenditure. The asset value of property, plant & equipment is **£5,461K** which is split 72% Aneurin Bevan Health Board and 28% Monmouthshire County Council. The costs incurred under the pooled budget is declared in the memorandum trading account.

Gwent Wide Integrated Community Equipment Service
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of an effective integrated GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the joint equipment store in the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£971K** for 2023/24 (£891K in 2022/23).

Mardy Park Rehabilitation Centre
The Health Board has entered into a pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are pooled under Section 33 of the NHS (Wales) Act 2006 to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council and the LHBs contribution is **£272K** for 2023/24 (£223K in 2022/23).

Gwent Frailty Programme
The Health Board has entered into a pooled budget with 5 Local Authorities in the Gwent area, namely Blaenau Gwent , Caerphilly, Monmouthshire, Newport and Torfaen County councils, for the provision of a Gwent wide integrated health and social care Frailty service, for service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the purpose of establishing a consistent service for the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£9,892K** for 2023/24 (£9,493K in 2022/23).

Continuing Healthcare - Older People in Care Homes
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision and commissioning of certain specialised services for older people (>65 years of age) in a care home setting in Gwent. Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.
The pool was established in August 2018 and is hosted by Torfaen County Borough Council. Under the arrangement, the Health Board makes a financial contribution equivalent to related expenditure in commissioning related placements in homes during the year. The LHB's contribution is **£41,298K** for 2023/24 (£36,563K in 2022/23).

Pooled Budget memorandum account for the period 1st April 2023 - 31st March 2024

Monnow Vale

	Cash	Own Contribution	Grants	Total
	£	£	£	£
Funding				
Aneurin Bevan Health Board	0	2,863,450	0	2,863,450
Monmouthshire County Council	425,860	882,742	0	1,308,602
Total Funding	**425,860**	**3,746,192**	**0**	**4,172,052**
Expenditure				
Aneurin Bevan Health Board	0	3,220,491	0	3,220,491
Monmouthshire County Council	658,462	788,398	0	1,446,860
Total Expenditure	**658,462**	**4,008,889**	**0**	**4,667,350**
Net (under)/over spend	**232,602**	**262,697**	**0**	**495,298**

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

Whilst the organisation is structured into divisions, the performance management and the allocation of resources flow from the Board of Aneurin Bevan University Health Board.

There are no hosted services within the health board. Divisions do not manage capital programmes, have any autonomy in relation to balance sheets or produce discrete accounts.

For the purposes of IFRS 8 it is therefore deemed that there is no requirement to report any operating segments.

34. Other Information

34.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2023 to 31 March 2024. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2023 and February 2024 alongside Health Board/Trust/SHA data for March 2023.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2023-24	2022-23
Statement of Comprehensive Net Expenditure for the year ended 31 March 2024	**£000**	**£000**
Expenditure on Primary Healthcare Services	**662**	585
Expenditure on Hospital and Community Health Services	**31,403**	27,842
Statement of Changes in Taxpayers' Equity For the year ended 31 March 2024		
Net operating cost for the year	**32,065**	28,427
Notional Welsh Government Funding	**32,065**	28,427
Statement of Cash Flows for year ended 31 March 2024		
Net operating cost for the financial year	**32,065**	28,427
Other cash flow adjustments	**32,065**	28,427
2.1 Revenue Resource Performance		
Revenue Resource Allocation	**32,065**	28,427
3. Analysis of gross operating costs		
3.1 Expenditure on Primary Healthcare Services		
General Medical Services	**662**	585
3.3 Expenditure on Hospital and Community Health Services		
Directors' costs	**103**	78
Staff costs	**31,300**	27,764
9.1 Employee costs		
Permanent Staff		
Employer contributions to NHS Pension Scheme	**32,065**	28,427
Charged to capital	**0**	0
Charged to revenue	**32,065**	28,427
18. Trade and other payables		
Current		
Pensions: staff	0	0
28. Other cash flow adjustments		
Other movements	**32,065**	28,427

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Aneurin Bevan University Health Board

Audit year: 2023-24

Date issued: July 2024

Document reference: 4335A2024

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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About Audit Wales

Our aims and ambitions

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

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

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Introduction

I have now largely completed my audit in line with my Audit Plan 2024. There are a number of minor queries that remain outstanding at the time of writing as well as some final review processes to be undertaken by the Audit Manager and Engagement Lead.

The audit team will provide the Audit, Risk and Assurance Committee with an update on any queries that remain outstanding.

This Audit of Accounts Report summarises the main findings from my audit of your 2023-24 Annual report and accounts. My team have already discussed these issues with the Director of Finance and Procurement and the Assistant Director of Finance (Financial Systems & Services).

I am very grateful to your officers for their support in undertaking this audit.

Adrian Crompton
Auditor General for Wales

Your audit at a glance

Audit opinions

We are proposing to give an unqualified true and fair opinion and the regularity opinion will be qualified following the failure to meet its financial duty to break-even against its revenue resource limit over the 3 years 2021-22 to 2023-24.

We have nothing to report under the other sections of my report, ie those relating to going concern; other information; other matters; or matters I report by exception.

We are also proposing to issue a substantive report which explains why our audit opinion in respect of the regularity of expenditure is qualified. This report will also refer to the fact that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan for the period 2023-26. The regularity opinion is not qualified for this.

Significant issues

There are no misstatements or significant issues to report.

Materiality

Materiality	£19.4million
Reporting threshold (‘trivial’)	£0.97million

Areas of specific interest:

- Remuneration report
- Related party disclosures

Financial statements' materiality

Materiality £19.4 million

My aim is to identify and correct material misstatements, ie those that might otherwise cause the user of the accounts to be misled.

Materiality is calculated using:

- 2023-24 gross expenditure of £1,940 million
- Materiality percentage of **1**%

I apply the materiality percentage to gross expenditure to calculate materiality.

I will report to you any misstatements above £970,000, calculated as 5% of materiality (called the 'trivial level').

Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts. We set lower materiality levels for these as follows:

- Remuneration report – £5k (or correct banding) for the "Salary and Pension entitlements of Senior Managers Remuneration" table; and
- Related party disclosures - £10k for individual interests.

Ethical compliance

Compliance with ethical standards

We believe that:

- we have complied with the ethical standards we are required to follow in carrying out our work;
- we have remained independent of yourselves;
- our objectivity has not been comprised; and
- we have no relationships that could undermine our independence or objectivity.

Proposed audit opinion

Audit opinion

We intend to issue an unqualified true and fair opinion and a qualified regularity audit opinion on this year's accounts once you have provided us with a Letter of Representation (see below).

The regularity opinion will be qualified following the failure to meet its financial duty to break-even against its revenue resource limit over the 3 years 2021-22 to 2023-24.

Our proposed audit report is set out in **Appendix 1,** along with our proposed substantive report which explains the basis of the regularity qualification.

The substantive report also refers to the fact that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan for the period 2023-26. The regularity opinion is not qualified for this.

Letter of representation

A Letter of Representation is a formal letter in which you confirm to us the accuracy and completeness of information provided to us during the audit. Some of this information is specified as being necessary by auditing standards; other information may relate specifically to your audit.

The letter we are requesting you to sign is included in **Appendix 2**.

Issues arising during the audit

Misstatements

A misstatement arises where information in the accounts is not in accordance with accounting standards.

Uncorrected misstatements

There are no uncorrected misstatements above our trivial level but lower than materiality.

Corrected misstatements

During our audit we identified misstatements that have been corrected by management, but which we consider should be drawn to your attention.

These are set out in **Appendix 3**.

Other significant issues

In the addition to misstatements identified during the audit we also report other significant issues to you.

There were no such issues identified during the audit.

Further considerations

We will continue to work with the Health Board, the wider Sector and Welsh Government to review our ambition to bring forward the audit deadline further as part of the 2024-25 accounts audit process. In order to meet these deadlines, it will be imperative that the accounts received are fully supported and all working papers are available at the commencement of the audit.

Whilst the majority of working papers were prepared by the Health Board in readiness for the start of the audit process this year, some were still being finalised and not available during the first week of the audit window. Audit Wales and the Finance department worked collaboratively to an agreed timescale for the delivery of working papers to manage the early stages of the audit and this did not cause us an issue in completing our work given the window available to us this year. However, we are conscious that when the accounts production and audit window reduce next year, this could be a potential issue in achieving the deadlines for future years.

We have not raised a recommendation in respect of this issue. We will pick this issue up as part of our audit post project learning with officers to assess the position and we would like to thank officers for their positive engagement with the audit team throughout the audit and providing us with good quality working papers to support the financial statements.

Appendix 1

Proposed audit report

The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Aneurin Bevan University Health Board for the year ended 31 March 2024 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Aneurin Bevan University Health Board as at 31 March 2024 and of its net operating costs for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, except for the matter described in the Basis for Qualified Regularity Opinion section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on regularity

I have qualified my opinion on the regularity of the Aneurin Bevan University Health Board's financial statements because the Health Board has breached its resource limit by spending £86.359 million over the amount that it was authorised to spend in the three-year period 2021-22 to 2023-24. This spend constitutes irregular expenditure.

Further detail is set out in my Report on page xx

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards

are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Aneurin Bevan University Health Board is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and;
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Aneurin Bevan University Health Board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and the other unaudited parts of the Accountability Report or the Annual Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
- assessing the Health Board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of

accounting unless the Directors and Chief Executive anticipate that the services provided by the Health Board will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the Health Board's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Health Board policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals;
- Obtaining an understanding of Aneurin Bevan University Health Board's framework of authority as well as other legal and regulatory frameworks that the Health Board operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Health Board; and
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, those charged with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and

- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Health Board controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

Please see my Report on pages X to Y.

Adrian Crompton
Auditor General for Wales
12 July 2024

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Aneurin Bevan University Health Board's (the Health Board's) financial statements. I am reporting on these financial statements for the year ended 31 March 2024 to draw attention to two key matters for my audit. These are the failure against the first financial duty and consequential qualification of my 'regularity' opinion and the failure of the second financial duty. I have not qualified my 'true and fair' opinion in respect of any of these matters.

Financial duties

Health Boards are required to meet two statutory financial duties – known as the first and second financial duties.

For 2023-24, the LHB failed to meet both the first and the second financial duty.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to Health Boards by allowing them to balance their income with their expenditure over a three-year rolling period. The three-year period being measured under this duty this year is 2021-22 to 2023-24.

As shown in Note 2.1 to the Financial Statements, the Health Board did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £5,007.912 million by £86.359 million.

Where a Health Board does not balance its books over a rolling three-year period, any expenditure over the resource allocation (i.e. spending limit) for those three years exceeds the Health Board's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires Health Boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. This duty is an essential foundation to the delivery of sustainable quality health services. A Health Board will be deemed to have met this duty for 2023-24 if it submitted a 2023 to 2026 plan approved by its Board to the Welsh Ministers, who were required to review and consider approval of the plan.

As shown in Note 2.3 to the Financial Statements, the Health Board did not meet its second financial duty to have an approved three-year integrated medium-term plan in place for the period 2023 to 2026.

Adrian Crompton

Auditor General for Wales

12 July 2024

Appendix 2

Letter of representation

Aneurin Bevan University Health Board's letter head

Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

xx July 2024

Representations regarding the 2023-24 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Health Board for the year ended 31 March 2024 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Health Board will continue in operation.

- ensuring the regularity of any expenditure and other transactions incurred.
- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Health Board and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware; and
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by Aneurin Bevan University Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Health Board on 11 July 2024.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Chief Executive	Chair of the Health Board
Date:	Date:

Appendix 3

Summary of corrections made

During our audit, we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention.

Value of correction	Accounts areas	Explanation
£2,004k	Note 4 – Miscellaneous income	£2,004k of income had incorrectly been classified as “Welsh Government” rather than as “Education, training and research”.
£2,268k	Note 30 – Related Parties	Two boxes in the Welsh Government row were left blank. “Amounts owed” was corrected to show £22k and “Amounts due” to £2,246k.
£540k	Note 30 – Related Parties	Disclosure missing for Kaleidoscope Project, which is a related party and had transactions with the Health Board. Amounts added: Expenditure: £50k Income: £413k Amounts Owed: £26k Amounts Due: £51k
£12k	Remuneration Report	One Independent Member had been underpaid by £12k during the year. Their salary band was therefore amended from £0-5k to £10-15k. Expenditure was increased by the same amount which impacted the year end position within the SOCNE and other subsequent notes.
Various	Remuneration Report	2 errors in Executive and Independent Member salary disclosures were identified and subsequently amended.

Value of correction	Accounts areas	Explanation
Various amounts and narrative	Other	During the audit, we identified a number of trivial amendments and errors in the narrative which the Health Board has chosen to amend.
Various narrative	Performance Report and Accountability Report	A number of amendments to the performance and Accountability Report, including the Annual Governance Statement were requested to ensure full compliance with relevant guidance.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We 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*, and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2023.

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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

* QAD is the quality monitoring arm of ICAEW.

Supporting you

Audit Wales has developed a range of resources to support the scrutiny of Welsh public bodies and to support those bodies in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

	our Good Practice work where we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.
	our newsletter which provides you with regular updates on our public service audit work, good practice, and events.
	our publications which cover our audit work completed at public bodies.
	information on our forward performance audit work programme 2023-2026 which is shaped by stakeholder engagement activity and our picture of public services analysis.
	various data tools and infographics to help you better understand public spending trends including a range of other insights into the scrutiny of public service delivery.

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

11 July 2024

Representations regarding the 2023-24 financial statements

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  - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Health Board will continue in operation.
- ensuring the regularity of any expenditure and other transactions incurred.
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  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
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Representations by Aneurin Bevan University Health Board

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We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:
Nicola Prygodzicz
Chief Executive
11 July 2024

Signed by:
Ann Lloyd CBE
Chair of the Health Board
11 July 2024

Archwilio Cymru
Audit Wales

Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: July 2024

Document reference: 3997A2024

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed / to be performed in accordance with statutory functions.

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.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts 2023-24	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the Health Board.	Closing	Audit of Accounts report to be presented to the July 2024 Audit, Risk and Assurance Committee
Audit of Charitable Fund Accounts 2023-24	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Not started	To be confirmed

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Deep dive on financial efficiencies	Chief Executive Officer	In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.	Fieldwork complete	September 2024
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the	Part 1 – Regional report in internal clearance	September 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Part 2 – Project brief issued	
Quality Governance Review Follow up (Local Work)	Executive Director of Nursing Medical Director Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Fieldwork starting soon	November 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Project Brief issued – fieldwork starting soon	November 2024
Structured Assessment 2024 - Core	Chief Executive Officer	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.	Fieldwork underway	November 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Chief Executive Officer	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Planning	To be confirmed
Eye Care Review (Local Work)	Chief Operating Officer	The precise focus of this work is still to be determined but will look to assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.	Scoping	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
Community Pharmacy Data Matching Pilot • **Article related to this report** • **Blog related to this report**	**May 2024**
Governance of National Park Authorities	April 2024
Supporting Ukrainians in Wales	March 2024
From firefighting to future-proofing – the challenge for Welsh public services	February 2024
Corporate Joint Committees – commentary on their progress	November 2023

Additional information

7 There have been no corporate documents published by Audit Wales since the last committee update.

8 There are no relevant Audit Wales consultations currently underway.

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Community Pharmacy Data Matching Pilot

May 2024

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Andrew Evans
Chief Pharmaceutical Officer
Cathays Park
Cardiff
CF10 3NQ

Reference: 4158A2024

Date issued: 23 May 2024

Dear Andrew

I am writing to share the findings from a community pharmacy data pilot project we have undertaken, working with NHS Counter Fraud Service Wales (NHS CFS Wales). Our aim was to analyse community pharmacy dispensing data at scale, to provide insight to NHS Wales on areas of high cost and potential fraud. We also saw this work as an opportunity to develop Audit Wales's expertise in fraud analytics techniques.

We chose community pharmacy as the focus of the pilot because it is an area of known fraud risk and does not appear to be scrutinised for fraud as much as some other NHS services.

Community pharmacy also involves considerable expenditure. NHS Wales spent a total of approximately £772 million on drugs, appliances and services related to community pharmacy activity in 2022-23. £162 million of this was for remuneration for the provision of community pharmacy services. The remaining £610 million was reimbursement for medicines and appliances purchased by pharmacies and dispensed against NHS prescriptions.

Our pilot covered Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board. We focused our analysis on three areas of known risks around fraud and cost: Expensive items; Specials; and Higher cost formulations.

We established and followed data governance procedures carefully, undertaking our work under the Auditor General's data matching powers set out in Part 3A of the Public Audit (Wales) Act 2004. We built an interactive data tool that analysed 31 million lines of data, covering three years of dispensing, and highlighted numerous outliers of interest. We highlighted these outliers to the two health boards involved.

The bullet points below summarise our conclusions:

- Our work did not find any immediate evidence of fraud, although we focused on a small number of fraud risks. While many of the outliers we flagged were known to the health boards in question, some were not. The health boards and NHS CFS Wales carried out further work to understand the issues underlying the outliers. We understand that two pricing errors were found, with a total overpayment value of £22,000, and NHS CFS Wales and NHS Wales Shared Services Partnership (NWSSP) are collaborating on how to reclaim these overpayments. Other outliers were deemed to be explainable and were not found to be cases of fraud or error.
- Our work has flagged a specific risk in relation to limited controls around the cost of Specials. No price restrictions are in place for certain Specials, presenting various opportunities for fraud or error. Although subject to various caveats, we estimate that during the three years covered by the pilot (April 2018 – March 2021), **approximately £700,000 could have been saved** in Wales if each instance of the highest cost dispensing of a Special was reduced to the Special's average dispensing cost. It is possible that our estimate may overstate the possible savings as we have included in our calculation some Specials that have a fixed price, and as such, no saving would be possible. It may also be the case that our estimate is understated because further savings could be possible by reviewing instances of dispensing that are of higher cost than the average but below the maximum cost.
- We flag inherent risks around contractors reimbursed large sums of money for dispensing activity in relation to Expensive items. The data tool identifies five contractors that dispensed more than £1 million of Expensive items during the period covered in the pilot. As a general principle, it may be advisable for health boards to carry out additional checks for contractors dispensing Expensive items at high levels such as this.
- We are aware of some work by NHS CFS Wales and a potential pilot by the Post Payment Verification (PPV) team at NWSSP that relate to identifying and reviewing fraud risks in community pharmacy dispensing activity. And we know that health boards' analysis of dispensing activity tends to focus on data from their health board alone. This approach may miss risks that could be identified by comparing their dispensing activity to other health boards. Also, processes for monitoring dispensing activity vary and a lack of capacity and resource can limit health boards' work. Overall, we concluded there is scope for more analysis of community pharmacy dispensing on a national basis for the purposes of detecting or preventing fraud and ensuring value for money.

We have decided to end the pilot and not develop the tool further. However, we have learnt valuable lessons and are looking for other areas of work in the field of fraud analytics. We also believe the NHS in Wales can learn from the work we have done. There is potential for others to adapt our tool, for example, to inform post-payment verification for dispensing. As such, we have provided our tool and wider learning from our approach to the PPV team at NWSSP. These staff are better placed to overcome the data governance complications we experienced and are also better placed to use the tool to explore outliers with health boards and dispensing contractors.

Any future approach to analysing dispensing data at scale would be greatly enhanced if other data sources could be joined up, particularly if users could access individual prescriptions. Health boards can access individual prescriptions via systems in place provided by NWSSP, but it would have been too complicated for us to access this data in the pilot. We have also learnt that subject matter knowledge, time and appetite from health boards, and multi-agency discussions, will be important to the success of any future fraud analytics approaches.

We are not making specific recommendations, but listed below are three questions that we believe NHS Wales, including its Directors of Pharmacy, should ask itself, given the findings of our pilot. I should be grateful if you could reply with details of any actions you intend to take in response to these issues:

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

Appendix 1 provides more detail about our data matching pilot. **Appendix 2** summarises our main findings.

I have copied this letter to the Chairs of the Welsh Parliament's Public Accounts and Public Administration Committee, the Health and Social Care Committee, and the Finance Committee, for information. We intend to publish the letter on the Audit Wales website and share the findings with the audit committees of the two health boards in question, as well as with Community Pharmacy Wales and the NHS Wales Counter Fraud Steering Group.

Many thanks to you and your colleagues for their input to this project.

Yours sincerely

Adrian Crompton
Auditor General for Wales

Adrian Crompton
Auditor General for Wales

Appendices

1 About our data matching pilot

2 Main findings from our data pilot

1 About our data matching pilot

Context

1 Fraud and error present a significant challenge to public finances in Wales. We have previously estimated that fraud and error cost anywhere between £100 million and £1 billion each year to Welsh public services[1]. Given our role in auditing public expenditure, Audit Wales has a keen interest in actions to minimise public sector fraud. We facilitate the detection of fraud and error through the National Fraud Initiative, and we are keen to develop further data matching exercises.

2 Our Data Analytics team has been working with NHS CFS Wales colleagues on a pilot project using community pharmacy dispensing data. Community pharmacy is an area of considerable expenditure and with known fraud risks. NHS Wales spent a total of approximately £772 million on community pharmacy activity, covering both prescribing and non-prescribing costs in 2022-23. £162 million of this was for remuneration for the provision of community pharmacy services. The remaining £610 million was for reimbursement for medicines and appliances purchased by pharmacies and dispensed against NHS prescriptions. Simple application of the Public Sector Fraud Authority's estimate that between 0.5% and 5% of all government spending is lost to fraud and error[2] suggests the amount lost in relation to the £772 million[3] could range from £3.9 million to as much as £38.6 million.

3 We took an innovative approach, accessing data in a new way[4], analysing large amounts of data, and producing an interactive data tool that flagged outliers and formed the basis of facilitated discussions with health boards.

1 Auditor General for Wales, Counter-Fraud Arrangements in the Welsh Public Sector, June 2019

2 Public Sector Fraud Authority, Cross-Government Fraud Landscape Annual Report 2022, March 2023

3 We calculated this figure using the NHS (Wales) Summarised Accounts Local Health Boards, NHS Trusts and Special Health Authorities in Wales. It is the sum of the 'cash limited' totals of 'Pharmaceutical Services' cost and the 'Prescribed drugs and appliances' cost in 'Table 2.1 Expenditure on Primary Healthcare Services'. 'Pharmaceutical Services' include non-prescribing costs, for example running costs and enhanced services of community pharmacies. 'Prescribed drugs and appliances' are mostly the cost of primary care prescriptions.

4 We accessed the data under the Auditor General's data matching powers provided under Part 3A of the Public Audit (Wales) Act 2004 for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales.

4 Beyond an overall aim of preventing and detecting potential fraud and error, the aims of the pilot project were to:

- generate new insights into areas of high cost and potential fraud by analysing dispensing data at scale and by highlighting outliers;
- facilitate discussion between stakeholders to explore outliers and agree improvement actions;
- develop our expertise in fraud analytics techniques to apply to other projects; and
- report on our findings to provide assurance and food for thought on future actions regarding fraud analytics and prevention.

What we did

5 Working with NHS CFS Wales, we involved various other stakeholders and subject matter experts when developing our approach. These included NWSSP, Swansea Bay University Health Board, and Cwm Taf Morgannwg University Health Board, Community Pharmacy Wales[5], the NHS Wales Chief Pharmacists Group, the NHS Counter Fraud Authority in England, and NHS Scotland Counter Fraud Services.

6 To limit the size of the pilot, we included only two health boards in our analysis. We chose Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board for a number of reasons, including the availability of staff willing to participate in the pilot[6]. We are very grateful for their involvement.

7 This was the first pilot of its kind and, because Audit Wales is not part of NHS Wales, we do not have permissions to directly access certain data. NHS bodies requested that data sharing agreements be put in place. Unfortunately, while such agreements are encouraged by the Information Commissioner's Office, they would not be lawful in this situation, as they would fetter the Auditor General's access rights. We resolved this by drafting a 'Data Sharing Protocol'. The protocol helped ensure that data protection obligations were observed but without such unlawful fettering. And before requesting and receiving the source data from NWSSP, we sent privacy notices to more than 200 community pharmacy dispensing contractors covered in our scope (approximately 28% of the 712 community pharmacies in Wales in 2021-22[7]).

5 Community Pharmacy Wales represents community pharmacies in Wales on NHS matters. Its main objective is to secure the best possible NHS service opportunities, remuneration and terms.

6 On 1 April 2019, the responsibility for providing healthcare services in Bridgend County Borough moved from Abertawe Bro Morgannwg University Health Board (the predecessor of Swansea Bay University Health Board) to Cwm Taf University Health Board (the predecessor of Cwm Taf Morgannwg University Health Board). By including these neighbouring health boards in our pilot, we ensured that our data covered the same sample of community pharmacies across all years.

7 StatsWales, Community pharmacies by LHB and year, 21 March 2024

8 Overall, the data governance aspects of the pilot, though necessary, were complicated and took a large amount of time to implement. They would also have been more time consuming had we involved more than two health boards.

9 We identified key areas of risk and focused on three markers of concern:

a **Higher cost formulations:** Different formulations (eg liquids, tablets, capsules, creams, branded and non-branded etc) of the same active substance[8] can vary widely in price. Higher cost formulations were involved in an NHS CFS Wales investigation that resulted in a criminal prosecution[9]. This came after a pharmacy had dispensed cheaper formulations, then claimed for more expensive formulations. We identified these items as a fraud risk, particularly in the case of hospital prescriptions. Hospital prescriptions are more likely than GP prescriptions to be handwritten and are therefore susceptible to being altered for fraudulent purposes.

b **Expensive items:** Items with a net ingredient cost[10] of £100 or more. In the investigation above, numerous prescriptions were for Expensive items. Therefore, we included this group of items as a potential indicator of fraud risk.

c **Special orders (Specials)**: Items requiring special preparation by a registered manufacturer. For many Specials – those not found in the Drug Tariff[11] – there is no restriction on their price. This presents a risk for potential high costs and/or fraud.

10 **Exhibit 1** provides an overview of the data we considered in the pilot.

8 Active substances give medicinal products their therapeutic effect and are often referred to as active pharmaceutical ingredients.

9 NHS Wales Shared Services Partnership, Pharmacist struck off following conviction for £76,475 fraud, September 2020

10 Net ingredient cost refers to the 'cost (which the dispenser is reimbursed) of the drug before discounts and does not include any dispensing costs or fees. It does not include any adjustment for income obtained where a prescription charge is paid at the time the prescription is dispensed or where the patient has purchased a pre-payment certificate.'

11 The Drug Tariff is a document produced each month by NHS Prescription Services on behalf of the UK Government's Department of Health and Social Care. It specifies what amount of money (as net ingredient cost) a dispensing contractor will be reimbursed for dispensing an item included in the tariff, establishing a fixed price for each item found in the tariff each month.

Exhibit 1: dispensing data reviewed in the pilot, April 2018 – March 2021

Dataset	Approximate number of items	Approximate net ingredient cost of items
Formulations	30,785,000	£96.2 million
Expensive items	327,000	£70.6 million
Specials	19,000	£2.8 million

Note: The datasets are not mutually exclusive, items in one dataset may be found in another. The formulations data includes approximately 70 active substances, corresponding to approximately 1,170 formulations. Each formulation has a distinct combination of strength, form, and/or brand for the given active substance. We worked with NHS CFS Wales and the health boards to identify a range of active substances with formulations that are particularly expensive and/or of concern.

Source: NHS Wales dispensing data provided by NWSSP

11 We built an interactive data tool iteratively using Microsoft Power BI. The aim was to produce a tool that allowed the data to be explored quickly and easily to identify points of concern relating to anomalies, potential fraud, and areas of high cost.

12 Once the health boards had used the tool, we met with them and NHS CFS Wales to explore the issues arising. We presented a sample of outliers that we identified from using the tool, then the health boards provided initial responses to the outliers raised. Some of the outliers were easily explainable and were known by the health boards. Others were not known so the health boards and NHS CFS Wales carried out further work to understand the issues underlying the outliers.

2 Main findings from our data pilot

13 This section summarises our main findings under the following headings:

a The data tool flags clear outliers of potential concern;

b Variation in the cost of Specials suggests potential for savings;

c NHS Wales has limited controls in place for Specials;

d There are inherent risks around community pharmacy contractors that are reimbursed large sums of money for dispensing activity in relation to Expensive items;

e There is scope for more central analysis of risks around community pharmacy dispensing; and

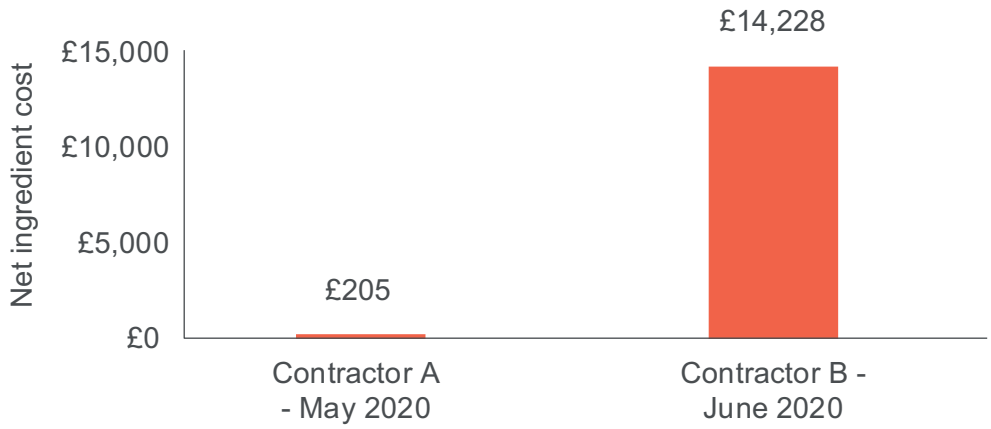
f Our pilot has identified valuable learning for future fraud analytics approaches.

The data tool flags clear outliers of potential concern

14 We have used anonymised examples, taken from our interactive tool, to illustrate the key findings. The tool highlights many more outliers and examples than presented here. Further exploration of these outliers will depend on appetite from the health boards and NHS CFS Wales to use the tool. While we are flagging outliers as highlighted in the data tool, this does not necessarily mean that fraud or error is present or that there is definite potential for cost savings.

15 **Exhibit 2** shows a clear outlier suggesting a large cost discrepancy. It shows an item submitted for reimbursement in May 2020 costing £205 for one contractor but then costing £14,228 when submitted for reimbursement in June 2020 by a different contractor. We found that this was due to an error in the source data, and the correct cost was £1,428 not £14,228. The higher price was reimbursed to the contractor. NHS CFS Wales and NWSSP are now collaborating on how to reclaim the relevant overpayment. We present this outlier because it shows the potential for data tools such as ours to flag such discrepancies.

Exhibit 2: discrepancy* in net ingredient cost for a particular item submitted for reimbursement by different contractors one month apart**



*The £14,228 was paid to dispensing Contractor B rather than the correct cost of £1,428, an overpayment of £12,800. The error is being reviewed by NHS CFS Wales and NWSSP to consider what action to take regarding this overpayment.

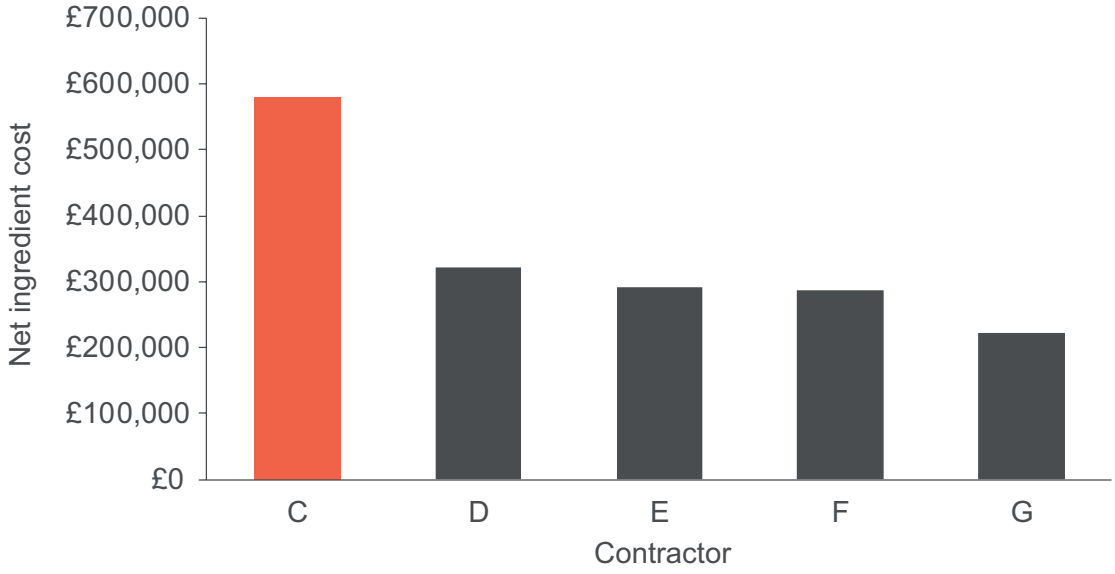
**Reimbursement refers to the money contractors are reimbursed for the medication costs alone and does not include dispensing fees or other costs. The medication costs reimbursed may not be the same as the total net ingredient cost of the items dispensed by the contractor, with contractors often receiving deductions in the total net ingredient costs of items they have dispensed.

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

16 **Exhibit 3** shows a clear outlier where contractor C has a large cost associated with Expensive items prescribed by hospital prescribers. Contractor C dispensed more than £580,000 worth of such items between April 2018 – March 2021, almost double the next nearest contractor. This is not necessarily unusual activity, with dispensing activity for hospital outpatient prescriptions depending, at least partly, on the policies and procedures of the health board in question.

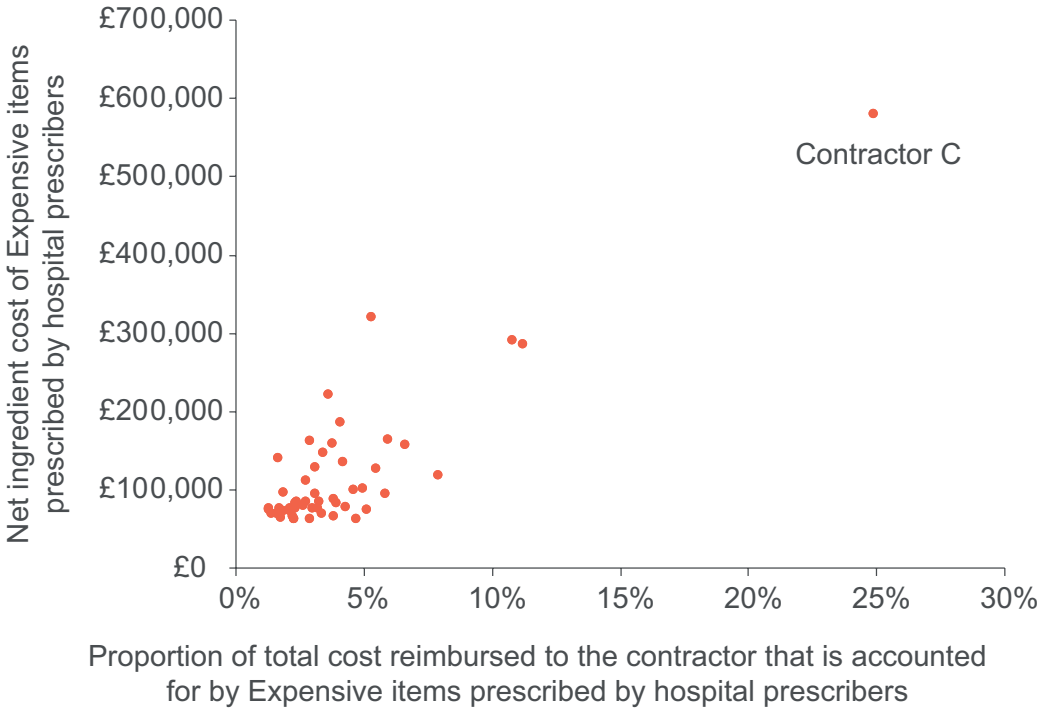
17 **Exhibit 4** combines analysis of the **Exhibit 3** metric with the proportion of the total cost reimbursed to community pharmacy contractors that is accounted for by Expensive items prescribed by hospital prescribers. **Exhibit 4** shows that contractor C is an outlier in relation to both metrics. This provided greater weight to the argument that contractor C was displaying different dispensing patterns to other contractors. In this case, the relevant health board easily explained this outlier due to contractor C's proximity to a hospital, but this example illustrates the potential for detecting anomalous dispensing patterns using one or more metrics.

Exhibit 3: the five community pharmacy contractors that dispensed the highest total net ingredient cost of Expensive items prescribed by hospital prescribers, April 2018 – March 2021



Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

Exhibit 4: comparison of two metrics of interest, applied to data for individual community pharmacy contractors, April 2018 – March 2021



Note: Each orange dot represents an individual contractor, showing the 50 community pharmacy contractors with the highest total cost of Expensive items, in terms of net ingredient cost, prescribed by hospital prescribers.

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

18 **Exhibit 5** shows how the data tool allows users to explore how community pharmacy contractors perform in relation to multiple metrics, helping to flag contractors that warrant further analysis. The exhibit suggests contractors H and K could be of particular interest to review.

Exhibit 5: example of seven community pharmacy contractors reviewed against multiple metrics, April 2018 – March 2021

This exhibit is based on comparisons for contractors with some of the highest values for Metric 2. Higher values are highlighted in bolder colour.

	Expensive items		Specials		Higher cost formulations	
Contractor	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	Metric 6
H	£1,498,199	24%	£15,836	0.3%	£1,184,442	31%
I	£805,751	22%	£19,847	0.5%	£847,091	31%
J	£767,544	33%	£3,527	0.2%	£375,844	20%
K	£767,056	27%	£353,425	12.6%	£482,895	16%
L	£698,364	23%	£6,472	0.2%	£544,566	22%
M	£571,122	22%	£23,304	0.9%	£424,811	17%
N	£503,651	26%	£6,303	0.3%	£302,580	17%

Notes:

Metric 1 is the total net ingredient cost of all Expensive items dispensed by each contractor. Metric 2 is the proportion of the total cost the contractor is reimbursed for that is accounted for by Metric 1.

Metric 3 is the total net ingredient cost of all Special items dispensed by each contractor. Metric 4 is the proportion of the total cost the contractor is reimbursed for that is accounted for by Metric 3.

Metric 5 is the total net ingredient cost for all the items in the formulations dataset dispensed by the contractor. Metric 6 is the proportion of metric 5 that is accounted for by the higher cost formulation items identified that are dispensed by each contractor.

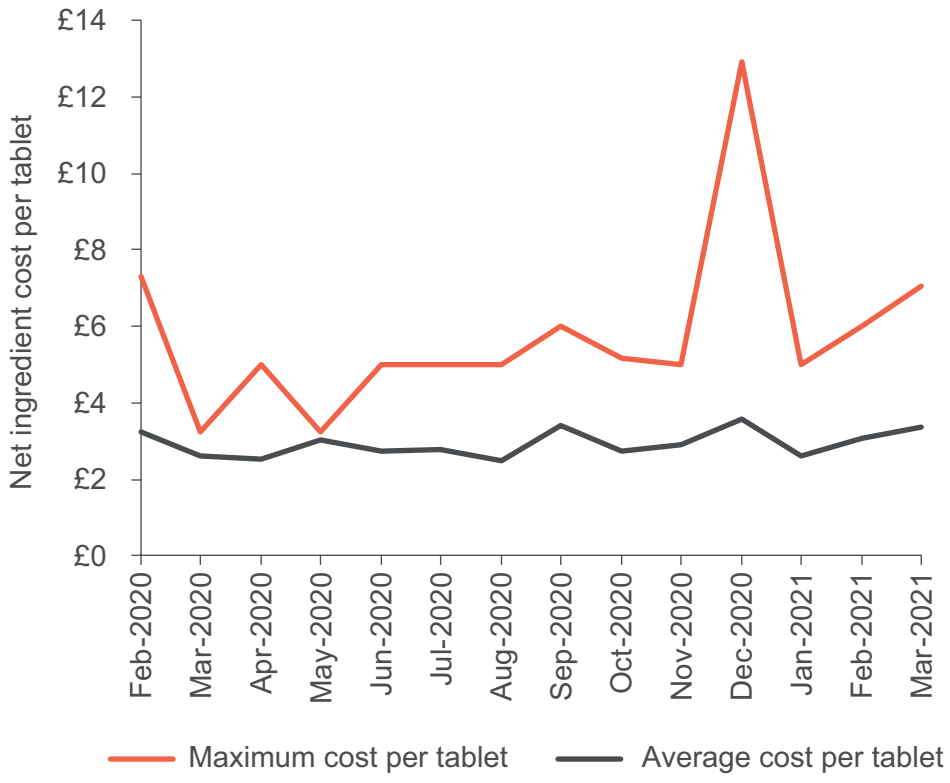
Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

Variation in the cost of Specials suggests potential for savings

19 As noted in **paragraph 9,** Specials not included in the Drug Tariff have no restriction on price. Our data tool highlights several cases where a particular Specials item has varied widely in price within a given month.

20 **Exhibit 6** shows a trend in the maximum and average net ingredient cost of dispensing a particular Specials item (Sucralfate 1-gram tablet)[12]. The costs vary greatly within each month, with instances of the price per tablet rising to nearly £13 in one month compared to an average of £3.56 for the same month. For each month of data, the differences between the maximum and average price indicate potential opportunities for cost savings. Where the cost is much greater than average, this might present cause for review to identify the potential for cost savings.

Exhibit 6: maximum and average net ingredient cost per tablet of Sucralfate 1-gram tablets dispensed by community pharmacy contractors, February 2020 to March 2021



Note: Dates refer to date submitted for reimbursement, which may be different to the date of dispensing.

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

12 Sucralfate 1g tablets were added to the Drug Tariff in March 2022, after we had completed our pilot. While we have highlighted this issue by using Sucralfate 1g tablets as an example, the general issue applies to all Specials items not named in the Drug Tariff.

21 We identified many other examples of variability in the maximum and average cost of Specials. For example, **Exhibit 7** shows an example where Contractor O submitted an item for reimbursement for £874, while other contractors had done so for £435 or less, for the same item (same medication, quantity, and strength) within the same month. This indicates an opportunity to potentially save £439 or more on this one item alone. NHS CFS Wales reviewed the prescriptions for these items. Price differences were due to different suppliers and pack sizes. The £874 claim price was identified as significantly different from the other claims, and a good example of a prescription that may require further verification work from the health board and/or the PPV team at NWSSP.

Exhibit 7: net ingredient cost of 112 tablets of Sucralfate 1g submitted for reimbursement in May 2018 by four community pharmacy contractors

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

22 The issues highlighted in **Exhibits 6 and 7** may present genuine potential for cost savings. However, without further investigation, working with the health boards, as well as someone with in-depth subject matter knowledge, to review individual prescriptions or invoices, we do not know which cases are normal behaviour, error, or fraud.

23 We estimate that for the two health boards reviewed, approximately £200,000 could have been saved over the three years covered in the pilot if each instance of highest cost dispensing of a Special for a given month[13] was reduced to its average cost for that given month. The calculation considers each month in isolation due to the cost for a Special potentially varying over the time of the pilot.

24 Using data from StatsWales[14] we determined the total net ingredient cost for medications for all of NHS Wales is approximately 3.5 times that of the two health boards. Extrapolating from the two health boards to all of NHS Wales using this figure produces an equivalent savings estimate of approximately £700,000.

25 These calculations are presented for illustrative purposes and are subject to certain caveats and a large degree of uncertainty. The calculations assume that it is reasonable to extrapolate the potential savings in the two health boards to all of Wales. The calculations also assume that all instances of the highest cost dispensing could be reduced, and so provide a potential saving opportunity. It is not clear from the data whether this is a reasonable assumption. It is also possible that our estimate may overstate the possible savings, given that we have included in our calculation some Specials that have a fixed price, and as such, no saving would be possible. Further information and investigation would be required to clarify the savings possible.

26 In addition, our calculations assume that it is reasonable to use just the highest and average cost of dispensing to estimate potential savings. We have used the highest and average cost because Specials are dispensed relatively infrequently, providing a limited number of dispensing instances to undertake the savings calculations each month for a given Special. However, it is possible that our estimate may understate the possible savings, given that it does not consider instances of dispensing that are higher than the average cost but below the maximum. Additionally, the average cost may not reflect good value. Reducing costs to below the average could identify further potential savings.

13 Highest net ingredient cost per unit of medication for medication for given month. The month being the date the item was submitted for reimbursement, which may be different from the date of dispensing.

14 StatsWales, Prescription items and cost by area and BNF chapter by year, 27 June 2023

NHS Wales has limited controls in place for Specials

27 The UK Government's Department of Health and Social Care decides which Specials to include in the Drug Tariff[15]. The Drug Tariff has changed over time, for example Part VIIID 'Arrangements for payment for Specials & Imported Unlicensed Medicines with Prices Determined Relative to a Commonly Identified Pack Size' was added in March 2022, introducing controls on payments for some additional Specials. We are not aware of any other fixed controls regarding the cost of Specials outside inclusion in the Drug Tariff.

28 Community pharmacies do not need approval from health boards before dispensing Specials. And health boards cannot direct contractors to use cheaper manufacturers unless specified in the Drug Tariff. Some health boards do review high-cost items to ensure they are appropriate. Health boards can also provide advice and support for the prescribers of Specials. The prescriber has responsibility to assess what is clinically appropriate for the patient and the dispensing contractor has responsibility to raise any clinical concerns.

29 Prices for Specials not found in the Drug Tariff can vary between different contractors, GP clusters of contractors, and health boards. Analysis of Specials costs across Wales, comparing health boards, may therefore highlight potential savings opportunities. We are not aware of such analysis being done.

30 Invoices for Specials specify what a manufacturer has charged a pharmacy contractor for a given item. They can be used to confirm that the contractor has claimed and been reimbursed for the correct amount. However, we are not aware of any requirement currently for contractors to submit invoices for Specials. And for invoices that are submitted, we are not aware of any routine inspection of them by NWSSP as part of the reimbursement processes to community pharmacy contractors for Specials. Review of these invoices in future analysis could highlight cases of error or fraud and lead to potential cost savings. Using a tool similar to ours could allow more informed decisions on which contractors to focus on.

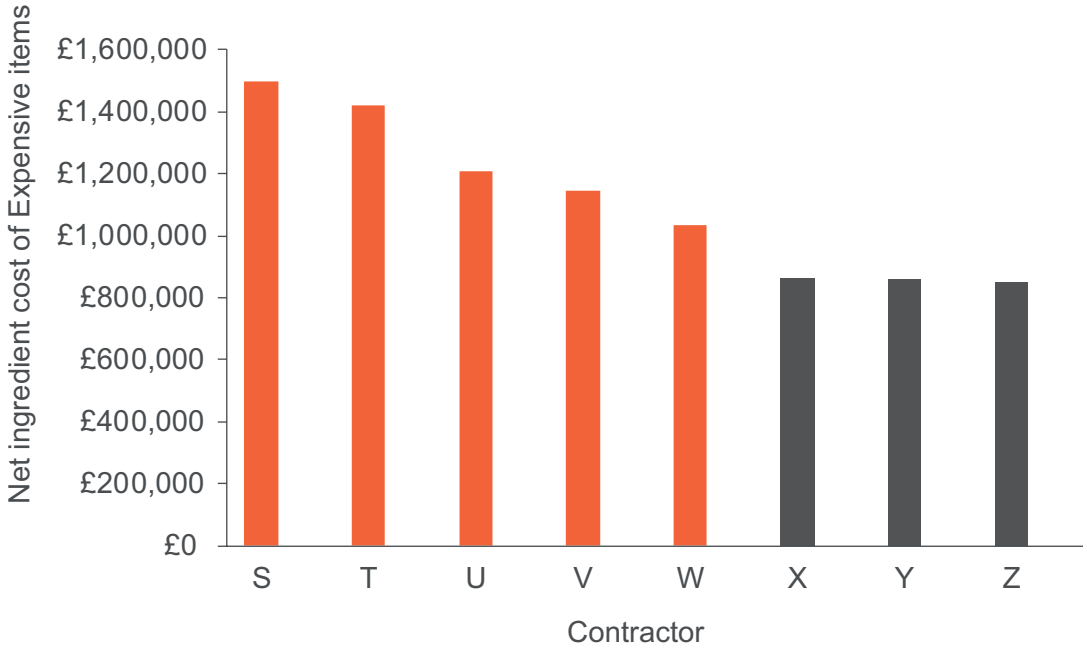
15 This control limits the amount the dispensing contractor can be reimbursed, in terms of the net ingredient cost of the item, for dispensing a Special in the Drug Tariff. This control is limited to this aspect in the supply of a Special. The dispensing contractor may have generated income or lost money depending on whether they paid more or less than the amount reimbursed to obtain the Special from the manufacturer. The contractor will also receive an additional dispensing fee for a Special.

31 As a result of our pilot highlighting concerns around the cost of Specials, NHS CFS Wales has discussed with the PPV team in NWSSP the potential for further work on dispensing risks. The PPV team has learnt from our approach to develop a dashboard to highlight data of concern as part of a pilot that may be carried out this year. The pilot would review prescription invoice claims for potential outliers, possible erroneous claims and potential incorrect data entry. Depending on the outcome, this may become a permanent check undertaken by the PPV team.

There are inherent risks around community pharmacy contractors that are reimbursed large sums of money for dispensing activity in relation to Expensive items

32 **Exhibit 8** shows the eight community pharmacy contractors in our dataset that dispensed the highest total cost (as net ingredient cost) of Expensive items. It shows that five contractors each dispensed more than £1 million of Expensive items during the period covered in the pilot.

Exhibit 8: the eight contractors in our dataset with the highest total net ingredient cost of all Expensive items dispensed, April 2018 – March 2021



Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

33 The data tool provided value in enabling these and other contractors with large reimbursement costs, for the medication and appliances dispensed, to be identified quickly and easily alongside other information regarding risks related to contractors. The health boards may wish to review these contractors given the large sums of money reimbursed to these contractors for Expensive items. As a general principle, it may be advisable for health boards to carry out some additional checks of contractors with high levels of reimbursement costs for Expensive items, as well as high levels of costs overall, given the large sums of money involved and the potential to identify savings and instances of possible fraud.

There is scope for more central analysis of risks around community pharmacy dispensing

34 **Paragraphs 20 to 26** highlight scope for specific savings but our pilot focused on only three markers of concerns. Fraud can take place in other ways. For example, a contractor may claim to have dispensed items that have not been collected by patients, fraudulently claiming for the cost of items and dispensing activity that has not been completed.

35 Health boards have processes in place to monitor various aspects of dispensing activity, however, these vary between health boards. Relying on the work of individual health boards alone may also miss opportunities to identify areas of high cost and potential fraud across Wales. For example, a group of contractors may not present as anomalous in the health board alone but could be identified as anomalous when compared to all contractors in Wales.

36 A lack of capacity and resource in health boards can limit health boards' work in interrogating risks around community pharmacy dispensing data. Processes can depend on the knowledge and availability of an individual member of staff, which poses succession planning risks, as well as risks around a single point of failure. The complexity of analysis required and the volume of data involved add further disincentives for health boards to carry out this work.

37 We have not been made aware of any analytical work to review community pharmacy dispensing fraud risks for NHS Wales other than work undertaken by NHS CFS Wales, the potential PPV pilot mentioned in **paragraph 31** and the analysis carried out by individual health boards in isolation. NHS CFS Wales has reviewed areas of risk around community pharmacy such as the initial investigation that informed our pilot, as well as reviews of out of pocket expenses. We concluded that more centrally supported work to detect and prevent fraud in dispensing activity, as well as to ensure value for money, could be beneficial.

Our pilot has identified valuable learning for future fraud analytics approaches

38 We have learnt valuable lessons from our pilot, including:

a **It is feasible to analyse entire populations of data** – Our approach and our interactive tool allowed us to focus on known risks and made it possible to explore millions of data items. This could allow much more in-depth analysis than more limited, sampling approaches.

b **Subject matter knowledge and multi-agency discussions are vital** – The analysis of specific risks was most effective when health board staff were in discussion with NHS CFS Wales and Audit Wales. These discussions brought together a blend of local and subject matter knowledge, as well as specialist fraud and data skills. Without detailed subject matter knowledge related to the everyday realities of community pharmacy and dispensing practices, it was sometimes difficult for us to fully understand the risks and issues.

c **Time and appetite are necessary in health boards to make use of data tools** – Our approach relied on health board staff having time to explore the data tool. Without this, future tools may not be used fully, and opportunities to identify and respond to concerns may be missed.

d **It would be beneficial to join up our pilot data with other data sources** – Any future approach to analysing dispensing data at scale would be greatly enhanced if other data sources could be joined up, particularly if users could access individual prescriptions. This would allow efficient exploration of outliers, with all data being in one place. The lack of data on individual prescriptions was a barrier in our pilot project. Health boards can access individual prescriptions via systems in place provided by NWSSP but it would have been too complicated for us to access this data in the pilot because we are not an NHS organisation and the data governance requirements would have been substantial.

39 Our work did not find any immediate evidence of fraud, although our work focused on a small number of fraud risks. While many of the outliers we flagged were known to the health boards in question, some were not. The health boards and NHS CFS Wales carried out further work to understand the issues underlying the outliers. We understand that two pricing errors were found, with a total overpayment value of £22,000, and NHS CFS Wales and NWSSP are now collaborating on how to reclaim these overpayments. Other outliers were deemed to be explainable and were not found to be cases of fraud or error.

40 We have decided to end the pilot and not develop the tool further. This is mainly due to the complexities of delivering such a project as an external organisation to the NHS in Wales (see **paragraphs 7 and 8).** However, we will build upon the learning from the pilot and look to undertake new fraud analytic projects, including one using a data matching approach to explore whether patients are accurately registered in GP lists.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Head of Internal Audit Opinion & Annual Report 2023/2024

June 2024

Aneurin Bevan University Health Board

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Appendix A Conformance with Internal Audit Standards
Appendix B Audit Assurance Ratings

Report status:	Final
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Final report issued:	27th June 2024
Author:	Head of Internal Audit
Executive Clearance:	Director of Corporate Governance
Audit, Risk and Assurance Committee:	July 9th 2024

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.

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

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

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

1.2 Head of Internal Audit Opinion 2023-24

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2023/24 is that:

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

1.3 Delivery of the Audit Plan

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

The Internal Audit Plan for 2023/24 year was initially presented to the Committee in April 2023. Changes to the plan have been made during the course of the year and these changes have been reported to the Committee as part of our regular progress reporting.

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

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy in March 2023, and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS). We are able to state that our service 'fully conforms to the IIA's professional standards and to PSIAS'.

1.4 Summary of Audit Assignments

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

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

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

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

A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2023/24

Substantial Assurance	Reasonable Assurance
• Financial Controls • Integrated Performance Dashboard – Data Quality • Early Supported Discharge – Stroke • Maternity Services - Action Plan • Stakeholder Engagement on IT Projects • IAP: YYF Breast Care Services	• Asset Management • Medical Equipment and Devices • Risk Management and Assurance • Integrated Medium Term Plan • Business Continuity Planning • Safeguarding • Waiting List Management (draft report) • Clinical Coding • Intra-site Patient Transfers • Long Term Sickness Absence Management • Network Infrastructure (VPN) • LINC Programme • Savings Programmes (draft report) • Directorate Review – Theatres
Limited Assurance	**Advisory/Non-Opinion**
• Bevan Health and Wellbeing Centre • Estates Assurance – Estates Condition • Facilities Bank Approval Process • Decarbonisation • Regional Partnership Board	• Follow-up of High Priority Recommendations • Flexible Working
Unsatisfactory Assurance	
• N/A	

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

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

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

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

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

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

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

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

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

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

2.2 Purpose of the Head of Internal Audit Opinion

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

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

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

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2023/24 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

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

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

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

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

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

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

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

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

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

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2023/24 and reported to the Audit, Risk and Assurance Committee has been aggregated at Section 5.

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

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

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

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

In reaching this opinion we have identified that the majority of reviews during the year concluded positively.

From the opinions issued during the year, six were allocated Substantial Assurance, fourteen were allocated Reasonable Assurance and five were allocated Limited Assurance. No reports were allocated an 'unsatisfactory' opinion. We also issued two reports that were not rated.

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

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

Corporate Governance, Risk Management and Regulatory Compliance

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

We completed a review of **Risk Management and Assurance** (reasonable assurance) where we assessed the risk management arrangements within the digital directorate. Overall, we found good arrangements in place, but identified that an overarching directorate risk register should be compiled and Datix utilised, when upgrades to the software have been completed.

We completed the **Follow-up of High Priority Recommendations** review (not rated) where we assessed if high priority (and other significant) recommendations from within an appropriate period had been implemented, together with the Recommendation Tracker being updated accordingly. Overall, we found the process for updating the Recommendation Tracker and extending recommendation deadlines is clear.

Strategic Planning, Performance Management & Reporting

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

The **Integrated Medium Term Plan** audit (reasonable assurance) was undertaken over the controls to ensure the delivery of the IMTP / strategic objectives. Overall, whilst we found processes in place for monitoring the deliverables within the IMTP we raised matters relating to the age of some of the performance data, responsibility for the IMTP targets within divisions and the delivery milestones regarding the Clinical Futures targets.

The overall objective of the **Integrated Performance Dashboard – Data Quality** audit (substantial assurance) was to assess the accuracy of data utilised within the Integrated Performance Report (IPR) dashboard. In particular, we focused on the accuracy of a sample of data used within the reporting of key metrics within the IPR dashboard i.e. that the source data utilised was consistent with the figures within the dashboard.

We found no data quality issues within the IPR dashboard, but we did note that compilation is largely a process of transcription from monthly data values provided by teams within the Health Board or taken from national data tables.

Financial Governance and Management

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

We completed an audit of **Financial Controls** (substantial assurance) over a sample of key financial controls within the Treasury function. In particular, the arrangements regarding bank reconciliations and supporting processes. We found good arrangements in place and no significant issues.

We completed an audit of **Asset Management** (reasonable assurance) to assess the effectiveness of the Health Board's processes to create and

maintain accurate and up-to-date records of its equipment assets. In particular, we focused on the rollout of the RFID asset tagging process.

We noted the asset register relies on manual processes for data capture and updating. This uses both paper flows from asset owners advising of additions, disposals and asset movements and capital spend analysis to update the equipment asset register. However, we found delays in the receipt of these change forms, potentially leading to register inaccuracy. The radio frequency (RFID) asset tagging process, which has now reached 67% of the eligible equipment base with a plan to complete by March 2025, improves asset management and, in particular, facilitates asset physical verification. However, as with the manual process, we found weaknesses persist around equipment disposal management, where controls need strengthening.

We provided an opinion over the **Financial Controls – Regional Partnership Board** (limited assurance) where we examined the compliance with the Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) of the Health Board, regarding Regional Partnership Board (RPB) payments made on behalf of the RPB, by the Health Board.

We found that the financial framework, for the management of RPB activities is, in principle, aligned to the Health Board's approach to ordering, receipting and payments of purchases. However, we noted a lack of a documented record of roles and responsibilities throughout that process, specific to the RPB.

In addition, detailed sampling of payment transactions identified examples of compliance issues with the FCPs and SFIs, partly due to the non-standard nature of the funding transactions, and opportunities for operational effectiveness to be improved. We raised the following matters arising:

- payments made in advance, prior to services provided;
- a single tender action not reported to the Audit, Risk and Assurance Committee in a timely manner;
- the completeness and timely provision of information and the lack of guidance regarding this process; and
- the receipting process and prompt payment of some invoices.

We completed an audit of **Savings Programmes** (reasonable assurance), where the Health Board evaluates savings achieved through a variety of mechanisms, linked to spending activity across the year. The 2023/24 savings target was c.£51.5m (2022/23 £17m), including a total of £30m of stretch targets. At the time of the audit c.£43.5m was expected to be achieved. We considered this overall position and the steps taken to develop an annualised savings plan, assigned executives to lead on savings programmes and the operation of the Value and Sustainability Board.

We identified recommendations to enhance the process and the reporting of the savings position.

Quality & Safety

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

The audit of **Early Supported Discharge – Stroke** (substantial assurance) tested the process for supporting patients that may be suitable for rehabilitation within the community. Overall, we found that, within the sample tested, there is a suitably documented and managed service that provided prompt rehabilitation to applicable patients that had suffered a stroke within the previous 12 weeks.

We found an appropriate resourced team to meet the patients' requirements promptly, where typically a triage is completed within approximately 24 to 48 hours of hospital discharge.

The audit of **Safeguarding** (reasonable assurance) focused on the role of the Corporate Safeguarding Team and how they ensure the arrangements in place across the Health Board meet the statutory requirements.

We found good arrangements and controls over the applicable processes, with allegations actioned appropriately. However, we raised recommendations over ensuring the timely completion of a safeguarding form, developing a Delivery Plan for Level Three Safeguarding training and a regular review / update of case files.

The **Clinical Coding** review (reasonable assurance) provided an opinion over the timely recording of Finished Consultant Episodes (FCE), in accordance with clinical coding standards.

We found the internal and external auditing of the function coding accuracy was seen to exceed target rates. However, we identified a number of weaknesses in the arrangements and processes, which are adversely affecting the generation of timely and complete management information. We noted the potential impact of inconsistencies with the structure and content of patient records, in particular, the efficiency of the coding activity. We also found that only a small percentage of the backlog of cases not processed in their designated month are processed in subsequent months and as a result significant volumes remain uncoded, although there were periodic recovery exercises completed to reduce the outstanding activity.

The **Maternity Services - Action Plan** (substantial assurance) audit was an assessment of the governance arrangements in place to monitor the implementation of external actions raised across several reviews.

The audit ascertained the external reviews that have taken place recently and the associated actions required. These were incorporated into the Maternity and Neonatal Services in Wales Assessment, Assurance and Exception Tool which was compiled by the Welsh Government. Whilst this recorded all relevant actions it was superseded by the Improving together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report. The report included timeframes for the delivery of each action which included short term, medium term and long-term timeframes.

The audit also reviewed a sample of actions and associated evidence to see whether appropriate progress is being made.

Overall, within the sample tested we found regular monitoring and reporting in place, including to appropriate committees. We also confirmed that progress has been made with the implementation of the actions sampled.

Information Governance & Security

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

The **Stakeholder Engagement on IT Projects** audit (substantial assurance) assessed the framework in place for stakeholder engagement on key IT projects. We found guidance in place for programme and project management that includes stakeholder engagement and templates for stakeholder communication. Stakeholders are engaged with at early stages with needs fed into requirement specifications. There is appropriate stakeholder involvement in the governance structures, which enables ownership of projects and programmes and users are included within the testing stages and project and programme sign off.

The **IT Infrastructure** audit (reasonable assurance) determined the adequacy of the systems and controls in place for the management of the network and IT Infrastructure assets.

We found good arrangements in place, but raised several recommendations.

The **LINC Programme** audit (reasonable assurance) reviewed the arrangements in place for the mitigation of risk associated with the non or late delivery of the LINC programme of work.

Overall, the key risk associated with the delay to the LINC programme is being appropriately mitigated against through the contingency project; LIMS 2.0. Our review highlighted that the key risk is reflected within both project and directorate risk registers.

Whilst other project-level risks associated with the delay have been appropriately identified and are well-managed, we noted inadequate risk management arrangements within the Pathology directorate.

Operational Service and Functional Management

We have undertaken **six** reviews in this area, with one in progress.

The **Medical Equipment and Devices** audit (reasonable assurance) assessed the management and tracking of ultrasound devices throughout the Health Board. Overall, whilst we found good governance architecture around the Health Board's medical equipment reviewed, sample testing of items revealed a number of weaknesses in equipment records management and accuracy.

The **Business Continuity Planning** audit (reasonable assurance) was a review of the arrangements that the Health Board has in place to maintain business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been considered.

We focused on the role of the Business Continuity Team and how embedded business continuity is across the Health Board. We found detailed guidance in place as required by the Civil Contingencies Act 2004. Within our sample of seven services areas, we found six had continuity plans in place, with one still in the process of being developed.

We raised recommendations over the testing of plans and action cards, in addition to staff training and incorporating actions from post pandemic reviews into operational plans.

The **Waiting List Management** audit (reasonable assurance) established 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, including suitable arrangements for communicating and supporting patients. We raised a significant recommendation over the ongoing clinical reprioritisation of patients on the waiting list and a recommendation over reviewing the costing baselines for patients transferred.

The **Directorate Review – Theatres** (reasonable assurance) provided an opinion over the effectiveness of the Health Board's processes to manage and monitor theatre stocks.

The Health Board manages with a commercial stock management system (Omnicell) an extensive range of items used in its operating theatres.

We identified one high priority issue related to the risk of stock loss or misappropriation, as there is currently no review of potential stock losses within the 'discrepancies' figures captured.

We also raised other medium priority issues relating to stock access; access management controls and compliance with the Health Board's year-end stocktake instructions.

The **Intra-site Patient Transfer** (reasonable assurance) audit has been undertaken to provide an opinion over the management of intra-site patient transfers. We focussed on the Flow Centre and a sample of maternity patients transferred from Ysbyty Ystrad Fawr (YYF) to the Grange University Hospital (GUH).

We found that the recommendations of previously issued reports regarding the Flow Centre were progressing, but had yet to be fully implemented and were continuing to be reported as overdue. Whilst this is being managed via the Audit Recommendation Tracker process we raised recommendations over ensuring the Flow Centre is achieving its objectives and that any further extension of the outstanding recommendations is by exception only.

We also completed a review of a patient transfer that would not be managed by the Flow Centre Team. In particular, maternity patient transfers from the Birthing Unit at YYF to the GUH were sampled and we commented on opportunities to further improve the recording and performance management. These latter recommendations have since been addressed.

The **Facilities Bank Approval Process** audit (limited assurance) assessed whether appropriate stock processes are in place and whether applicable controls within the process for allocating / approving bank shifts are effective.

Whilst we raised a recommendation over retrospective bank shifts, the main risks identified were associated with the management of stock within the Facilities Division. We raised numerous recommendations regarding procedures, non-compliance with the Health Board's stock management policies, unknown stock levels and insufficient waste management awareness.

Furthermore, an audit over the process for **Refugees and Asylum Seekers** is in progress, which will be reported during 2024/25, but the audit work completed to date has been considered within the Head of Audit Internal Audit Opinion.

Workforce Management

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

The **Long Term Sickness Absence Management** audit (reasonable assurance) sought to provide assurance that the NHS Wales Managing Absence at Work Policy was being adhered to. We found within the sample tested that the policy is primarily being applied correctly, alongside additional actions to aid staff in implementing the policy. These actions include training, sickness absence groups and deep dives to assist with the design of action plans.

The **Flexible Working** advisory review (not rated) assessed the Health Board's progress in embedding flexible working practices and identification of good practice.

We found good adoption of the default principle that flexible working requests should be accepted. Throughout our testing we saw this embedded throughout the organisation. There was also good awareness of the flexible working arrangements amongst staff.

To help strengthen the processes we identified areas for improvement, including updating legacy parameters within ESR; the removal of redundant documents; and the reviewing of requests that are showing as still outstanding past the decision timeframe.

Capital & Estates Management

We have undertaken **four** reviews in this area and two additional IAP audits are in progress.

The **YYF Breast Care Services** audit (substantial assurance) reviewed the arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit, in the period after the prior audit, which was completed in December 2022.

Following Welsh Government approval and commencement on site, the contract completion date has only been extended by two weeks – noting the audit was completed eight weeks prior to the anticipated completion.

The project was forecast to be delivered £200k under the approved budget, resulting in a small gain share for the Health Board and Supply Chain Partner (which has not been accounted for within the above).

Generally, the audit observed sound controls and good compliance across the assurance objectives. The project was delayed by 12 months from its intended start date, primarily due to the change in market conditions and the withdrawal of the main sub-contractor's original cost submission. Accordingly, costs have been revised due to these changes with additional funding sought, and approved, by the Welsh Government. Budgeted costs were aligned with the revised funding, with no variance anticipated to date.

However, we raised recommendations to establish roles and responsibilities, improve the interaction of commercial meetings and to enhance the management and monitoring of key risks.

The **Decarbonisation** review (limited assurance) was undertaken to determine if the Health Board was adhering to the Welsh Government's requirements for the achievement of net zero carbon emissions.

We determined that the Health Board is unlikely to reach the Welsh Government (WG) target of 34% carbon emissions reduction by 2030. We found that this is not due to poor governance or an unwillingness from the organisation to achieve the target, but rather the Health Board faces similar issues as other NHS Wales organisations, with a lack of funding to implement the necessary steps to achieve the WG target.

Furthermore, 67% of the Health Board's overall emissions sit within its procurement processes, which is managed by NHS Wales Shared Services Partnership (NWSSP) and therefore, outside of its direct control.

Positively, there has been clear progress and development of the internal controls since our previous audit. This included a clearly defined governance framework and a well-developed decarbonisation action plan (DAP) monitoring process.

The **Bevan Health and Wellbeing Centre** audit (limited assurance) sought to review the delivery and management arrangements in place to progress the Bevan Health and Wellbeing Centre.

This assessment primarily recognises the significant delays to the delivery of the project (currently circa 49.6 weeks) which are attributed to the Supply Chain Partner (SCP). There will therefore be a corresponding delay in achieving the anticipated business case objectives.

The project was also forecast to be £828k (4.2%) over the approved budget, £478k of which had already been funded from the discretionary capital programme for 2023/24 with the remaining overspend to be funded from the Health Board's 2024/25 discretionary capital allocation.

At the time of the review, discussions were ongoing with the Welsh Government regarding extra funding – particularly as a significant element of cost increase was associated with unfunded inflationary uplifts.

The SCP delays outlined above have allowed the UHB to apply and continue to apply damages for the period from expected completion to the revised completion date.

The SCP is disputing the attestation of culpability for the delays with the associated costs estimated to range between £2.58 and £4.51m. Welsh Government has been fully briefed and the Health Board has engaged legal advice on the matter.

The project faces significant challenges going forward as the contractor is likely to be operating at a loss – accordingly, maintaining reasonable performance from the SCP through existing project management tools will be essential through to completion and handover.

The **Estates Assurance – Estates Condition audit** (limited assurance) The audit sought to evaluate the arrangements put in place by the Health Board to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

A full survey of the estate was last undertaken in 2017 (a refresh now overdue, being beyond the recommended five-year interval). In the interim, "high" risk backlog has increased from an assessed £200,000 to over £37m (based on UHB estate department assessments and departmental funding requests etc).

A 2019 Estates Strategy targeted backlog reduction by 10% per annum. However, since that date, the reported total backlog has effectively doubled. At the time of the current review, there was no revised plan in place to fund the increased levels of backlog.

In the short to medium term, the Health Board has utilised a combination of all Wales capital funding, targeted EFAB funding, planned / reactive maintenance, and discretionary funding to address identified high priority areas. We raised a range of recommendations over the improvement of the baseline data and a review of the risk profile.

Furthermore, two Integrated Audit Plans (IAP) audits linked to specific capital project works are in progress. These will be reported during 2024/25, but the audit work completed to date has been considered

within the Head of Audit Internal Audit Opinion. These included **Nevill Hall Hospital - Radiotherapy** and **Newport East**.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

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

2.4.4 Limitations to the Audit Opinion

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

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

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.4.5 Period covered by the Opinion

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

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in

progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2023/24 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

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

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

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2023/24.

2.6 Statement of Conformance

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

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in February and March 2023. CIPFA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles. It is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2023/24.

Our conformance statement for 2023/24 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023; and
- the results of the EQA undertaken by CIPFA in 2023.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2023/24 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other member of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2023/24.

2.7 Completion of the Annual Governance Statement

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

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

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

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

NHS Wales Shared Services Partnership (NWSSP)

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

Audit	Opinion	Outline Scope
Accounts Payable	Reasonable	The purpose of the audit review was to evaluate and determine the adequacy of the systems and controls in place for the NWSSP Accounts Payable service.
Primary Care (GMS)	Reasonable	The purpose of the audit review was to provide assurance that Primary Care Services is maintaining a robust system to facilitate timely and accurate payments to General Medical Services primary care contractors.
Payroll	Substantial	The overall objective of this audit was to evaluate the design and operation of the systems and controls in place within payroll services.
Procurement	Reasonable	To review the adequacy of the systems and controls in place for procurement of contracts above OJEU thresholds.

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

Digital Health & Care Wales (DHCW)

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

Audit	Opinion	Outline Scope
Benefits Realisation	Reasonable	To determine if the principles of an appropriate benefits realisation framework have been implemented to support decision making.
Programme Management	Reasonable	To provide an opinion of the project management being operated over the Digital Services for Patients and Public (DSPP) programme.
Business Continuity (Ransomware)	Reasonable	To assess the adequacy and effectiveness of business continuity arrangements, including in the event of a cyber-attack (including ransomware).
Legacy Software Modernisation	Reasonable	To review the management of risks associated with older technology.

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

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

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

Audit	Opinion	Outline Scope
WHSCC – Welsh kidney network	Substantial	To consider the governance arrangements in place for the Welsh Kidney Network following the independent governance review undertaken in 2022. We also aimed to provide assurance that there are robust and effective risk management arrangements in place that strengthen and contribute to the overall governance framework.

WHSSC – Integrated commissioning plan development process	Substantial	The overall purpose of the review was to provide assurance on the processes that WHSSC has in place to develop its Integrated Commissioning Plan, with a focus on the financial planning element.
EASC – Adult critical care transfer service	Substantial	Our review focused on the governance arrangements, financial monitoring, meeting outcomes and performance monitoring, and the process to meeting longer term needs.

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

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

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2023/24 operational audit plan.

The audit plan approved by the Committee in April 2023 contained 29 planned reviews. We undertook an additional review over an emerging risk with the audit of the Facilities Bank Approval Process. We also deferred three audits: The Health and Social Care (Quality and Engagement)(Wales) Act; Job Planning; and Allegations against Staff Policy to a more appropriate time. These changes were reported to and approved by the Audit, Risk and Assurance Committee. As a result of these agreed changes we have

delivered 27 reviews (one in progress), plus three (two in progress) capital audits completed as part of the integrated audit plan.

The assignment status summary is reported at Section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

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

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2023/24	G	April 2023	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2023/24	G	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	70%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%

5. RISK BASED AUDIT ASSIGNMENTS

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

5.1 Overall summary of results

In total 32 reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings

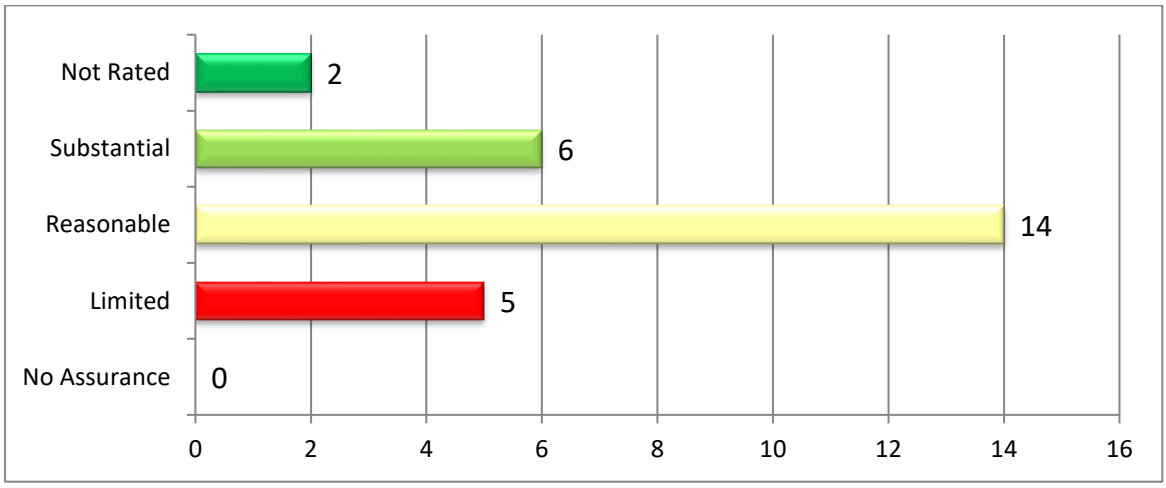

Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP.

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

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

5.2 Substantial Assurance (Green)

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

Review Title	Objective
Financial Controls	The overall objective of the audit was to assess the controls in place to ensure appropriate financial reporting.
Integrated Performance Dashboard – Data Quality	The overall objective of the audit was to assess the accuracy of data utilised within

Review Title	Objective
	the Integrated Performance Report (IPR) dashboard.
Early Supported Discharge – Stroke	The overall objective of the audit is to assess whether the arrangements in place for the early supported discharge of stroke patients are operating effectively.
Maternity Services – Action Plan	The internal audit reviewed the governance arrangements in place within Maternity Services, to ensure performance is being monitored effectively and risks managed appropriately.
Stakeholder Engagement on IT Projects	To review the framework in place for stakeholder engagement on key IT projects.
IAP: YYF Breast Care Services	The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit which was completed in December 2022.

5.3 Reasonable Assurance (Yellow)

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

Review Title	Objective
Asset Management	To assess the implementation of the electronic tagging and tracking of financial assets across the Health Board.
Medical Equipment and Devices	To assess the implementation of the electronic tagging and tracking of medical

Review Title	Objective
	equipment and devices across the Health Board.
Risk Management and Assurance	To assess the effectiveness of the risk management and assurance arrangements in place within the Health Board, in order to ensure that strategic objectives are achieved.
Integrated Medium Term Plan	To assess the controls to ensure the delivery of the IMTP / strategic objectives.
Business Continuity Planning	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.
Safeguarding	To review the arrangements in place to ensure that the Health Board discharged its statutory responsibilities.
Waiting List Management	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, including the arrangements in place to communicate and support patients.
Directorate Review - Theatres	To undertake an audit of compliance with key policies and procedures and the management of risk within the Theatres directorate.
Clinical Coding	To determine if appropriate controls were in place for the timely recording of Finished Consultant Episodes, in accordance with clinical coding standards.
Intra-site Patient Transfers	To assess if the arrangements in place were appropriate for the transfer of patients between sites within the Health Board.
Long Term Sickness Absence Management	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

Review Title	Objective
	parties and working in accordance with the wider wellbeing strategy.
Network Infrastructure (VPN)	To ensure that all risks associated with the provision of virtual protocol networks (VPNs) were appropriately mitigated.
LINC Programme	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.
Savings Programme	To provide assurance that the savings programmes are specific, realistic and measurable and that monitoring arrangements are effective.

5.4 Limited Assurance (Amber)

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

Review Title	Objective
Bevan Health and Wellbeing Centre	The audit sought to review the delivery and management arrangements in place to progress the Bevan Health & Wellbeing Centre.
Estates Assurance – Estates Condition	The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.
Facilities Bank Approval Process	To provide assurance over whether appropriate stock processes were in place and whether applicable controls within the

Review Title	Objective
	process for allocating / approving bank shifts were effective.
ABUHB Financial Controls - Regional Partnership Board	The overall aim of this audit was to ensure that the Health Board's Budgetary Control Financial Control Procedure (the 'FCP') is adhered to when local actions / financial transactions, in relation to the Regional Partnership Board, are processed internally.
Decarbonisation	To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan. Following on from the advisory review delivered in 2022/23, the proposed scope included governance, strategy progress and implementation.

5.5 Unsatisfactory Assurance (Red)

No reviews were assigned an 'unsatisfactory' opinion.

5.6 Assurance Not Applicable (Grey)

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

Review Title	Objective
Follow-up of High Priority Recommendations	To assess whether high priority internal audit recommendations had been implemented.

Review Title	Objective
Flexible Working	An advisory review to determine if the requirements of the Flexible Working Policy and Guidance were being applied consistently across the organisation.

5.7 Draft Audit Reports

The following audits have been substantially completed, with the draft reports issued. Therefore, the conclusions of our audit work have been taken into account for the 2023/24 Head of Internal Audit Opinion. Overall, there is no adverse impact on the Opinion.

Review Title
Waiting List Management
Savings Programmes

5.8 Deferred Audits

There were three deferred audits this year, including The Health and Social Care (Quality & Engagement) (Wales) Act; Job Planning; and Allegations against Staff Policy. In each case, agreement with the Audit, Risk and Assurance Committee was obtained prior to the deferral. This was carefully considered and there has been no impact on the Opinion.

5.9 Work in Progress

At the time of producing the Annual Report, the following audits were still work in progress and the assurance ratings had not been determined. The outcomes of these audits will therefore feed into the Head of Internal Audit Opinion for 2024/25.

Review Title	Objective
Providing Care to Asylum Seekers	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).

Review Title	Objective
IAP – NHH - Radiotherapy	To review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives i.e. time, cost, and quality.
IAP: Newport East	To evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the organisation to support delivery of the Internal Audit assignments undertaken within the 2023/24 plan.

Stephen Chaney
Actio Pennaeth yr Archwiliad Mewnol/Acting Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
June 2024

Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit, Risk and Assurance Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit, Risk and Assurance Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation.

	The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit, Risk and Assurance Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit, Risk and Assurance Committee. An annual report and opinion is produced for the Audit, Risk and Assurance Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported

	to the Audit, Risk and Assurance Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B - Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
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CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Internal Audit Progress Report

Audit, Risk and Assurance Committee

July 2024

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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Appendix B: Audit Assurance Ratings *8*

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2023/24 and 2024/25 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the July 2024 Audit, Risk and Assurance Committee (the 'Committee');
- provide the final Head of Internal Audit Opinion; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against 2023/24 & 2024/25 Internal Audit Plan

We have completed our audit work for the 2023/24 Head of Internal Audit Opinion and have commenced the 2024/25 Internal Audit Plan (the 'Plan'). The Plan consists of 27 individual reviews and in addition, our Specialist Services Unit (SSU) undertake assurance work over major capital projects, as part of our Integrated Audit Plans.

The following audits are progressing as part of the 2024/25 Internal Audit Plan:

1. Declarations of Interest (rescheduled to enable testing of updated policy);
2. Directorate Review Mental Health and LD;
3. Energy Management;
4. The Grange A&E Expansion (IAP);
5. Nevill Hall Hospital – RAAC; and
6. Analytics and Information Use.

In addition, the following 2023/24 final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 21st May 2024:

AUDIT ASSIGNMENT	ASSURANCE RATING
Financial Controls	Substantial
LINC Programme	Reasonable
Directorate Review Theatres – Stock	Reasonable
Intra-site Patient Transfers	Reasonable
Financial Controls – RPB	Limited
Decarbonisation	Limited
Flexible Working	Advisory

The delivery status of the audits is illustrated within Appendix A and further information over the assurance rating detailed above is included within Appendix B.

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reports issued since the last meeting on 21st May 2024.

Financial Controls (substantial assurance)

The audit tested a sample of key financial controls within the Treasury function. In particular, the arrangements regarding bank reconciliations and supporting processes. We found good arrangements in place and no significant issues.

LINC Programme (reasonable assurance)

We reviewed the arrangements in place for the mitigation of risk associated with the non or late delivery of the LINC programme of work.

Overall, the key risk associated with the delay to the LINC programme is being appropriately mitigated against, through the contingency project; LIMS 2.0. Our review highlighted that the key risk is reflected within both project and directorate risk registers.

Whilst other project-level risks associated with the delay have been appropriately identified and are well-managed, we noted inadequate risk management arrangements within the Pathology directorate.

Directorate Review Theatres - Stock (reasonable assurance)

This audit provided an opinion over the effectiveness of the Health Board's processes to manage and monitor theatre stocks.

The Health Board manages this via a commercial stock management system (Omnicell), which covers an extensive range of items used in its operating theatres.

We identified one high priority issue related to the risk of stock loss or misappropriation, as there is currently no review of potential stock losses within the 'discrepancies' figures captured.

We also raised other medium priority issues relating to stock access; access management controls and compliance with the Health Board's year-end stocktake instructions.

Intra-site Patient Transfers (reasonable assurance)

We provided an opinion over the management of intra-site patient transfers. We focussed on the Flow Centre and a sample of maternity patients transferred from Ysbyty Ystrad Fawr (YYF) to the Grange University Hospital (GUH).

We found that the recommendations of previously issued reports regarding the Flow Centre were progressing, but had yet to be fully implemented and were continuing to be reported as overdue. Whilst this is being managed via the Audit Recommendation Tracker process we raised recommendations over ensuring the Flow Centre is achieving its objectives and that any further extension of the recommendations is by exception only.

We also completed a review of a sample of patient transfers that would not be managed by the Flow Centre Team. In particular, maternity patient transfers from the Birthing Unit at YYF to the GUH were sampled and we commented on opportunities to further improve the recording and performance management.

Financial Controls – RPB (limited assurance)

We tested the compliance with the Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) of the Health Board, regarding Regional Partnership Board (RPB) payments made on behalf of the RPB, by the Health Board.

We found that the financial framework, for the management of RPB activities is, in principle, aligned to the Health Board's approach to ordering, receipting and payments of purchases. However, we noted a lack of a documented record of roles and responsibilities throughout that process, specific to the RPB.

In addition, detailed sampling of payment transactions identified examples of compliance issues with the FCPs and SFIs, partly due to the non-standard nature of the funding transactions, and opportunities for operational effectiveness to be improved. We raised the following matters arising:

- payments made in advance, prior to services provided;
- a single tender action not reported to the Audit, Risk and Assurance Committee in a timely manner;
- the completeness and timely provision of information and the lack of guidance regarding this process; and
- the receipting process and prompt payment of some invoices.

Decarbonisation (limited assurance)

This audit was undertaken to determine if the Health Board was adhering to the Welsh Government's requirements for the achievement of net zero carbon emissions.

We determined that the Health Board is unlikely to reach the Welsh Government (WG) target of 34% carbon emissions reduction by 2030. We found that this is not due to poor governance or an unwillingness from the organisation to achieve the target, but rather the Health Board faces similar issues as other NHS Wales organisations, with a lack of funding to implement the necessary steps to achieve the WG target.

Furthermore, 67% of the Health Board's overall emissions sit within its procurement processes, which is managed by NHS Wales Shared Services Partnership (NWSSP) and therefore, outside of its direct control.

Positively, there has been clear progress and development of the internal controls since our previous audit. This included a clearly defined governance framework and a well-developed decarbonisation action plan (DAP) monitoring process.

Flexible Working (advisory review)

This audit assessed the Health Board's progress in embedding flexible working practices and the identification of good practice.

We found good adoption to the default principle of flexible working requests should be accepted. Throughout our testing we observed that this was embedded throughout the organisation. There was also good awareness of the flexible working arrangements.

To help strengthen the processes we identified areas for improvement, including updating legacy parameters within ESR; removal of redundant documents; and the reviewing of requests that are showing as still outstanding past the decision timeframe.

4. 2024/25 Internal Audit Plan

The 2024/25 Internal Audit Plan (the 'Plan') was formally approved at the May 2024 Audit, Risk and Assurance Committee. The final version is included for information.

5. 2023/24 Final Head of Internal Audit Opinion

The 2023/24 Final Head of Internal Audit Opinion is presented to this Audit, Risk and Assurance Committee and remains as previously indicated, at reasonable assurance.

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 workforce procedures; and
- liaison with senior management.

7. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and to **receive** the 2023/24 Head of Internal Audit Opinion for assurance.

Appendix A: Progress against 2024/25 Internal Audit Plan

Audits	Status
Financial Sustainability	Not started
IMTP – Service Delivery Plans	Not started
Contract Management	Planning
Facilities Stock	Not started
Performance Framework	Not started
Embedding of Policies	Not started
Declarations of Interest	Planning
Divisional Governance Arrangements	Not started
Directorate Review - Mental Health and Learning Disabilities	Planning
Maternity Services Improvement Plan	Not started
End of Life Care	Not started
Health and Safety	Planning
Waiting List Management	Not started
Partnership Arrangements	Planning
Medical Equipment and Devices	Not started
Records Management	Not started
Job Planning	Not started
Staff Culture	Not started
Medical E-Rostering	Planning
Follow-up of High Priority Recommendations	Not started
Welsh Intensive Care System	Not started
Analytics and Information Use	Work in progress
Technical Continuity	Not started
Electronic document and records management solution	Not started
Capital Systems/Major Project Provisions (not separately provided)	Not started
Nevill Hall RAAC	Work in progress
Estates Assurance – Energy Management	Work in progress
The Grange A&E Expansion	Work in progress

Appendix B: Audit Assurance Ratings

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

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

Annual Internal Audit Plan

Internal Audit Charter

juli 2024

Aneurin Bevan 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 2024/25 (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 2024/25. 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, Trust and SHAs 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 2024/25

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. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Team and endorsed by the Audit, 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 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Stephen Chaney
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Financial Sustainability	1	SRR001 SRR001g SRR001h	To determine if appropriate recovery plans are in place to achieve a sustainable financial position, including the impact of any associated reduction in non-recurrent public health funding.	Director of Finance, Procurement and Value / Director of Public Health and Strategic Partnerships	Q3
IMTP – Service Delivery Plans	2	SRR001	To provide an opinion over the arrangements in place for developing IMTP deliverables based on models of data e.g. demand and capacity.	Director of Strategy, Planning and Partnerships	Q2
Contract Management	3		To determine if contract management controls are operating effectively, including engagement with stakeholders.	Chief Operating Officer	Q4
Facilities Stock	4	SRR001	A dedicated follow-up review over the implementation progress of the recommendations raised within the 2023/24.	Chief Operating Officer	Q2

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Performance Framework	5		To provide assurance over the new performance framework, including escalation arrangements.	Director of Strategy, Planning and Partnerships	Q3
Embedding of Policies	6	SRR008	To ensure the Serious Incident Policy and Whistleblowing Policies have been fully implemented.	Director of Nursing	Q2
Declarations of Interest	7		To provide assurance over the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests.	Director of Corporate Governance	Q4
Divisional Governance Arrangements	8		A review of the governance arrangements in place within divisions (excl. Mental Health and LD), to ensure key risks / matters arising are escalated and / or managed effectively.	Chief Operating Officer	Q2
Directorate Review - Mental Health and Learning Disabilities	9	SRR003	A review to ensure that arrangements from the 90 day plan for the division have been embedded.	Chief Operating Officer	Q2
Maternity Services Improvement Plan	10	SRR005	A continuation from the 2023/24 internal audit of Maternity Services Action Plan, to ensure that external	Director of Nursing	Q3

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			recommendations raised are on track to being fully implemented.		
End of Life Care	11		To determine if packages of care are appropriately planned in advance for end-of-life patients.	Director of Nursing	Q1
Health and Safety	12	SRR010	To complete a review over how key health and safety risks are managed in accordance with the Health Board's policies and procedures, including RIDDOR reporting relating to falls.	Director of Therapies and Health Science	Q4
Waiting List Management	13	SRR005	To review the arrangements in place to reduce the patient waiting lists of services not reported at a national level.	Chief Operating Officer	Q4
Partnership Arrangements	14	SRR001e	To review the processes and procedures that the Health Board has in place to manage its partnership arrangements.	Director of Strategy, Planning and Partnerships / Director of Public Health and Strategic Partnerships	Q2

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Medical Equipment and Devices	15		To assess the implementation of the electronic tagging and tracking of medical equipment and devices across the Health Board.	Director of Therapies and Health Science	Q3
Records Management	16		To assess the implementation of the recommendations raised within the 2022/23 internal audit.	Director of Digital / Chief Operating Officer	Q2
Job Planning	17		To provide assurance that arrangements are in place and operating effectively for consultant job planning.	Medical Director	Q4
Staff Culture	18	SRR008	A review of the actions underway to influence change following on from the NHS Wales Staff Survey results.	Director of Workforce and OD	Q3
Medical E-Rostering	19	SRR005	To provide an opinion over the processes for the implementation of the roll-out plan for the management of medical e-rostering.	Medical Director / Director of Workforce and OD	Q1
Follow-up of High Priority Recommendations	20		To assess whether high priority internal audit recommendations have been implemented.	Director of Corporate Governance	Q4

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Welsh Intensive Care System	21	SRR006	A review of the arrangements in place for implementing the Welsh Intensive Care System.	Director of Digital	Q1
Analytics and Information Use	22	SRR006	To evaluate and determine the processes in place to deliver information products to staff and maximise the use of analytics in an appropriate and secure manner.	Director of Digital	Q2
Technical Continuity	23	SRR004	Review of the enactment of technical resilience and awareness of fault domains to ensure the Health Board is maximising the potential for resilience within the architecture.	Director of Digital	Q3
Electronic document and records management solution	24		An opinion over the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.	Director of Digital	Q4
Capital Systems/Major Project Provisions (not separately provided)	25		Having been omitted from internal audit plans in recent years, it is proposed to reintroduce periodic capital systems audits. These audits review the control framework, systems and processes in place to manage	Director of Strategy, Planning and Partnerships	Q3

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			discretionary, EFAB or other capital/ estates funded schemes (not progressed through integrated audit plans (IAP) – ensuring compliance with minimum requirements. The focus of the audit for 2024/25 may include: • initial governance arrangements, • tendering and/or selection, and • approval to award and contract completion.		
Nevill Hall RAAC	26	SRR002 SRR002a	The review will focus on the works to manage and address the Reinforced Autoclave Aerated Concrete (RAAC) identified within Nevill Hall General Hospital.	Chief Operating Officer	Q1
Estates Assurance – Energy Management	27		Recognising the increase in utility costs and the associated financial risks, the audit will examine the arrangements in place to manage energy consumption, optimisation, conservation and efficiency. The audit will look to gain assurance the	Chief Operating Officer / Director of Finance, Procurement and Value	Q4

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			appropriate arrangements are in place to gather data, ensuring that the data is of suitable quality/ reliability. The audit will also look at resulting strategies and/ or plans to address key risks.		
Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	N/A		In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the UHB to "assess the risk profile of the scheme and provide appropriate levels of review". A small provision of days is included within the 2024/25 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.

* refers to audit work being completed across other NHS Wales organisations.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	☑	100%
Draft audit opinion 2023/24 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]	☑	95%
Report turnaround management response to draft report [15 working days]	☑	80%
Report turnaround draft response to final reporting [10 days]	☑	95%

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 2024

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Bevan Health & Wellbeing Centre

Final Internal Audit Report

June 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The audit sought to review the delivery and management arrangements in place to progress the Bevan Health & Wellbeing Centre.

Overall Audit Opinion and Overview

Limited assurance has been determined at this review.

This assessment primarily recognises the significant delays to the delivery of the project (currently circa 49.6 weeks) which are attributed to the Supply Chain Partner (SCP). There will therefore be a corresponding delay in achieving the anticipated business case objectives.

The project was also forecast to be £828k (4.2%) over the approved budget, **£478k** of which had already been funded from the discretionary capital programme for 2023/24 with the remaining overspend to be funded from the University Health Board's (UHB) 2024/25 discretionary capital allocation.

At the time of the review, discussions were ongoing with Welsh Government (WG) regarding extra funding – particularly as a significant element of cost increase was associated with unfunded inflationary uplifts.

The SCP delays outlined above have allowed the UHB to apply and continue to apply damages for the period from expected completion to the revised completion date.

The SCP is disputing the attestation of culpability for the delays with the associated costs estimated to range between £2.58 and £4.51m. Welsh Government has been fully briefed and the UHB has engaged legal advice on the matter.

The project faces significant challenges going forward as the contractor is likely to be operating at a loss – accordingly, maintaining reasonable performance from the SCP through existing project management tools will be essential through to completion and handover

Report Classification

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved	2022/23

Assurance Summary [1]

Assurance objectives		Assurance
1	Project Performance	Limited
2	Validation of Management Action	Reasonable
3	Project Management	Reasonable
4	Site Records	Substantial
5	Change Management	Substantial
6	Performance	Reasonable
7	Risk Management	Limited

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	The Project was in an overspend position with further costs anticipated in respect of unfunded cost increases and potential delay compensation.	*1*	Operation	**High**
2.1	The Project Board should meet on a monthly basis.	*3*	Operation	**Medium**
3.1	Formal KPI monitoring for the Supervisor appointment should be considered.	*4*	Design	**Medium**
3.3	The Project Board should have an opportunity to review/discuss KPI returns in advance of their submission to WG	*6*	Operation	**Medium**
4.1	The UHB should adopt more robust mechanisms to manage ongoing issues of poor performance and service delivery from suppliers.	*6*	Design	**Medium**
5.1	Risk registers should include risk costs, risk owners (named individuals), and time parameters for risk mitigations.	*7*	Operation	**Medium**
5.2	The estimated contingency requirement should be periodically updated in the Project Risk register.	*7*	Operation	**Medium**

1. Introduction

1.1 The audit reviewed the delivery and 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 an associated capital cost of £19.488m. The main works contract specified commencement on 4th May 2021, with completion due on 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: consideration of performance against project objectives (e.g., time, cost, benefits, critical success factors etc.).

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, this audit notes that:

Time

2.3 The project time performance is summarised below:

	Business Case	**Contract**	**Revised Contract**	**SCP current programme** (M05.02)
Commencement	May 2021	4th May 2021	4th May 2021	4th May 2021
Completion	April 2023	22nd August 2023	11th September 2023	28th August 2024

2.4 The overall contract completion date was revised to the 11th of September 2023, following an agreed extension to the original programme of twenty days.

2.5 After this date, the UHB had applied liquidated and ascertained damages of £2,121 per day, in accordance with clauses X7 and X7.3 of the contract with the Supply Chain Partner (SCP).

2.6 Whilst the contract did not include sectional completion, the project consisted of two phases. The first being the delivery of the Bevan Wellbeing and Health Centre which at the time of the review was due to be handed over to the UHB on the 18th of December 2023. At this juncture, to recognise partial possession, the damages to be applied will reduce to £666.67 per day, in accordance with clauses X7 and X7.3 of the contract.

2.7 The second phase of the contract includes some demolition work and the provision of car park facilities which was anticipated to complete on the 28th of August 2024 (as per the SCP's latest programme (M12) – an overall delay of 49.6 weeks).

2.8 At the time of the review, the UHB had reported that the SCP had invoked the contractual disputes resolution process to challenge the assessment of culpable delay. In response, the UHB had appointed a firm of solicitors to provide legal advice to support the UHB's position.

Cost

2.9 The forecast out-turn cost position, as summarised at the October 2023 Commercial Cost Report (No58), was:

Costs	WG Approvals £m	Forecast Outturn £m
Works	12,753,520	13,713,797
Fees	2,078,699	2,353,211
Non-works	845,436	1,050,318
Equipment	189,585	189,585
Contingency	643,675	-
VAT (incl. reclaim)	2,977,057	3,009,827
Total	**19,488,000**	**20,316,738**
Anticipated (over) / underspend		**(828,738)**

2.10 The costs as detailed in the table above, include unfunded costs (related to inflation allowances on works and fees, electric vehicle (EV) charging and other required changes).

2.11 The UHB reported that a meeting took place with NWSSP Specialist Estates Services (SES) to discuss the unfunded costs; the figure at the time a reported £1.137m (ex VAT). The UHB are to submit a funding request to WG for the funds to cover this.

2.12 Should WG approve this funding, this would then change the relative outturn position for the project into a more favourable position. However, should this additional funding not be approved, this will present a financial risk to the UHB.

2.13 The Strategic Capital Projects and Estate Rationalisation report dated 1st November 2023 and presented at the UHB's Partnerships; Population Health & Planning Committee notes this risk detailing that:

'Discussions are ongoing with WG regarding the funding of this cost pressure. If WG do not support the additional funding, this will be a financial risk to the Health Board'.

2.14 It was noted that further risks were identified in relation to five unresolved compensation events which have been assessed by the UHB's Cost Advisers as potentially totalling between £2.589m and £4.151m, which were not built into the forecast outturn and had been challenged by the SCP. If these claims were later found to be valid, they would significantly increase the reported overspend position and further add to the overall financial risk to the UHB. (**MA1.1**)

2.15 **Quality**

2.16 The original investment objectives (included within the business case) were to:

- Support the co-location and potential merger of General Practitioner (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 were delivered within Tredegar.

2.17 While there were delays to intended enhancements to service provision and the estate, existing services continue to be provided elsewhere.

2.18 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.

2.19 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.

Validation of Management Action: *to confirm that previously agreed recommendations have been appropriately actioned by management.*

2.20 The table below provides an overview of progress in implementing the previously agreed management actions in relation to the 2022/23 audit report (published in March 2023).

Original Priority Rating	Number of Recommendations	Implemented	Not implemented	Closed / superseded
High	2	1	-	1
Medium	9	8	1	-
Low	3	1	2	-
Total	**14**	**10**	**3**	**1**

2.21 Recommendations requiring further action are detailed at **Appendix B.** The key outstanding/ superseded recommendations related to:

- Risk monitoring (high priority) – This issue has been re-raised at the current review, as arrangements required improvement to include quantified total of mitigated risks reported against remaining contingency, risk costs, risk owners (named individuals), and time parameters for risk mitigations at risk registers.
- Leases (medium priority) - Management should obtain signed lease agreements with relevant parties at the earliest opportunity.

2.22 Recognising the actions taken, **reasonable assurance** has been determined in relation to previously agreed actions.

Project Management: *assurance that effective arrangements were in place to administer and manage the project, including change management, risk management and programme management.*

2.23 Project governance arrangements were defined at the Programme Execution Plan (PEP) which included the programme objectives, structures, and key roles. The PEP had been reviewed/ revised in September 2023.

2.24 A new Senior Responsible Officer (SRO) was appointed at the Project in August 2023.

2.25 Up to April 2023, oversight had been provided by the Primary Care & Community Estates Programme Board ('the Programme Board'), with onward reporting to the Strategic Capital & Estates Programme workstream.

2.26 There was however a hiatus in April 2023 with no further Programme Board meetings held.

2.27 The UHB clarified that a decision had been made to establish a dedicated Project Board in response to the findings of a project governance recommendation made in earlier audit reports regarding the review of this scheme and another ABUHB project.

2.28 There was an absence of project oversight then until August 2023, when the newly formed Project Board met for the first time with a second meeting in October 2023.

2.29 Regular Project Board Meetings are an essential aspect of robust project governance. The delay in replacing the Programme Board with the Project Board denied the scheme appropriate scrutiny at a key stage of the scheme particularly

noting the adverse time and cost pressures being experienced at the project. (**MA2.1**)

2.30 The Project Board was chaired by the SRO, and membership included the Strategic and Capital Project Director, Capital Programme Manager, Head of Primary Care and Divisional Director of Primary Care and Community Services (Vice Chair).

2.31 The Project Board was supported by a Project Team, the membership of which included the Strategic and Capital Project Director, Capital Programme Manager, Capital Finance Lead, estates personnel, and user representation.

2.32 A review of the minutes for a sample of Project Board and Project Team meetings, confirmed that they had been well attended, being quorate with the minutes reflecting a good level of discourse around the agenda items presented.

2.33 Subsequent to the audit fieldwork, it was evident that monthly Project Board meetings had been reinitiated (addressing the absence of Project Board oversight during a period of 2023). Recognising the same, **Reasonable Assurance** has therefore currently been determined in relation to governance arrangements applied at the project.

Site records: *assurance that appropriate site inspections and records were maintained in accordance with the contract.*

2.34 The Supervisor team had access to site records (drawings, programme etc.) via A-Site (a construction document management system).

2.35 The Supervisor provided weekly progress & activity reports. The reports were found to be comprehensive in nature and shared with the UHB in a timely manner.

2.36 Noting the Supervisor appointment was not made from the NHS Building for Wales Framework, the associated 6-monthly key performance indicators (KPIs) had not been mandated. Whilst management confirmed they had no concerns over Supervisor performance to date, with delivery of duties and quality of output monitored against the Schedule of Services contained within the Contract, the addition of formal performance metrics would enhance this process. **(MA3.1)**

2.37 Good practice was evidenced in relation to site inspections and reporting, accordingly **substantial assurance** has therefore been determined.

Change Management: *assurance that changes were processed / authorised in accordance with the contract and local internal control procedures.*

2.38 The change management process (Compensation Event / Early Warning Notice) was detailed within the National Engineering Contract 3 (NEC3) adopted.

2.39 The Health Board's own Capital Project Change Management Procedure was included as an appendix within the latest version of the PEP (v3 21st September 2023).

2.40 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. 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. A copy of which was included within the monthly Project Manager's Progress Report.

2.41 The latest project Highlight report as prepared for the November 2023 Project Team meeting, recorded that 127 Compensation Events had been issued by the SCP since the beginning of stage 4, of which 3 remain to be implemented. With a further 1 awaiting quotation.

2.42 Noting the above, **substantial** assurance has currently determined in relation to change management.

Performance: *assurance that appropriate arrangements were in place to performance manage the internal team, external advisers (including the role of the Supervisor), and the main contractor – identifying appropriate corrective action to address performance.*

2.43 The NHS Building for Wales framework requires 6-monthly KPIs to be submitted by all parties.

2.44 The UHB had submitted KPIs to NWSSP: SES in accordance with the requirements of the framework. However, it was noted that the submissions were made a month after the deadline set by NWSSP: SES. **(MA3.2)**

2.45 It was also observed that whilst the KPI's for October 2023 were shared with the Project Team meeting prior to submission, the Project Board were not sighted until the November 2023 meeting. **(MA3.3)**

2.46 The KPIs as completed show that the overall performance of both the SCP and advisers had been assessed by the Project Director as having only improved slightly over the six-month period covered by the two submissions reviewed.

2.47 In the case of the PM Adviser role the scores as assessed remain within the classification – 'neutral tending towards satisfaction', with timely delivery of services/information being a particular concern, and with no improvement evident over time from the scores as submitted. **(MA4.1)**

2.48 Noting the above, **reasonable** assurance has currently been determined in relation to performance management.

Risk Management: *assurance that appropriate arrangements were in place to oversee the management of project risks, including the action taken by management to mitigate/ manage key risks.*

2.49 The UHB maintained two risk registers in respect of the project:

- Capital Cost Risk Register – the register was provided within the Project Manager's reports and additionally included within Highlight reports.
- Opening risk register – this operational risk register was focused on internal UHB risks that were not related to the build itself. Examples being revenue implications and future risks to service delivery.

2.50 Good practice was noted in that the Capital Cost Risk Register

as maintained had been:

- routinely updated, and contained details of potential risks arising from Early Warning Notices, these reconciled back to those detailed within the Project Manager's Progress report and were detailed in PPR returns to Welsh Government.
- The Capital Cost Risk register split risk ownership between either client or SCP risks.
- It was given due prominence, being published within the monthly Project Manager's reports, that the Project Board members were sighted on ahead of Project Board meetings.

2.51 However it was noted that the potential values of Compensation Event claims, and Early Warning Notices (best, worst, and likely case scenarios) had not been included within the risk register as required by NEC guidance. (**MA5.1**)

2.52 This assessment of values of Early Warning Notices was included in the stage 4 commercial report prepared by the UHB's Cost Advisers. This was detailed as representing forecast outturn scenario planning and included an estimate of potential future claims by the SCP.

2.53 The copy of the Capital Cost Risk Register (main scheme) as included as part of the bi-monthly PPR returns for September 2023 identified total quantified risks of £151k.

2.54 In addition, the quantification of costs driven by risk was included in the UHB's month 6 summary capital plan which details unfunded costs of £1.137m ex vat and further risks in relation to five unresolved compensation events totalling £1,960m ex vat. **(MA5.2)**

2.55 Whilst noting the form, updates and availability of the project risk register, the copy as presented at Project Board and Team meetings remained uncosted. Similarly, the version included within PPR returns included a quantification of cost yet excluded those pertaining to unfunded costs and potential delay claims. Acknowledging the above, **limited** assurance has currently determined in relation to risk management.

Appendix A: Management Action Plan

Matter Arising 1: Project budget cost risks - frequency (Operation)	**Impact**
The Bevan Health and Well-being Centre scheme was forecasting an overspend of £0.828m which was being funded by the Discretionary Capital Programme (DCP) across the 23/24 and 24/25 financial years. The above includes £1.137m ex VAT of unfunded costs in relation to inflation allowances on works and fees. The UHB had been engaged in discussions with WG to try to secure extra funding which would meet these costs, if realised this would alter the complexion of the current forecast budget position. The project contingency of £658k had been fully utilised and as noted the shortfall in funding was to be met from discretionary capital. Further costs could be incurred, the UHB's Month 7 2023/24 Summary Capital Plan (Board Report) noted that any additional costs accepted as part of the most recent delays will increase the overspend that was being funded by DCP. With the UHB (along with all other UHB/Trusts in Wales) having a reduced allocation of discretionary capital funding and needing to meet increasing competing demands with finite resources, the need to divert funds to meet Project shortfalls presents a significant financial risk to the UHB. ***Note:*** *The above does not account for five unresolved compensation events which total £2.006m plus VAT which are currently being disputed by the SCP.*	Potential risk of: • Project Cost exceeding agreed cost envelope.
Recommendations	**Priority**
1.1 The UHB should formally clarify how it intends to meet the potential funding shortfalls, including any associated impact on the UHBs discretionary capital programme and investment priorities (reporting the same to the Project Board and Board as appropriate).	**High**

Agreed Management Action	Target Date	Responsible Officer
Actioned - A paper was prepared and presented at the Executive Team Meeting held on the 11th April with further inclusion at the In-Committee Board Meeting held on the 16th April. The paper which is commercially sensitive details the not to exceed value in respect of the claim arising through the NEC Contract disputes process, and the UHB's process through which the financial risk will be mitigated, primarily being managed through the Health Board Discretionary Capital Programme.	Actioned – the UHB has formally clarified how it intends to meet the potential funding shortfalls, including any associated impact on the UHBs discretionary capital programme and investment priorities	Executive Director of Planning, Partnerships and Strategy

Matter Arising 2: Project Board Meetings - frequency (Operation)		**Impact**
Up until April 2023, oversight had been provided by the Primary Care & Community Estates Programme Board ('the Programme Board'), with onward reporting to the Strategic Capital & Estates Programme workstream. A dedicated Project Board was then established, this first met in August 2023, with its second meeting taking place in October 2023. There was a period of four months between the last meeting of the Programme Board meeting and the first Project Board meeting taking place. The UHB attributed this delay in transitioning to a dedicated Project Board to internal resource/timing difficulties. Regular Project Board Meetings are an essential aspect of robust project governance. The delay in replacing the Programme Board with the Project Board denied the scheme appropriate scrutiny at a key stage of the scheme particularly noting the adverse time and cost pressures being experienced at the project.		Potential risk of: • The Project lacks appropriate and timely scrutiny of progress against the key measures of time, quality, and cost.
Recommendations		**Priority**
2.1 The Project Board should meet in line with the frequency set out in the Project Execution Plan. To ensure continuing robust governance and oversight of the project.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Actioned –Subsequent to the completion of the audit fieldwork, the reconstituted Project Board have met monthly.	N/A Actioned since audit fieldwork	N/A Actioned since audit fieldwork

Matter Arising 3: Site records – monitoring and reporting (Design)	**Impact**
The NHS Building for Wales Framework does not provide for Supervisor services, therefore the associated framework KPIs are not mandated for the role. Management noted that performance was monitored locally. However, formal record of this assessment was not maintained or reported. Whilst acknowledging that no concerns had been noted regarding Supervisor performance to date, formal performance monitoring (aligned to the NHS Building for Wales process but recognising this will have to be managed separately) would be good practice, recognising the financial value and importance of this appointment. The UHB had made six monthly returns of Key Performance Indicators (KPIs) to NWSSP: SES in accordance with the NHS Building for Wales Framework requirements for the SCP and remaining adviser appointments. However, it was noted that the submissions were made a month after the deadline dates set by NWSSP: SES. It was also observed that whilst the KPI's for October 2023 were shared with the Project Team meeting prior to submission, the Project Board were not sighted until the November 2023 meeting. Therefore, the Project Board were not afforded the opportunity to discuss the scores as assessed and the rationale behind them prior to submission.	Potential risk of: • Inadequate performance may not be appropriately recorded, reported, and addressed. • Failing to meet obligations in respect of reporting to SES. • Project Board are not made aware of the determined KPIs ahead of their submission.

Recommendations	**Priority**
3.1 Formal KPI monitoring for the Supervisor appointment should be considered.	**Medium**
3.2 KPI returns should be submitted in a timely manner in keeping with SES timescales	**Low**
3.3 The Project Board should have an opportunity to review/discuss KPI returns in advance of their submission to WG	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

3.1 Agreed – As the Supervisor is appointed under the SBS Framework, the completion of KPI's is not a mandatory obligation. The Health Board however will ensure that KPI's are stipulated when entering into any new project. Specifically in relation to Bevan HWBC, the Health Board has agreed a set of KPI's with the new Supervisor for the Phase II This will form part of a check list for future/other projects	KPIs agreed in May 2024 for Bevan HWBC Phase II. Future Projects for future KPIs	Assistant Director of Strategic Capital
3.2 Agreed – Specialist Estate Services (SES) manage this process for all Wales projects. The Health Board completed and returned the previous round of KPI's within the timescales agreed. The UHB will ensure we continue to meet the timescales with these being reporting into Project Board for transparency. This will form part of a check list for future/other projects	For Bevan HWBC – actioned already. Future Projects.	Assistant Director of Strategic Capital
3.3 Agreed – Under the current Specialist Estate Services (SES) process, the Health Board and wider project team no longer has sight of returned KPI's until all have been submitted and reports have been completed. The Project Board will review Health Board submitted KPIs and, following issue by SES will review all KPIs in Project Board. Under the new Building for Wales Framework there will be sanctions implemented by SES for consistently poor KPIs.	Future Projects and from July 2024 for Bevan HWBC	Assistant Director of Strategic Capital

Matter Arising 4: Performance – monitoring of adviser performance (Operation)		**Impact**
The KPIs completed show that the overall performance of both the SCP and advisers had been assessed by the Project Director as having been positive and having improved slightly over the six-month period covered by the two submissions reviewed. However, a more detailed review of the scores identified that, in the case of the Project Manager role, the scores as assessed remain within the classification – 'neutral tending towards satisfaction', with timely delivery of services/information being a particular concern, and with no improvement evident over time from the scores as submitted. From a review of the project documents and reports, it was not clear what corrective action had been agreed.		Potential risk of: • Inadequate performance may not be appropriately recorded, reported, and addressed.
Recommendations		**Priority**
4.1. The UHB should adopt more robust mechanisms to manage ongoing issues of poor performance and service delivery from suppliers. This should include the formal agreement of corrective action to address the identified shortfalls in performance.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Agreed - For this project the new Project Director has addressed issues and set out expectations with regional directors. The KPI process is a vehicle for addressing performance concerns. Under the new Building for Wales Framework there will also be sanctions implemented by SES under the KPI process which will support this approach in future projects.	Actioned already for Bevan HWBC	Assistant Director Strategic Capital

Matter Arising 5: Risk register	Impact
The NHS Wales Infrastructure Investment Guidance 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"* Management provided two risk registers for review: • Opening risk register – this version contained generic operational risks. It was un-costed and was for management the Project Team to track mitigating actions for assigned risk owners. • Capital Cost Risk Register – this was provided within Project Highlight reports and Project Manager reports, distinguishing between client and SCP risks, but not further identifying risk owners or action dates. While it contained some costs, these were not totalled to enable comparison of remaining client risk with Health Board contingency. A copy of the Capital Cost Risk Register was included within the PPR returns to WG, this included some costs but did not incorporate wider financial risk presented by unfunded costs and potential compensation claims from the SCP	Potential risk of: • Risks are not quantified, and contingent plans were not included demonstrating how risks will be mitigated.
Recommendations	**Priority**
5.1 Risk registers should include risk costs, risk owners (named individuals), and time parameters for risk mitigations.	**Medium**
5.2 As the project progresses, and requirements become firmer, so the risks in future works and commitments would be reduced. The estimated contingency requirement should be periodically updated to reflect this.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
5.1 Agreed – Actioned already within the project but noting that a current review of risk owners for Phase II is underway	Actioned already for Bevan HWBC	Assistant Director Strategic Capital
5.2 Agreed – this has now been actioned, however noting that the project is overspent there is effectively no contingency remaining. As an approach however this is to be taken forward in other projects	Actioned already for Bevan HWBC	Assistant Director Strategic Capital

Appendix B: Status of previously agreed recommendations (2022/23)

Bevan Health & Wellbeing Centre (March 2023)			Previously providing		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
1.1	Governance- Project groups	The role and responsibilities of the Primary Care & Community Estates Programme Board, in acting as the Project Board for major Primary Care projects, should be clearly defined in the Terms of Reference.	Implemented A dedicated Project Board had an inaugural meeting in August 2023 with Terms of Reference presented at the same meeting.	Director of Primary Care, Community and Mental Health services. June 2023	**Medium**
1.2	Governance – Project groups	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.	Implemented Monthly Project Board Meetings established in August 2023 with monthly meetings commencing in October 2023.	Director of Primary Care, Community and Mental Health services. June 2023	**Medium**
2.1	Governance- Roles and responsibilities	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.	Implemented A new SRO had been in post since August 2023 and a revised PEP updated July 2023 detailed the roles and responsibilities. Further revision of PEP in September 2023 adds details around authorisation	Project Director June 2023	**Medium**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
			of changes and links to Standing orders/SFIs		
2.2	Governance-Roles and responsibilities	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	Implemented The PEP was revised in July 2023.	Project Director June 2023	**Medium**
3	Governance-Risk management	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	Not Implemented - superseded Review of Capital and Service Risk Registers for period August – October 2023 do not reflect the completion of the Management action.	Project Director June 2023	**High**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
		numbering / referencing of common risks at project management, and contractual versions of the register.			
4	Governance-User agreements	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Ongoing However, at time of audit, evidence was provided to demonstrate that efforts were being made to finalise the lease agreements. Shared Services are taking forward this action	Project Director June 2023	**Medium**
5.1	Governance-Cost reporting	Management should review the Project Progress Return submissions to Welsh Government to ensure accuracy.	Implemented PPR was included as an agenda item at the Project Team Meeting held on 23rd October 2023.	Project Director 30th June 2023	**Medium**
5.2	Governance- Cost reporting	The current cost reports should be reviewed by the UHB and the Cost Adviser and enhanced to improve clarity to afford greater scrutiny by the Programme Board and UHB officers.	Implemented Cost reports from the UHB's Cost Adviser have been revised and in addition the Cost Adviser now provides an additional section no 11. This section is sent by email and is for client information only.	Project Director 30th June 2023	**Medium**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
6	Governance-Measurable benefits	Quantified, measurable and achievable targets should be set to appraise project benefits.	Not fully Implemented UHB remarked that this was work in progress and was being taken forward by the Locality	Project Director 30th June 2023	**Low**
7	Open book-Valuation validation	The Cost Adviser should provide assurance that appropriate sampling had 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).	Not Implemented UHB confirmed that the Cost Adviser had not provided this additional information despite a request to do so.	Project Director 30th June 2023	**Low**
8	Site management – Health & Safety	Records of site inspections and audits should be presented to project forums for appropriate scrutiny and action.	Implemented Emails provided demonstrating that the appointed Site Supervisor provides a weekly NEC Supervisor Report. This is distributed to the	Project Director 30th June 2023	**Low**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
			UHB along with the UHB's advisers and the SCP. Additionally, a weekly M&E Report is provided by email, distribution as per NEC report, evidence as seen covers period May to October 2023.		
9.1	Change management	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.	Implemented – Change control procedures have been reviewed, updated, and actioned. The revised PEP v3 as issued 21st September 2023 records under the summary of changes that a revision has been made of internal governance change control process. This is detailed under section 9 and included under appendix D is the UHB's Change control procedures.	Project Director 30th June 2023	**Medium**
9.2	Change management	Change control procedures should be reviewed and updated to ensure consistency (i.e. between the NEC	Implemented	Project Director 30th June 2023	**Medium**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
		form of Contract, Health Board Standing Orders/Standing Financial Instructions, and the Project Execution Plan).	Change control procedures updated and included as appendix within revised PEP.		
10	Equipping – Single tender action	Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions.	Implemented Tangible example provided of this being followed.	Project Director 30th June 2023	**High**

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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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Updates received for Q1 April – June 2024

2022 Tredegar Health & Wellbeing Centre	Assurance Rating Limited	Priority Rating High
Executive Lead: Director of Public Health (transferred due to the cessation of the Director of Primary Care)		
Recommendation 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.		
Management Response: 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.		
Final Report Agreed Implementation Date: 01/06/2023		
Status – COMPLETED – June 2024		
2024-05-31 Risk Register Tredegar M This has now been actioned evidenced by the Capital Risk register attached. A Project Dashboard has also now been set up which includes both Project Risk Logs and Capital Risk log.		

2022 Tredegar Health & Wellbeing Centre	Assurance Rating Limited	Priority Rating Medium
Executive Lead: Director of Public Health (transferred due to the cessation of the Director of Primary Care)		
Recommendation 4 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.		
Management Response: Agreed. The provision of the signed lease is being actively addressed so that they are in place well before the planned occupation of the building.		
Final Report Agreed Implementation Date: 01/06/2023		
Status – OVERDUE - June 2024		
New Deadline Proposed – 30/09/2024		
Position Update: Whilst the leases are still not finalised, Shared Services Partnership and Legal Advisors are actively working through queries/ issues which have been raised by tenants. There has been		

engagement from some tenants, but there is failure to engage from one of the GP practices. Therefore a meeting has been held between the Assistant Director of Capital and the Interim Head of Primary Care to discuss how these issues can be addressed. Subsequent meetings are being arranged to work through and complete leases. This has also been escalated to the Divisional Director of Primary Care who has been made aware of the lack of engagement from the one GP Practice and has agreed that this will be addressed as a matter of urgency.

2022 Tredegar Health & Wellbeing Centre	**Assurance Rating** Limited	**Priority Rating** High
Executive Lead: Director of Public Health (transferred due to the cessation of the Director of Primary Care)		
Recommendation 10 Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions		
Management Response: Agreed. Non-compliance to be advised to the Programme Board via submission of this audit report and the Director of Finance.		
Final Report Agreed Implementation Date: 01/06/2023		
Status – COMPLETED – June 2024		
ASBU STA 135 781.pdf		

If the Audit Committee approves the completion of R3 and R10 as described above, at the end of Q1, the Tracker will have only one outstanding recommendation from the Tredegar Health & Wellbeing Centre's 2022 internal audit. However, the 2023 report indicates that two of the 2022 report's recommendations (R6 and R7) were not fully implemented, as detailed on the following page. However, the Project Director reported them as completed, and this information was recorded in the Audit Tracker.

Previously Completed Recommendations showing as not implemented in the 2023 Tredegar Health & Wellbeing Centre

2022 Tredegar Health & Wellbeing Centre	**Assurance Rating** Limited	**Priority Rating** Low
Executive Lead: Director of Public Health (transferred due to the cessation of the Director of Primary Care)		
Recommendation 6 Quantified, measurable and achievable targets should be set to appraise project benefits.		
Management Response: The Benefits register will be updated to reflect quantified targets as of the end of March 2023.		
Final Report Agreed Implementation Date: 01/06/2023		
Status – COMPLETED April 20024		
Updated Benefits Register Adms & Refs data Tredegar Health & W		
2023 Tredegar Health & Wellbeing Centre Final Report states that this recommendation has **not** been fully implemented and remarked that this was a work in progress and was being taken forward by the Locality.		
Additional information to support completion or provide a status update This was addressed at Project Board June 2024 and whilst it is too early to be able to realise all benefits, it was agreed to be addressed through a sub-group led by the locality to identify tangible, measurable benefits. Group to be set up and will report back to Project Board		

2022 Tredegar Health & Wellbeing Centre	**Assurance Rating** Limited	**Priority Rating** Low
Executive Lead: Director of Public Health (transferred due to the cessation of the Director of Primary Care)		
Recommendation 7 The Cost Adviser should provide assurance that appropriate sampling had been made of supporting documentation for costs claimed in respect of Plant and Materials (utilising an Open Book approach as specified in the Project Execution Plan).		
Management Response: The Cost Adviser has been requested to provide such assurance.		
Final Report Agreed Implementation Date: 01/06/2023		
Status – COMPLETED November 2023		
Evidence for Completion • SRO and Project Board in place for both Tredegar and Newport projects.		
2023 Tredegar Health & Wellbeing Centre Final Report states that this has **not** been Implemented UHB confirmed that the Cost Adviser had not provided this additional information despite a request to do so.		

Additional information to support completion or provide a status update

The following exercise has been undertaken by the Cost Advisor

- On 18 August 2023, Steve Watkins (QS for Kier) was contacted by phone, followed immediately by an email requesting evidence of payment for a representative sample of items within the Plant, Materials & Misc. items schedule. The sample, selected randomly, comprised around 10% of the total items on the schedule and included items across various price ranges.

- On 12 September, Steve Watkins provided an example approach for evidencing payments, which was confirmed that same day as acceptable. Two days later, on 14 September, the requested information was received, consisting of 128 invoices supporting 97.5% (£129,450.64 evidenced of £132,777.67) of the total value. Given the small percentage (2.5%) which had not been evidenced at this time it was concluded that, on the balance of probability, the remaining invoices were likely valid. This completed the audit sample exercise, and no adjustments to the costs included in interim assessments were deemed necessary.

It is important to note the sample review outlined above represented a particular point-in-time assessment. Given the project is yet to reach conclusion, a further comprehensive analysis and assessment will be undertaken as part of our final account exercise and further review and scrutiny will be undertaken at the project closure stage. This final review will provide a complete view of project expenditures and allow for any necessary adjustments, if necessary, at that this finalisation point to draw the project to a close.

ABUHB Financial Controls - Regional Partnership Board

Final Internal Audit Report

July 2024

Aneurin Bevan University Health Board

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Final report issued:	5th July 2024
Auditors:	Stephen Chaney, Acting Head of Internal Audit Philip Lewis-Davies, Principal Auditor
Executive sign-off:	Rob Holcombe, Director of Finance and Procurement Hannah Evans, Director of Strategy, Planning and Partnerships Rani Dash, Director of Corporate Governance
Distribution:	Chris Commins, Assistant Director of Finance
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over compliance with the Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) of Aneurin Bevan University Health Board (the 'Health Board'), regarding Regional Partnership Board (RPB) payments made on behalf of the RPB, by the Health Board.

Overview

We found that the financial framework, for the management of RPB activities is, in principle, aligned to the Health Board's approach to ordering, receipting and payments of purchases. However, we noted a lack of a documented record of roles and responsibilities throughout that process, specific to the RPB.

In addition, detailed sampling of payment transactions identified examples of compliance issues with the FCPs and SFIs, partly due to the non-standard nature of the funding transactions, and opportunities for operational effectiveness to be improved. We have raised five matters arising, with the most significant points detailed below:

- payments made in advance, prior to services provided;
- a single tender action not reported to the Audit, Risk and Assurance Committee in a timely manner;
- the completeness and timely provision of information and the lack of guidance regarding this process; and
- the receipting process and prompt payment of some invoices.

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 Health Board's Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) are adhered to	Reasonable
2	A sample of relevant requisition orders, invoice processing, receipting, Oracle posting and budget holder responsibility etc. are in accordance with the SFIs / FCP Policy.	Limited
3	Appropriate monitoring and escalation processes are in place.	Reasonable

[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	Roles and Responsibilities	1&2	Operating Effectiveness	Medium
2	Purchase Order and Invoice Principles	2	Design	High
3	Approval of Purchase Commitment	2	Design	Medium
4	Single Tender Application	2	Operating Effectiveness	High
5	Invoice Transaction Processing	2	Design	Medium

1. Introduction

1.1 The review of ABUHB Financial Controls – Regional Partnership Board was included within the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board').

1.2 As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards are required to establish Regional Partnership Boards (RPBs) to manage and develop services to secure strategic planning and partnership working. Overall, this seeks to:

- improve the well-being of the population; and
- improve how health and care services are delivered.

1.3 The RPB is comprised of partners including the Health Board, local authorities, and third sector organisations and has established six strategic hubs covering:

- adult;
- carer;
- child and family;
- mental health and learning;
- health, social care and housing; and
- dementia.

1.4 The Health Board sits within the region of the Greater Gwent Health, Social Care and Well-being Partnership Board. This was established to lead and guide the implementation of the Social Services and Well Being (Wales) Act 2014 in the Gwent region.

1.5 The overall aim of this audit was to ensure that the Health Board's financial control procedures (the 'FCPs') are adhered to when local actions / financial transactions, in relation to payments made on behalf of the Regional Partnership Board, are processed internally. Objectives of the area under review were:

- to determine if the Health Board's Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / the FCP(s) are adhered to;
- to ensure a sample of relevant requisition orders, invoice processing, receipting, Oracle posting and budget holder responsibility etc. are in accordance with the SFIs / FCP; and
- to ensure appropriate monitoring and escalation processes are in place.

1.6 The risks considered in the review included:

- financial transactions are not processed in accordance the SFIs / FCP;
- the Health Board's statutory duty is not delivered;
- inappropriate expenditure incurred;
- lack of accountability / oversight of financial transactions regarding the RPB; and
- cost centres / budgets are not managed appropriately.

2. Detailed Findings

Objective 1: the Health Board's Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) are adhered to

2.1 The Health Board's Model Standing Orders, Reservation and Delegation of Power, Standing Financial Procedures and FCPs, as relevant to the processing of payments, were located and copies obtained. A comparison of the Health Board's Standing Orders, SFIs and FCPs with the approach adopted by management was performed.

2.2 The end-to-end process for accounts payable relating to the RPB was mapped out and reviewed. We noted that it reflects the total end to end accounts payable process, including the engagement of the Finance Team and the application of the standard budgetary control approval process.

2.3 However, whilst not all elements of the standard Health Board processes are detailed, our review of the document confirmed it is compliant in principle with the Health Board's approach to ordering, receipting and the payments for purchases.

2.4 Whilst this process encapsulates key budgetary control principles, it does not provide guidance or details over the treatment of RPB related expenditure. For example, RPB payments may include funding in advance to third sector organisations and the funding of accrued costs. Whilst this is permitted within specific funding awards, it is not permitted / defined within Health Board FCPs. Further detail is included within audit objective two, following detailed sample testing.

2.5 Furthermore, we noted that there was no documented process between the RPB and the Health Board, detailing the payment services to be provided and the level of performance required. There is also an opportunity to clarify the Health Board's accounts payable approach in detail and link this to a roles and responsibilities document that defines activity across the Health Board, the RPB and funding recipients, as well as defining the consistent and timely information to be provided by all parties. These two documents would provide greater clarity of process and aid operating effectiveness. We have raised these two findings within matter arising 1 in Appendix A.

Conclusion:

2.6 We found that the RPB payment process was compliant in principle with the Health Board's approach to the management and control of payments relating to goods and services ordered and received by the Health Board. We have raised one matter arising regarding the lack of a documented process and / or the setting out of roles and responsibilities. Furthermore, we also considered our conclusions from our sample testing, referenced within objective two. Therefore, we have provided **reasonable assurance** over this area.

Objective 2: a sample of relevant requisition orders, invoice processing, receipting, Oracle posting and budget holder responsibility etc. are in accordance with the SFIs / FCP Policy

2.7 We tested a sample of RPB payments made by the Health Board on behalf of the RPB. The sample comprised of 15 transactions selected from the Oracle general ledger, across the preceding twelve months, to cover a range of financial budget codes.

2.8 For each transaction selected we tested compliance with the FCPs from purchase order requisition through to the purchase order, receipting, and to the payment of the invoice. As referenced above, we noted instances where the non-standard nature of the funding transactions was not effectively covered by the existing FCPs. We raised a series of inter-linked matters arising, which are summarised below and included within Appendix A. In particular, we have **raised matter arising 2** regarding this testing and additional recommendations within **matter arising 5**.

Subject	Issue	Relevant FCP	Matter Arising
Creation of Purchase Order Requisitions	Information required by Finance to initiate	Accounts Payable FCP Section 6.1	**2**
Purchase Order Detail	Insufficient information	n/a	**2**
Receipting	Insufficient evidence to affect receipting, e.g. funds paid in advance	n/a	**2**
Addressing of Purchase Invoices to Health Board	Purchase invoices not sent directly to Accounts Payable	Accounts Payable FCP Section 6.7.1 Invoice Received	**5**
Scrutiny of Purchase Invoices	Scrutiny of invoices not evidenced	n/a	**2**
Prompt Payment of Invoices	Payments not made promptly	n/a	**5**

2.9 In addition, we identified specific issues and have raised separate matters arising, including:

- The Health Board's Signatory List (ASL) had been amended to increase the Chief Executive's financial limits on specific financial budget codes, to a level that obviates the need for possible Chair's Actions. It was not clear whether such increases in delegated financial limits have been communicated with the Audit, Risk and Assurance Committee and reflected in the Health Board's FCPs. This issue has been raised in **matter arising 3 in Appendix A.**
- In one instance we noted that the commitment had been awarded as a result of a single tender action (STA). Whilst the STA form reviewed had

been signed by relevant authorised management and approved in March 2023, there was no evidence that the approved form had been subsequently reported to the Audit, Risk and Assurance Committee. This issue has been raised in **matter arising 4 in Appendix A**.

Conclusion:

2.10 We have raised four matters arising under this objective relating to the purchase order requisitions, purchase orders, receipting, purchase invoices, payments and oversight of single tender awards. These comprise of a mix of compliance with FCPs and operational effectiveness matters. Therefore, we have provided **limited assurance** over this area.

Objective 3: appropriate monitoring and escalation processes are in place

2.11 A review of the RPB payment budget monitoring and control processes adopted was performed and compared to the FCP Budgetary Policy.

2.12 Internal management reporting is actioned monthly by the Finance Team and reported as part of the monthly budgetary review process. However, the budget is monitored at a high level and focuses on the position statement that demonstrates a balanced budget for the year. In addition, there is no formal written report that comments on matters such as:

- compliance with deliverables / responsibilities agreed with the RPB regarding the processing of payments;
- confirmation, or otherwise, of compliance with the Health Board's FCPs;
- current risks, as per the risk register;
- emerging risks; and / or
- matters for escalation / note by management.

Whilst we have not raised this as a specific recommendation, as there are a multitude of reporting / monitoring mechanisms etc. already embedded, the Health Board may wish to consider if further enhancements are required.

2.13 In addition, we reviewed the various external reports that commented on the totality of the RPB funding activity, actual and projected for the financial year. We have not commented on the format of the external reporting as this is outside of scope of this audit. However, we noted that reporting is heavily dependent upon regular, monthly tracking reports promptly provided by the individual recipients of funding payments, as well as minutes of meetings of the RPB and the Regional Partnership Leadership Group.

Conclusion:

2.14 We found that internal management reporting processes were in place and that oversight of a balanced budget was provided. Whilst we have not raised any matters arising under this objective, we have commented on reporting enhancements if deemed required by the Health Board and the inherent reliance placed upon information provided by external parties. Therefore, we have provided **reasonable assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Roles and Responsibilities (Operating Effectiveness)	Impact
We noted that there is no detailed document between the Regional Partnership Board (RPB) and the Health Board detailing roles and responsibilities / expectations, to ensure the swift and accurate processing of RPB payments. In addition, there would be benefit from defining the roles and responsibilities of the various parties regarding the processing of RPB payments. Furthermore, this should extend to defining the documentary evidence required to support: the purchase order requisition, receipting, and purchase invoice related activities necessary, to ensure a prompt and accurate three-way match of evidence. Such a document would be of value to all those receipting funds and the RPB, enabling them to understand the roles within the Health Board, as well as their responsibilities in support of prompt payment processing. This document could be extended to include other deliverables provided to the RPB by the Health Board and consideration should be given to the inclusion of the governance services provided to the RPB by the Regional Partnership Team, hosted by Torfaen County Borough Council.	Potential risk of: Ineffective monitoring and oversight of the payment deliverables. Lack of understanding of the role and the responsibilities of the RPB and funding recipients in supporting and enabling the payment process.

	Recommendations	Priority
1.1	We recommend that the Health Board engages with the RPB to develop a documented process covering the payment deliverables provided on behalf of the RPB. Therefore, providing the RPB with details of key process points for ensuring each organisation fully delivers their outputs required. Any process could be extended to cover other outputs provided to the RPB.	**Medium**
1.2	We recommend that the Health Board develop a roles and responsibilities document (internal and external), detailing the process for receipting funds and the information required (including meeting minutes). This approach could be replicated to cover all outputs provided by the Health Board to the RPB and consideration should be given to including the deliverables provided by the Regional Partnership Team hosted by Torfaen County Borough Council, as they also impact activities.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	The Health Board accepts that a refreshed agreement needs to be developed between the RPB and all partners in relation to providing clarity of roles and functions. This cannot take the form of a Service Level Agreement as the RPB is not a statutory organisation. However, following a governance review undertaken by the RPB a revised Memorandum of Understanding (MoU) is being developed for inclusion within the RPB Governance Framework document. The MoU has been drafted to include a set of financial procedures for the administration of partnership funding as well as clarifying the roles and responsibilities of organisation within the Partnership and of the Health Board in acting on behalf of the RPB and is awaiting ABUHB Executive sign-off, prior to RPB review.	31/10/2024	Deputy Director of Strategy, Planning & Partnerships
1.2	As above, further clarity of the roles and responsibilities have been included within the draft MoU and the RPB Governance Framework, which is currently being reviewed by ABUHB Corporate Governance. However, this is not solely an action for the Health Board but all partners as part of the RPB Governance Framework. To ensure there is a clear differentiation of roles and responsibilities internally to ABUHB and appropriate segregation of duties, the process of raising requisitions, which currently is actioned by the PMO Finance Team, will be transferred to the PMO Team going forward.	31/07/2024	Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospitals & Partnerships

Matter arising 2: Purchase Order and Invoice Principles (Design)	Impact
The Accounts Payable FCP, Section 6.3, Order Creation does not comment on RBP transactions, where purchase orders relate to the funding of third parties, rather than actual goods and services received by the Health Board. Furthermore, there is no detail within the FCP over the approval of invoices for payment in advance of receiving goods or services. Whilst Section 10.6 of the Model Standing Orders, Reservation and Delegation of Powers for LHBs, Standing Financial Instructions (the 'SFIs'), comments on prepayments, including an example of a voluntary services compact, this is not incorporated into the FCPs. From the sample of RPB payments tested we noted that the purchase requisitions and the purchase orders reviewed provided high level commentary on the funding commitments. However, there was no detailed reference to the goods or services provided / to be provided with the funds remitted, thus limiting any effective subsequent receipting control and where funding is provided in advance to third sector organisations, the receipting control is perfunctory as it is not possible to audit or review costs yet to be incurred. Furthermore, the detail on the purchase order did not always note the specific source of the funding from the Welsh Government to the RPB that was being committed to the recipient, whether it was to be paid in advance or arrears, and if it was in arrears whether this was to include accruals or not. The sample of payments tested identified that purchase invoices are reviewed by the Finance Team, in advance of them of being checked by the Accounts Payable Team. The Finance Team confirm the financial coding, check invoice details to the purchase order quoted, or add the purchase order reference number where not provided, and check the mathematical accuracy of the document. Once the checks have been performed, the Accounts Payable Team are emailed with instructions to process and pay invoices attached to the email, as financially coded by the Finance Team. It is noted that these checks are in addition to the standard checks performed by the Accounts Payable Teams. However, we were unable to review evidence over the scrutiny of the purchase invoices and whether this has been completed successfully. Any variations identified and actions taken to correct were similarly not recorded. The Accounts Payable FCP does not detail the steps required to support this checking process. Consequently, purchase order requisitions are not always supported by detailed information, to enable the application of the correct budget code.	Potential risk of: Financial transactions are not processed fully in accordance the Accounts Payable FCP as the FCP only comments on goods and services to be ordered and receipted by the Health Board and does not detail RPB funding payments to third parties. Roles and responsibilities are not clearly defined. A lack of clear understanding over the process for classifying and information required for RPB financial transactions.

Recommendations		Priority
2.1	We recommend that the Health Board ensures that clarity is provided by defining the purchase requisition and purchase order process for RPB funding payments, made by the Health Board on behalf of the RPB, indicating the level of detail required to be noted on purchase requisitions and purchase orders. This should include specific reference on the documents that payments may, or may not, be made in advance to third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	**High**
2.2	We recommend that the Health Board ensures that consideration is given to amending the Accounts Payable FCP, to include reference to any bespoke purchase order process covering RPB funding processes. This should include possible payments in advance, referring to the requirements of the SFIs, Section 10.6, Prepayments, and the inclusion of funding to third parties on the basis of accrued costs.	**High**
2.3	We recommend that the Health Board ensures that clarity is provided over the steps to be taken with any internal financial checks and the evidence retention required, to ensure Section 6.1 of the Accounts Payable Financial Control Procedure is adhered to.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	<u>Purchase Order Requisition</u> Detail included within the purchase requisitions now include reference to 'Grant Funding', as well as the relevant funding stream. The scheme name continues to be included as a unique identifier. Examples of the requisitions raised include the below description. Gwent RPB - RIF REVENUE 24-25 - Grant Funding for Family Intervention Team (FIT) Gwent RPB - RIF DEMENTIA 24-25 - Grant Funding for Shared Lives Dementia. <u>Payments to Third Sector Organisations</u> The MoU referenced above has been set out to address this matter where by Third Sector Organisations can only claim funding monthly in arrears going forward. This information has also been reflected within the grant terms and conditions for 2024/25 and therefore not required for inclusion in the requisition detail. However, communication to the organisations impacted by this change will need to be managed in line with the issuing of the grant award letter There are exceptional instances whereby a payment will need to be paid in advanced, for example, the funding for small grant schemes. This will be managed as noted in section 2.2.	30/04/2024 31/07/2024 30/08/2024	Assistant Finance Director for Out of Hospitals & Partnerships Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospitals & Partnerships Assistant Finance Director for Out of Hospitals & Partnerships

	Accruals The terminology 'accrual' was set out in the previous award letter. This has now been amended to 'costs incurred' by the organisation. This is to ensure that all committed costs are accounted for and claimed appropriately within the specified financial year. No further information is deemed necessary as there is a financial database and a portfolio register maintained with identifiable information of each scheme.	30/04/2024	Assistant Finance Director for Out of Hospitals & Partnerships
2.2	This will be reviewed and updated as required following the conclusion of sections 2.1, 2.3, 5.1 and 5.2.	30/08/2024	Assistant Finance Director for Out of Hospitals & Partnerships
2.3	Section 6.1 of the Accounts Payable Financial Control Procedure states that 'it is the responsibility of the requisitioner of goods and services to ensure that the correct financial code is inserted within the requisition.'	31/10/2024	Assistant Finance Director for Out of Hospitals & Partnerships
	On receipt of appropriate documentation such as award letters or RPB approved reports, the RPB Finance team are currently responsible for raising requisitions on behalf of the RPB, ensuring that the appropriate governance routes and procedures have been adhered to. The ledger on the system is set up so that the correct financial code is driven by the appropriate funding stream, which is included in the award letters that are issued. However, as noted in section 1.2, to ensure there is a clear differentiation with roles and responsibilities to support the segregation of duties, the process of raising requisitions will be allocated to the PMO Team going forward, rather than PMO Finance.	31/07/2024	Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospitals & Partnerships
	A list of appropriate documentation, such are award letters, approved reports, minutes and decision logs, will also be included in the standard operating procedure to ensure orders are raised with the correct evidence and approvals.	31/07/2024	Assistant Finance Director for Out of Hospitals & Partnerships

Matter arising 3: Approval of Purchase Commitment (Design)	Impact
From the sample of RPB payments tested we noted that purchase order requisitions are approved by the budget holder for the relevant financial budget code, subject to financial limits of delegated authority. Whilst this was evidenced for the sample tested it was noted that the Health Board's Signatory List (ASL) had been amended to increase the Chief Executive's financial limits on specific financial budget codes, to a level that obviates the need for possible Chair's Actions. It was not clear whether such increases in delegated financial limits have been communicated with the Audit, Risk and Assurance Committee. For some financial budget codes the Chief Executive's limit has been increased up to £2m. The Approval of Orders Greater than £100k FCP provides details of a number of types of payments, that typically exceed £100K. However, the listing does not make reference to RPB related delegations in excess of £100k. Were a requisition to be in excess of the financial limit of the Chief Executive, then decisions can still be made via a Chair's Action. However, as the Chair of the Health Board is currently the RPB Chair too, there is a potential lack of independence, as potentially the same person can initiate commitments for the RBP, but within the Health Board's purchase process.	Potential risk of: The increases in delegated authority limits provided to the Chief Executive, regarding specific financial budget codes used to record and manage RPB payments, are not reflected in the current Approval of Orders Greater than £100k FCP and may not have been effectively communicated and scrutinised by the Health Board via the Audit, Risk and Assurance Committee.

Recommendations		Priority
3.1	We recommend that the Health Board ensures that the Approval of Orders Greater than £100k FCP is updated for specific approval limits, to include reference to RPB payments and to reflect RPB funding type transactions.	**Medium**
3.2	We recommend that the Health Board ensures that the revisions to the authorised signatory list, regarding RPB payments, including the significant increases in the Chief Executive's delegated limits, are communicated to the Audit, Risk and Assurance Committee.	**Medium**
3.3	We recommend that the Health Board ensures that consideration is given to potential conflicts of interest over commitments with the Chair of the Health Board.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	The Health Board, led by the Director of Corporate Governance, is currently undertaking a review of the Scheme of Delegation, including specific approval limits. Once any amendments have been suggested and approved, by the appropriate Governance route, the Orders Greater than 100k FCP will subsequently be updated.	31/10/2024	Assistant Finance Director - Corporate
3.2	Specific approval limits, including those in reference to RPB, are revised only when the appropriate Governance route has been completed and documented. Communication of any amendments would not be relevant for the Audit, Risk and Assurance Committee as the Board has reserved authority to approve its delegated financial limits. The Director of Corporate Governance is currently undertaking a review of specific approval limits. Proposed amendments will be presented to the Board for approval in September 2024, pending further work on a comprehensive Financial and Non-Financial Scheme of Delegation.	31/10/2024 – for initial changes to specific approval limits 31/03/2025 – for Financial and Non-Financial Scheme of Delegation	Director of Corporate Governance Director of Corporate Governance

3.3	The Health Board has a defined process for the handling and recording of conflicts of interest in place via the Standards of Business Conduct Policy with a reviewed Policy due to be presented to the Board for approval in September 2024. This would cover any conflicts that may/actually arise for the Health Board Chair. Conflicts of interests arising within the RPB Board's membership (including the Chair of the RPB), will need to be handled in-line with the RPB's governance framework and recorded through the RPB's host body arrangements (Torfaen County Borough Council). RPB funding will only be approved by the Health Board's Chair where there is prior RPB approval in place. There is no circumstance where the Chair has authority to approve RPB expenditure in isolation. In exceptional circumstances, the RPB Chair is able to take Urgent Chair's Action, in conjunction with other Statutory Partnership Bodies, and this process is defined within the RPB's Governance Framework.	31/03/2025 – RPB Governance Framework to be fully developed and agreed	The RPB Governance Framework is led by the RPB Partnership Team and not in the direct control of the Health Board. Director of Corporate Governance to work with RPB Partnership Team

Matter arising 4: Single Tender Application (STA) (Operating Effectiveness)	Impact
Our review of the RPB payments sample tested identified that in one instance the commitment had been awarded as a result of a single tender action (STA). Whilst the STA form reviewed had been signed by relevant authorised management and approved in March 2023, there was no evidence that the approved STA form had been subsequently reported to the Audit, Risk and Assurance Committee.	Potential risk of: The STA form is not approved in accordance with SFIs, with no evidence of Finance Director review and approval recorded on the STA form. The approved STA form is not subject to oversight by the Audit Committee in accordance with SFIs.

Recommendations	Priority
4.1 We recommend that the Health Board ensures that the outstanding single tender action is promptly reported to the Audit, Risk and Assurance Committee for their oversight, in compliance with the SFI requirements.	**High**
4.2 We recommend that the Health Board considers an update to the process for reporting and overseeing STAs. In particular, to determine if further financial oversight is required within the STA process.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
4.1	Procurement will ensure that the STAs referenced are included in the Q1 report for 2024/25 for the Audit, Risk and Assurance Committee.	30/08/2024	Procurement Business Manager
4.2	The STA Template Document has been amended to require sign off from the director of finance before any STA can be awarded, in addition the Procurement team will introduce additional checks to ensure that all STA's undertaken by procurement are logged in the STA register for reporting to Audit Committee.	31/07/2024	Procurement Business Manager

Matter arising 5: Invoice Transaction Processing (Design)	Impact
From the sample of 15 RPB payments selected for testing, we noted the following points to improve control, the effectiveness and efficiency of process. i. Invoice Processing - invoices are not sent to the central Accounts Payable address, but sent to the Partnership & Integration, South Gwent Area Health Authority, St. Cadoc's Hospital, despite instructions on purchase orders to the contrary. This is contrary to Accounts Payable FCP Section 6.7.1 Invoice Received. ii. Invoice Processing - Purchase invoices tested are not always being paid promptly. In some instances, we noted payments had been made over four months following the date of the invoice. We also noted instances where purchase orders were receipted after the date of the related purchase invoices.	Potential risk of: Recipients of funding from the RPB experience delays of receipt of funds that may adversely impact their organisations' cashflows.

Recommendations	Priority
5.1 We recommend that the Health Board provides clarity to all parties, to ensure purchase invoices are sent to the central Accounts Payable address. If this is not considered appropriate, then the purchase order detail should be amended, and any such deviation from the Accounts Payable FCP be documented and approved.	**Medium**
5.2 We recommend that the Health Board ensures that clarity is provided over the invoice and receipting process through to the service level expected for the prompt payment of invoices.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
5.1	Having considered the recommendation and the complexities of the partnership arrangement, it has been agreed that it is not appropriate for invoices to be sent directly to the central Accounts Payable address. This will increase the risk of payments being made in error. Arrangements will be made for the purchase order details to be amended, and the deviation from the Accounts Payable FCP to be documented and approved.	31/07/2024	Assistant Finance Director for Out of Hospitals & Partnerships

5.2	Currently, the receipting of a purchase order is driven by collective assurance provided by both the PMO and PMO Finance team, followed by approval from the Assistant Director Partnership & Integration or Deputy Director of Strategy, Planning & Partnerships. This can sometimes take more time if appropriate assurance is not provided by the receiving organisation and can lead to invoices being received prior to receipting taking place. This process is currently being reviewed to ensure that project assurance and delivery can be verified in a timely manner to avoid unnecessary delays to invoice payments.	31/10/2024	Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospitals & Partnerships

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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Decarbonisation
Final Internal Audit Report

July 2024

Aneurin Bevan University Health Board

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan. Following on from the advisory review delivered in 2022/23, the scope included governance, strategy progress and implementation.

Overview

We have issued limited assurance on this area.

In determining the overall assurance opinion, the audit recognises that the Health Board is unlikely to reach the Welsh Government (WG) target of 34% carbon emissions reduction by 2030. This is not due to poor governance or unwillingness from the organisation to achieve the target.

The Health Board faces similar issues as other NHS Wales organisations with a lack of funding to implement the necessary steps to achieve the WG target. Furthermore, 67% of the Health Board's overall emissions sit within its procurement processes, which is managed by NHS Wales Shared Services Partnership (NWSSP) and therefore, outside of its direct control.

Positively, there has been clear progress and development of the internal controls since our previous audit. This includes a clearly defined governance framework and a well-developed DAP monitoring process.

However, the significant matters which require management attention include:

- Creating a funding strategy.
- Analysing carbon emission data to better understand the current position.
- Escalating risks, where required.

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

Report Opinion

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A previous report was advisory

Assurance summary[1]

Objectives		Assurance
1	Governance	Reasonable
2	Internal Strategies	Reasonable
3	Funding Strategy	Limited
4	Monitoring	Reasonable
5	Projects	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
4	Funding	3 & 5	Design	High
3	Action Log and Data Analysis	2	Operation	High
1	Training	1	Design	Medium
2	Risks	1	Design	Medium

1. Introduction

1.1 The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably as arising from the 2016 Paris Accord. Accordingly, they have sought to create a framework of controls, guidance and support to achieve these aims.

1.2 Targets include waste reduction, and reductions in supply chain carbon as part of the overall carbon footprint.

1.3 To support these aims, the Welsh Government published a number of strategic documents entitled Prosperity for All – Economic Action Plan, Prosperity for All – A Low Carbon Wales and Prosperity for All – A Climate Conscious Wales.

1.4 In March 2021 the Welsh Government approved a net zero target for the public sector of 2030. Net zero means balancing the greenhouse gas emissions with the amount of gases being removed from the atmosphere. For NHS Wales, an accompanying "Strategic Delivery Plan" was published, setting interim targets (from a 2018/19 base) of:

	Carbon budget reduction
2025	16%
2030	34%

1.5 Category targets were also set for:

- Buildings;
- Procurement;
- Fleet and business travel; and
- Staff, patient, and visitor travel.

1.6 All Wales activity support streams have been created, including estates planning, and approaches to healthcare.

1.7 The Welsh Government has made funding available of circa £19.9m for decarbonisation initiatives via the Estates Funding Advisory Board, in both 2023/24 and 2024/25 (based on each organisation matching 30% of the WG contribution from their own discretionary programme).

1.8 This audit builds upon the advisory review undertaken in 2022/23 which identified common themes nationally to be considered by the Health Board.

1.9 The risks considered during this review were:

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions.
- Reputational risk by failing to meet emission targets.

- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health. In so doing not meeting the requirements of the Well Being of Future Generations Act (2016).

1.10 NWSSP Procurement were not audited as part of this review.

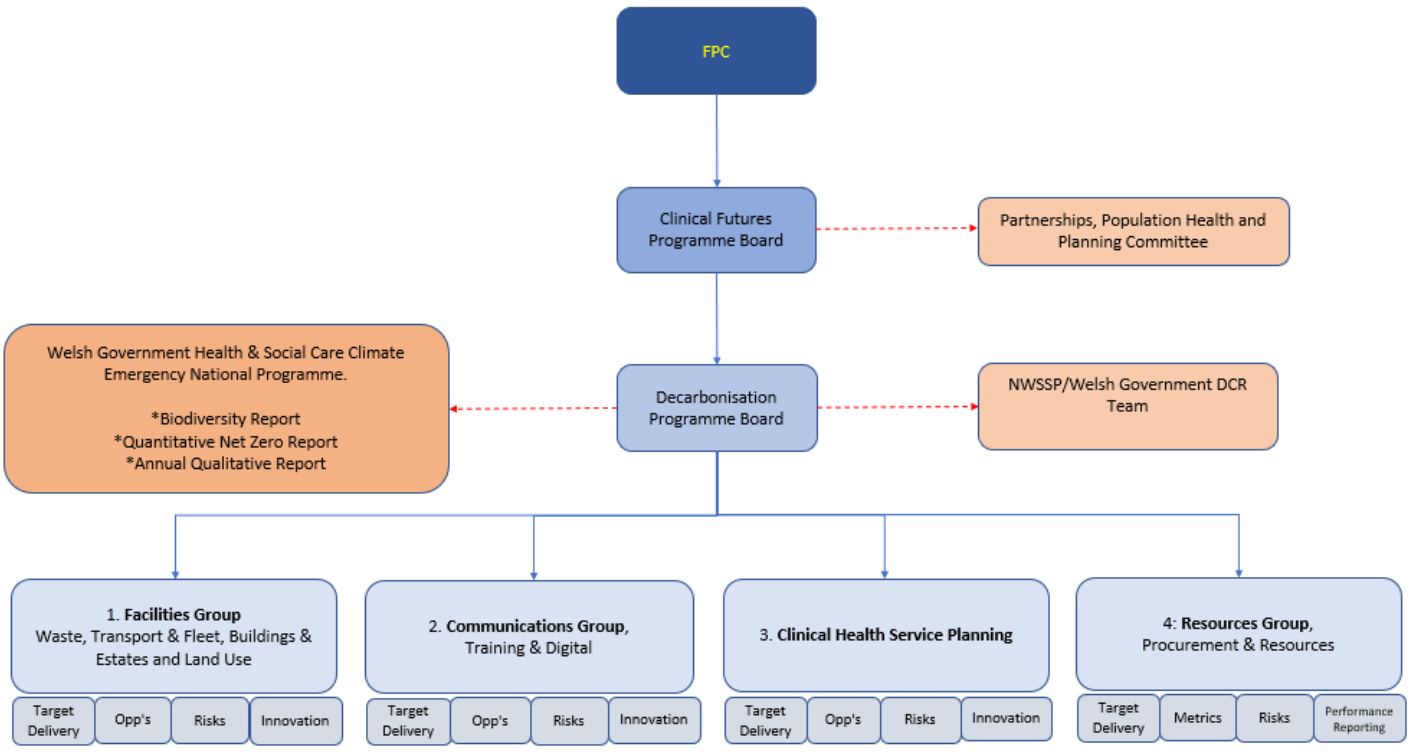
2. Detailed Audit Findings

Objective 1: Governance – appropriate governance arrangements have been established in relation to decarbonisation that integrate with existing organisational accountability and reporting structures

2.1 Decarbonisation is coordinated by the Clinical Futures Team. The Decarbonisation Programme Board (DPB) is currently responsible for defining the approaches and leading on implementing the operational initiatives detailed within the Decarbonisation Action Plan (DAP). The Programme Board is led by the Director of Finance, Procurement & Value. The DPB provides the Health Board with the mechanism to plan, implement and monitor actions and progress against the initiatives set out in the NHS Wales Decarbonisation Strategic Delivery Plan.

2.2 Our prior year decarbonisation reports across NHS Wales raised that recruiting to operational posts had been difficult across Wales. However, it is positive to note that the Health Board has taken a number of steps to address gaps within their organisation. The Health Board has leads for all four of its decarbonisation work streams: Facilities, Communications, Clinical Health Service Planning and Resources. Furthermore, consideration is being given to establishing further roles, if required and as the DAP progresses.

2.3 Below is an organogram detailing the ABUHB structure regarding decarbonisation:



2.4 The Health Board has refreshed its Decarbonisation Action Plan (DAP) for 2024-25. The DAP is integrated with other sustainability plans, e.g. the Sustainability Strategy. The DAP will be approved at the upcoming Decarbonisation Programme Board (DPB) in July.

2.5 The DPB has been established to work through the implementation of the DAP, the DPB features membership from key stakeholders across the organisation and is well attended. The terms of reference of the board clearly define its responsibilities and reporting structure. The purpose of the DPB is to act as a responsible group to consider, discuss and resolve the tasks and issues related to the Health Board's DAP.

2.6 Relevant staff with environmental management system (EMS) responsibilities have undertaken environmental training. 30 training places have been funded through the Health Board's Continuous Improvement Department with 25 staff having completed or booked training. Furthermore, the Health Board has five staff members that are qualified as Carbon Literate through a HEIW training module, to become a Climate Smart Champion.

2.7 However, there is no training matrix in place (for staff/groups who have EMS responsibilities) that details the relevant environmental training required for their role. Currently, training is not mandatory and is therefore, not actively monitored. The Health Board should consider whether formalising training would be beneficial as the decarbonisation programme progresses and matures. **Matter arising 1**.

2.8 A risk register forms part of the Decarbonisation Co-ordination Report (DCR). This is a quarterly report to NWSSP's Decarbonisation Co-ordination Reporting Group led by NWSSP on behalf of the Welsh Government. The DPB is responsible for collating the reporting of the delivery of the NHS Wales Decarbonisation Strategic Delivery Plan for organisations throughout NHS Wales.

2.9 Risks are raised via the DCR report where they are RAG rated, scored using a risk matrix, with risk owners assigned for each risk. Risks can be raised at the Partnerships Population Health and Planning Committee where decarbonisation updates are provided. No risks are currently recorded on the Corporate Risk Register. General risks to the decarbonisation programme have been identified.

2.10 However, the Health Board's current position is that it will not achieve the Welsh Government carbon reduction targets and will miss both the 2026 and 2030 deadlines. Although much of this is outside of the Health Board's control, given 67% of their total emissions (based on their 2018/19 baseline data) sits with procurement activities and thus, managed by NWSSP. Furthermore, funding constraints significantly impact how quickly the estate can be improved to assist with the Health Board's carbon emissions reduction. However, in spite of this, the responsibility of carbon reduction still belongs to the Health Board, and as such this risk and the accompanying challenges should be escalated / articulated as a key risk. **Matter arising 2**.

2.11 Furthermore, risks to the achievement of the DAP were raised within the Decarbonisation Programme Update Report, which was presented to the

Partnerships Population Health and Planning Committee in October 2023. The key risks identified were:

- future funding schemes to support the ongoing changes to deliver net zero by 2030;
- the pace of change required verses the complexity of delivery to reduce the carbon footprint by 16% (2025 target);
- investing in biodiversity now (2023), but not realising the benefits of tree carbon offset for 8-10 years;
- resources to support the schemes going forward where no funding currently exists;
- availability of financial support from the Welsh Government for large scale interventions on carbon reduction / avoidance schemes such as renewable energy.

Conclusion:

2.12 The Health Board has a defined structure for managing and administering their DAP. There is a clear reporting line on decarbonisation across the organisation, however, the process for the escalation of risks should be strengthened. Therefore, we have provided this objective with **reasonable assurance.**

Objective 2: Localised Strategies – a tailored decarbonisation strategy and action plan has been developed in accordance with available legislation and guidance. Documents have been appropriately scrutinised and approved prior to submission to Welsh Government. The strategy and plan are adequately reflected within wider organisational documentation such as the IMTP.

2.13 When the NHS Wales Carbon Footprint 2018/19 was calculated it stood at 1,001,378 tCO^2e including ABUHB. 14% (140,193tCO2) of which is attributable to the Health Board and places it among similar sized entities within NHS Wales. Procurement related emissions were the largest component (approx. 67%) of the Health Board's carbon footprint. Operational emissions account for the remaining 27% of the Health Board's baseline.

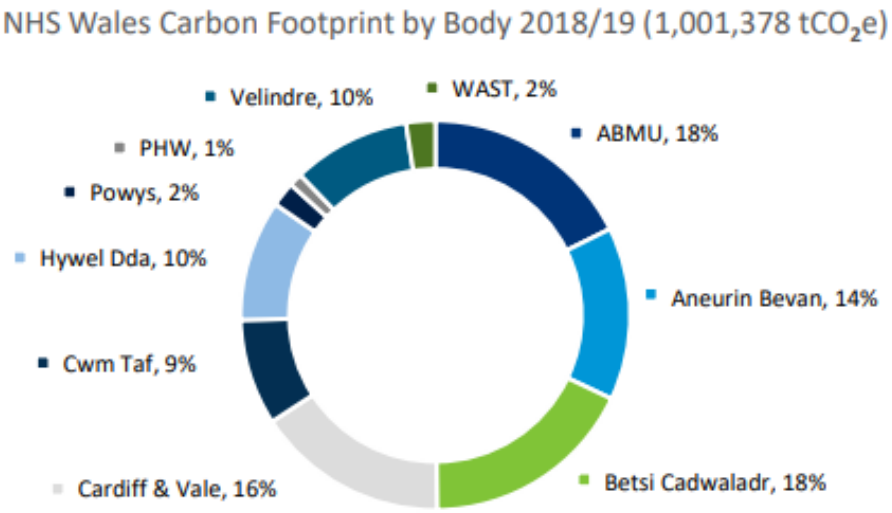


Figure 5 NHS Wales Carbon Footprint by Body 2018/19

2.14 The NHS Baseline identified four key source areas for its carbon emissions:

- building Use;
- procurement;
- fleet and business travel; and
- staff, patient & visitor travel.

2.15 The 'NHS Wales Decarbonisation Strategic Delivery Plan 2020-2030' (the 'Plan') published in March 2021 lays out 46 initiatives that will facilitate the reduction of carbon emissions. These initiatives should form the basis of NHS organisations decarbonisation action plans. Each organisation is required to implement actions to achieve these initiatives that are in support of the NHS Wales carbon reduction targets, as part of the Welsh Government's 'Net Zero' agenda.

2.16 In response to the Plan, the Health Board has created a its own Decarbonisation Action Plan (DAP). It outlines the primary deliverable decarbonisation activities that will be put in place over the upcoming years. The DAP has been updated to now cover actions to be completed between 2024-25.

2.17 The DAP covers actions over a one-year period and details actions to be taken against the 46 initiatives. The DAP follows the NHS Wales Baseline categories, grouping each action into one of the four main categories, as noted above.

2.18 It is supported by a live action log which is updated before each Decarbonisation Programme Board meeting. This action log identifies necessary actions to be completed throughout the year to progress the DAP and responsible owners are attached to each action. We noted that multiple actions were open and overdue without a new due date being provided in any action update notes. **Matter arising 3.**

2.19 The Health Board has not yet done analysis understanding their starting position (i.e. the 2018/19 baseline) and their current emissions to date position, e.g.

analysing the trend of drops and rises in emissions. For example, the Health Board is not able to state what the percentage change in carbon emissions has been and the cause of these changes e.g. X% increase in emissions, due to opening of the Grange University Hospital.

2.20 Consequently, there has been a significant change to the Health Board's emissions level since the baseline data was collated, due to the opening of a number of new sites, including:

- The Grange University Hospital;
- The opening of the Hospital Sterilisation and Decontamination Unit (HSDU);
- Specialist Breast Unit at Ysbyty Ystrad Fawr (YYF); and
- Bevan Health and Well Being Centre at Tredegar.

2.21 Additionally, a number of gases were not included within the baseline data, which the Welsh Government now require the Health Board to include. With such significant changes to the Health Board's estate portfolio, the emissions baseline should be updated to reflect the Health Board's current position. However, we note that the baseline cannot be changed without the Welsh Government's approval and discussions are continuing to remedy this position.

2.22 The Decarbonisation Programme has progressed significantly in terms of maturity over the past year. However, the next steps are to complete the analysis referenced above and present the current position clearly, including projecting the likelihood of achieving the Welsh Government's target of 34% reduction in emissions by 2030. It will also enable the Health Board to report more accurate and timely emissions figures to the Welsh Government **Matter arising 3**.

2.23 We confirmed that decarbonisation is included within a designated section of the IMTP. It specifically references decarbonisation and notes: "We recognise that achieving net zero is everyone's business, touching all parts of our system, from the management of the estate to approaches to how we will sustainably organise, procure, and deliver healthcare".

Conclusion:

2.24 A DAP is in place and actions to achieve the Welsh Government targets have been noted. Strengthening the clarity of information regarding the Health Board's current position on emissions and future reductions is required. Therefore, we have provided **reasonable assurance** for this objective.

Objective 3: An appropriate funding strategy targeting discretionary, EFAB and All-Wales funding is in place.

2.25 The DAP should be supported by funding strategies e.g., differentiating between local/national funding, revenue or capital funding. The Health Board does not have a funding strategy in place and has not fully costed its DAP. A funding strategy that linked future decarbonisation related costs to a roadmap of delivery should be implemented, including which areas should be prioritised.

2.26 Funding schemes the Health Board has applied for, both internally and externally, are not detailed within one document. It may be beneficial to consider tracking all schemes by adding this information to the DAP. We were informed that four funding bids have been successful.

2.27 Without an overall strategy over the funding arrangements, it is not clear how the Health Board plan to continue progressing with their decarbonisation programme. The current approach for the Health Board is to apply for funding as and when they are notified of potential funding schemes. This does not allow for a long-term approach to achieving the goals set out in the DAP. **Matter arising 4**.

2.28 There is evidence that funding is being applied for and has been achieved for initiatives such LED lighting installations, an orchard and biodiversity reports. Within the Decarbonisation Annual Update Report presented at the October 2023 Partnerships, Population Health and Planning Committee, a table lists the decarbonisation schemes undertaken or are in progress, together with the emissions saved:

Scheme	Status	Tonnes CO2 saved p.a.	£ saved per annum
Optimisation of the Building Control System (BMS) within the main hospitals	In progress	79.7	£71, 930
LED lights – RGH/YYF/YAB/STC	Complete	515	£182, 360
Anaesthetic Scavenging Systems	In progress – implemented manually at RGH, SWH, NHH and YYF. Plans for GUH.	40	£40-£50k
N2O – decommissioning of manifolds	Complete – YYF, NHH, RGH and STW	TBC	£14.5k
Theatre Ventilation Shutdown	In progress – complete in YYF and RGH. NHH will take place in November with plans for GUH later in the year/early 2024	TBC	TBC
Anaesthetic gases – Desflurane removal	complete	281	108k
Entonox Capturing Technology	In progress – 1 x monitor and 1 x capturing machine place on labour ward in GUH in August. Exposure to Entonox data is being recorded and a working group is being established to look at reducing (where necessary) the exposure to a level within guidelines.	TBC – data analysis underway	TBC
Reduction in use of non-sterile gloves (Gloves R Off)	In progress – implemented in CCU in September and rolling out into Recovery and DSU across sites	Baseline – CCU spend last 12 months £49630, equates to 876000 pairs of gloves.	March 2024

2.29 We found that decarbonisation funding has primarily been provided for three main projects across NHS Wales:

- LED lighting in buildings;
- electrical vehicle (EV) charging points; and
- solar panels.

2.30 The Health Board has achieved funding for both LED lighting and EV charging points. Furthermore, we were informed that consideration is underway for solar panels at appropriate sites.

Conclusion:

2.31 Although some funding for decarbonisation has been sought, the lack of a funding strategy does not allow for a long-term view or prioritisation of decarbonisation initiatives. Therefore, we have provided this objective with **limited assurance**.

Objective 4: Monitoring & Reporting – To ensure appropriate monitoring and reporting arrangements are in place.

2.32 There is a defined decarbonisation reporting hierarchy as per objective one. The DPB is responsible for monitoring the progress of the Decarbonisation Programme during bi-monthly meetings. Our review of the minutes from this group identified actions that are tracked and discussed across the four main categories noted above (building use; procurement; fleet and business travel; and staff patient and visitor travel). The Group's objectives cover areas such as:

- develop and agree the Health Board's Decarbonisation Programme with clear outcomes and benefits; and
- drive the delivery of the programme ensuring outcome and process milestones are met; and
- engagement and coordination of a regional / All Wales approach that includes both funding and technology;
- ensure alignment with the NHS Wales Decarbonisation Strategic Delivery Plan and the policy drivers developed by the Welsh Government, including the individual Health Board's Annual Plans and IMTP; and
- provide training and support to staff who are involved in ABUHB Decarbonisation Programme to ensure it is on track to deliver the intended benefits.

2.33 We found the DPB engagement to be positive, as even without significant funding, each of the four workstreams that form part of the DPB have a responsible officer assigned. In particular, there are regular updates and engagement with the decarbonisation agenda throughout the Health Board, including clinical staff.

2.34 For example, as part of workstream three there is regular engagement with clinical staff to jointly review carbon reducing initiatives, including measuring the carbon

impact of anaesthesia and nitrous oxide, and reducing plastic waste with paracetamol use.

2.35 The Finance and Performance Committee monitor the progress of the decarbonisation programme. Our review of the minutes confirmed that decarbonisation progress has been discussed and funding for decarbonisation schemes noted.

2.36 The Partnerships, Population Health and Planning Committee also monitors progress on the DAP and receives the Decarbonisation Annual Report. These meetings are well attended, and updates are noted within the minutes.

2.37 The Health Board is required to present a quarterly report to NHS Wales Shared Services Partnership's (NWSSP) Decarbonisation Co-Ordination Reporting Working Group (DCR), led by NWSSP on behalf of the Welsh Government. The quarterly DCR reports are sent for approval by the DPB. Our review of the DCR reports confirm they are produced in a timely manner, conform to the correct template and provide progress updates.

2.38 The Health Board is required to submit annual quantitative and qualitative reports to the Welsh Government, detailing the progress of their contribution to the Climate and Nature Emergency and associated targets as outlined in the DAP. Review of these returns identified continued progress of the DAP.

2.39 Within the most recent qualitative return, completed April 2024, the Health Board provided a RAG rating of red against their confidence of delivering a minimum of 16% reduction in emissions by 2025. This is the most recent report we reviewed and is the first where clear attention is being brought to the issues faced by the decarbonisation programme.

2.40 We found that there is oversight and monitoring of the DAP from numerous groups, both internally within the Health Board and externally through the Welsh Government returns.

Conclusion:

2.41 We confirmed that the decarbonisation monitoring and reporting processes operated by the Health Board, from the DPB through to the relevant committees, are well established and operating effectively. Areas of improvement are addressed in the previous objectives and matters arising two and three, therefore, we have provided **reasonable assurance** for this objective.

Objective 5: Project Delivery: To obtain assurance that projects included within the 2023/24 funding commitments have been successfully delivered, and that appropriate arrangements are in place to secure available funding during 2024/25.

2.42 As noted within objective three, there is evidence that funding is being applied for and has been achieved for initiatives.

2.43 Furthermore, we were informed that funding discussions for 2024/25 have commenced, but are still at an early stage.

2.44 ReFit Cymru is a national energy performance framework endorsed by both the UK and Welsh Governments. The framework allows for an OJEU compliant mechanism to procure energy and carbon saving technology for the public sector. The framework has 16 service providers that can bid for work across the public sector and is supported by the Welsh Government Energy Service.

2.45 Whilst Refit funding requirements for 2024/25 have not yet been confirmed, progress is being made and it is anticipated funding will be requested during the year.

2.46 Other future projects will be identified as and when funding becomes available. Without a funding strategy as noted in objective three, there is a risk that the Health Board is not obtaining all of the potential funding available to achieve their DAP. Funding is limited and although the Health Board is progressing with projects, the significant investment in the Health Boards infrastructure such as modernising old inefficient buildings has not taken place due to lack of funding. Therefore, there has yet to be a significant material impact on the reduction of emissions. **Matter arising 4.**

Conclusion:

2.47 Projects which have received funding are progressing, a clear funding strategy and prioritisation should be implemented, which has already been noted within objective three. There is a significant challenge for the Health Board to achieve the funding required to materially reduce carbon emissions. Therefore, we have provided this objective with **limited assurance**.

Overall conclusion:

2.48 We have assigned limited assurance due to the significant risk that the Health Board will not achieve the Welsh Government emissions targets, primarily due to the uncertainty over the funding approach for the DAP.

2.49 The governance arrangements in place for the Decarbonisation programme are sufficient, however, even if the Health Board were to implement the actions identified within Appendix A, it would still require additional funding to achieve the overall carbon emission reduction required.

2.50 Finally, the baseline data from 2018/19 to which the Health Board is being assessed against no longer reflects the Health Board's estate portfolio. For example, the Grange University Hospital has opened since the emissions baseline was developed, but has not been updated to reflect this addition. This will require engagement with the Welsh Government to be able to reflect this position.

Appendix A: Management Action Plan

Matter Arising 1: Training (Design)			**Impact**
There is no training matrix in place (for staff/groups who have environmental management system responsibilities) that details the relevant environmental training required for their role. Currently, training is not mandatory and is therefore, not being actively being monitored. The Health Board should consider whether formalising training would be beneficial as the decarbonisation programme progresses and matures.			Potential risk of: • Staff with EMS responsibilities may not be adequately trained to carry out their roles. • The Health Board being unaware of which staff are satisfactorily trained and which staff need training.
Recommendations			**Priority**
1.1	Management should identify the required training packages for its staff and which training needs to be mandatory. Mandatory training should be monitored for staff compliance.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Training to date has been voluntary and supported through limited available funding, however awareness raising and voluntary engagement and involvement in the decarb, biodiversity and sustainability is promoted through the Board sub-groups and the Health Board's extensive intranet site, with over 60 projects underway. It is agreed that it would be useful to implement a more structured training approach. However, mandatory training will need to be tested against the ABUHB Policy Group. Additionally, an appropriate e-training product would need to be developed or procured.	October 2024	Director of Finance/Decarbonisation SRO

Matter Arising 2: Risks (Design)	**Impact**
The Health Board's current position is that it will not achieve the Welsh Government carbon reduction targets and will miss both the 2025 and 2030 deadlines. Although much of this is outside of the control of the Health Board given 67% of their total emissions (based on their 2018/19 baseline data) sits with Procurement (NWSSP) and funding constraints affecting how quickly and what can be done to older parts of the estate, the responsibility of carbon reduction still belongs to the Health Board. The significant challenges and risks that the decarbonisation programme faces have not been adequately raised or articulated at a corporate risk level.	Potential risk of: • The Board / senior management is not aware of the significant issues facing the achievement of the DAP. • Risks not being effectively managed. • Carbon emission reductions are not achieved.

Recommendations		**Priority**
2.1	The specific risk that the Health Board is unlikely to reach the Welsh Government targets of 16% emissions reduction by 2025 and 34% reduction by 2030 needs to be clearly raised.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed – this is already under consideration and a risk analysis is in construction for the Board	September 2024	Director of Finance

Matter Arising 3: Action log and data analysis (Design)	**Impact**
A live action log supports the DAP which is updated before each Decarbonisation Programme Board meeting. This action log identifies the actions to be completed throughout the year to progress the DAP and responsible owners are identified for each action. We noted that multiple actions were open and overdue without a new due date being provided in any action update notes. The Health Board has not yet completed analysis to understand their starting position (i.e. the 2018/19 baseline) and their position regarding emissions to date and analysing the trend of drops and rises in emissions. In particular, the Health Board is not able to state what the percentage change in carbon emissions is. For example, a 12% increase in supply chain data and the cause of these changes e.g. opening of the Grange University Hospital. There has been a significant change to the Health Board's emissions since the baseline data was collated due to the opening of a number of new sites such as but not limited to: • The Grange University Hospital; • Hospital Sterilisation and Decontamination Unit (HSDU) at Llanfrechfa Hospital; • Specialist Breast Unit at Ysbyty Ystrad Fawr (YYF); and Bevan Health and Well Being Centre at Tredegar. Additionally, a number of gases were not included within the baseline data which the Welsh Government now requires the Health Board to include. With such significant changes to the Health Board's estate, the emissions baseline should be updated to reflect the Health Board's current position. However, we note that the baseline cannot be changed without Welsh Government approval and discussions with Welsh Government are on-going. Overall, however, the DAP has not detailed or identified how the level of carbon emission reduction required will be achieved by 2025 or 2030.	Potential risk of: • Actions going incomplete or being unnecessarily delayed reducing the efficiency of the decarbonisation action plan. • Carbon emissions data is not clear which results in poor management decision making. • Carbon emission reductions are not achieved.

Recommendations		Priority
3.1a	Management should ensure the decarbonisation action log is regularly updated.	High
3.1b	Management should complete an analysis of their progress to date with the decarbonisation plan. The percentage reduction or increase in emissions compared to the original baseline the reasoning for any increases should be captured. Management should seek dialogue with Welsh Government to agree an updated emissions baseline figure which reflects the changes in the Health Board's site since the original baseline in 2018/19.	
3.1c	The DAP should clearly set out the actions for achieving the level of carbon emissions reduction required, once calculated.	

Agreed Management Action		Target Date	Responsible Officer
3.1a	Agreed – actions are progressing and reflected in minutes but the log needs updating.	September 2024	Decarbonisation SRO
3.1b	Agreed – the re-basing of ABUHB carbon impact will also need clarity on National Procurement and other Shared Services data – something that has been repeatedly requested. A report has recently been received, post audit (attached). This will pursued as part of establishing a revised figure. Aneurin Bevan University Health Bo	October 2024	Director of Finance / Decarbonisation SRO / ABUHB Head of Procurement

3.1c	ABUHB has more than 60 projects focussed on decarbonisation. Not agreed – the Board has considered the cost of developing a fully costed decarbonisation plan (as it would require consultancy input) to be unaffordable at the current time, this may be re-visited once available funding can be identified. As a mitigation to the above a consultancy firm has been engaged to provide expertise on options under the refit funding plans e.g. Solar power and will provide options for ABUHB to consider.	N/A	N/A

Matter Arising 4: Funding (Design)		**Impact**
The Decarbonisation Action Plan (DAP) should be supported by specific funding strategies e.g., differentiating between local/national funding, revenue or capital funding. Without a funding strategy it is not clear how ABUHB plan to continue their progress with decarbonisation. Currently, the approach of the Health Board is to apply for funding as and when it is notified of potential funding schemes. This does not allow for a long-term approach or prioritisation to achieving the goals set out in the DAP. There may also be more efficient ways of funding decarbonisation projects that the Health Board is unaware of.		Potential risk of: • Not all available funding is being utilised and ABUHB may miss opportunities to complete their DAP. • More efficient funding options could be being missed e.g. Welsh Government funding for a project rather than capital funding.
Recommendations		**Priority**
4.1	Management should develop a long-term financial strategy which links to a fully costed DAP to funding available which prioritises projects/actions that provide the largest emissions savings.	**High**

Agreed Management Action		Target Date	Responsible Officer
4.1	Agreed in principle. ABUHB is in financial deficit and prioritisation of funding for patient care takes precedent. ABUHB as with other NHS organisations will only be able to deliver Decarbonisation targets with significant additional funding. Opportunities to improve the footprint are taken whenever possible including new funded capital projects (which will provide the greatest impact) as well as more local smaller projects that have a wider 'engagement and influence' impact too. ABUHB will optimise the use of existing funding and policies in making decisions to reduce the carbon footprint at all opportunities but this will generally be aligned to core business e.g. product choices, gas and travel policies and maintenance and building works. The national EFAB fund will be maximised to support the decarbonisation agenda through bids too. The above identifies a strategic approach to decarbonisation through capital funding and refit funding and opportunistic revenue decisions, but a full scale discrete strategic funding approach to decarbonisation is not possible at this point in time.	Local approach In Place	Director of Finance & Director of Strategic Planning and partnerships

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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LINC Programme
Final Internal Audit Report

May 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To review the arrangements in place for the mitigation of risk associated with the non or late delivery of the LINC programme of work.

Overview

We have issued **reasonable** assurance on this area. Overall, the key risk associated with the delay to the LINC programme is being appropriately mitigated against through the contingency project; LIMS 2.0. Our review highlighted that the key risk is reflected within both project and directorate risk registers.

Whilst other project-level risks associated with the delay have been appropriately identified and are well-managed, we noted inadequate risk management arrangements at directorate-level.

The matters requiring management attention include:

- Two out of three risks on the Pathology Directorate risk register have not been updated since October 2023 and, there is an overall lack of detail on the impact of the delay to the LINC Programme on Pathology services.
- The Pathology Directorate Meeting has not met since August 2023, and papers evidence limited review of LINC Programme risks.

Report Opinion

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A First Review

Assurance summary[1]

Objectives		Assurance
1	The risks associated with delays to the LINC programme are clearly identified and monitored.	Limited
2	Actions to mitigate the delays to the LINC programme are in place and being implemented.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Directorate risks	1	Operation	High
2	Pathology Directorate Meeting	1	Operation	High

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board' or 'organisation') a review of the Laboratory Information Network Cymru (LINC) Programme was undertaken.

1.2 The LINC programme is to deliver the new Laboratory Information Management System (LIMS), which will manage the 35 million plus tests processed by NHS Wales' 21 pathology labs every year.

1.3 The new LIMS Service will be used across NHS Wales in Blood Sciences, Cellular Pathology and Mortuary, Microbiology and Public Health Wales Cytology and Newborn Bloodspot Screening Services.

1.4 Key benefits identified include faster turnaround of tests, a reduction in the number of repeat tests, improved clinical safety through electronic test requesting and ensuring the service can cope with increasing demand.

1.5 The new system was due to roll out in 2023 and replace the existing LIMS system, supplied by InterSystems which was introduced in 2013. However, challenges with the delivery of the system have meant that it will not be delivered within the anticipated timescale.

1.6 The potential risk considered as part of this review was as follows:

- Strategic risk 6 – Delivery of a digital and information infrastructure to support organisational transformation.

2. Detailed Audit Findings

Objective 1: The risks associated with delays to the LINC programme are clearly identified and monitored.

Detailed Audit Findings Summary

2.1 At its meeting in November 2022, the Health Board approved the inclusion of a new high-scoring risk of 25 (CRR045) to its Corporate Risk Register in relation to the LINC Programme. It appropriately identified that if the new LIMS service was not fully deployed before the InterSystems contract expired 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. The risk remained on the Corporate Risk Register until July 2023.

2.2 In our review we have considered this to be the key risk associated with the delay of the LINC Programme. Whilst we have identified areas of concern regarding less than robust risk management arrangements at directorate-level, overall, we have found that the main risks reflective of the LINC Programme delay have been appropriately captured with mitigating actions in place, which are being suitably progressed. Thus, we have concluded with reasonable assurance overall.

Background

2.3 The LINC programme was established by the NHS Wales Collaborative in November 2017 on behalf of the health boards and NHS trusts in NHS Wales, to support the delivery of a new all-Wales Pathology System to replace the existing solution (TrakCareLab 2016 LIMS). The existing Laboratory Information Management System (LIMS) provided by InterSystems Corporation is nearing its end of life and cannot operate securely beyond September 2025. As part of the programme a procurement exercise was undertaken and a full Business Case for the LINC programme was approved by all health boards and trusts in September 2021, with a formal agreement awarded to Citadel Health in October 2021.

2.4 The agreement between Citadel Health and NHS Wales enabled individual health boards to 'call off' services in the form of deployment orders. Cardiff and Vale University Health Board (CAVUHB) were to be the first health board to go live and signed the deployment order in January 2022. In the months that followed, it transpired that Citadel Health would not be able to deliver the defined services within the timeframe that had been agreed. As a result of the ongoing delays to delivery, and to ensure continuity in Laboratory Services, all health boards and trusts endorsed the decision to terminate the Citadel contract and extend the current Laboratory agreement with InterSystems. A joint board meeting was held between Digital Health and Care Wales (DHCW) and CAVUHB on 20th April 2023, whereby the decision was agreed to terminate the contract, and to invoke the contingency plan (extension with InterSystems) at the earliest opportunity to ensure operational continuity.

2.5 In July 2023, the Health Board approved the extension of the agreement term by five years, to 30th June 2030. The deadline to replace the legacy LIMS (WLIMS1) remains the same, as the current system will be out of contractual support. The termination of the contract resulted in the national contingency project being initiated; LIMS 2.0. The project will be completed in two years (instead of four for LINC), resulting in a reduced scope to ensure a fully supported LIMS will be delivered to NHS Wales by October 2025.

LINC Programme Risks

2.6 At its July 2023 meeting, the Health Board received a report, which detailed the requirements of the contract extension and sought approval to proceed. Well-informed risks and appropriate mitigating actions were clearly communicated. Due to the potential sensitivity of the information, we have refrained from including specific details of these and other risks within our report.

2.7 Following the Board's approval, CRR045 was de-escalated to the divisional risk register for continued management and oversight at the Pathology Directorate Meeting. We reviewed an extract of the risk register from Datix, and whilst the risk is included (ID 8791), it has not been updated since October 2023 and does not reflect the current position of the programme, i.e. the contingency plan has been invoked.

2.8 Two additional risks related to the LINC programme are recorded; ID 7672 and 7092. Whilst risk 7672 has been appropriately updated and is subject to regular

review, risk 7092 has not been updated since October 2023 and does not reflect the current position.

2.9 We consider there to be an overall lack of detail within the risk register regarding the impact of the delay of the LINC programme on Pathology services, which could potentially lead to unexpected issues and missed opportunities that could negatively affect the LIMS 2.0 project. For example, due to timeframes, the contingency project will be delivering a Minimal Viable Product (MVP) to go live in 2025 and as a result, the Health Board has not been involved in elements of planning and design. There is a risk that the new solution will not deliver sufficient functionality and/or there could be a loss of functionality. We note that the risk has been captured on the LIMS 2.0 project risk register, however, this has not been recorded on the Pathology Directorate Risk Register - whose services could be affected if the risk materialises.

2.10 In addition, we noted that the LINC programme was due to deliver Electronic Test Requesting to replace current paper-based processes. Despite the growing demand for Pathology tests and subsequent increased risk of errors and repeat-testing potentially impacting on clinical safety, this has not been captured on the directorate risk register. **See Matter Arising 1 at Appendix A**.

LIMS 2.0 Risks

2.11 The key risk associated with the LINC programme has been mitigated through the extension of the contract with InterSystems and commencement of the LIMS 2.0 contingency project. In October 2023, members of the project team conducted a 'lessons learned' exercise, whereby an assessment of the Citadel project and previous implementations of LIMS was undertaken to inform recommendations for improvements and to ensure all risks had been considered. We reviewed the project's risk register and noted that it is well-managed with comprehensive details for each of the twelve open risks, inclusive of the cause, event and effect, owners, inherent risk scoring, action plans and regular action updates. The risks presented within the SBAR to the Board in July 2023 have been included on the LIMS 2.0 risk register and cover a broad spectrum of categories, such as finance, business disruption, compliance/legislation, and business objectives.

Governance

2.12 Our review highlighted that there is sound project governance inclusive of the LIMS 2.0 Project Board and Digital Pathology Programme Board. Risks are presented in detail to both Boards on a monthly basis, and our review of papers confirmed that appropriate action logs are maintained and regularly updated.

2.13 As noted above, directorate risks are overseen within the Pathology Directorate Meeting, however, we note from the papers provided that meetings have not taken place since August 2023 and only brief overviews of the highest scoring risks were presented. Minutes from February, May and August 2023 indicate that limited to no discussion was had regarding the LINC programme and associated risks. **See Matter Arising 2 at Appendix A.**

Conclusion:

2.14 Risks associated with the delays to the LINC programme have been appropriately identified as evidenced by the SBAR to the Board, and the risk register held by the project team. The key risk of non-delivery of a LIMS system has been mitigated through the extension of the InterSystems contract, and risks associated with this new development have been captured and are appropriately overseen by relevant Boards. Whilst three LINC programme related risks are identified on the Pathology Directorate Risk Register, we noted inadequate details and a lack of updates for two of them. We further noted that the Pathology Directorate Meeting has not taken place for several months, therefore, there is a risk that unexpected issues may arise without sufficient consideration and oversight. Consequently, we have concluded **limited** assurance for this objective.

Objective 2: Actions to mitigate the delays to the LINC programme are in place and being implemented.

2.15 As noted under objective one, the key action to mitigate the delay to the LINC programme is in place and currently being implemented through the contingency LIMS 2.0 project. The risks noted within the SBAR to the Board in July 2023 had mitigating actions where applicable and are reflected within the LIMS 2.0 risk register for continued monitoring. Detailed action plans are in place for each risk, and we noted regular progress updates reflect the current status of their implementation.

2.16 We observed a robust project framework for the implementation of LIMS 2.0, inclusive of appropriate project team membership, a comprehensive Project Initiation Document, and a sound governance structure. An initial local implementation plan has been developed based on the phases of the national plan and is subject to ongoing review and revision as the project matures. The plan contains a comprehensive list of actions and milestones required for implementation, and the Health Board is due to go live in quarter two of 2025/26.

2.17 Whilst the key mitigating action to identified risks associated with the delay of the LINC programme is being implemented, the absence of a full impact assessment by the Pathology Directorate as noted in Matter Arising 1, poses the risk that not all actions have been adequately considered.

Conclusion:

2.18 The key actions to mitigate the delay to the LINC Programme have been achieved through the contract extension with InterSystems and commencement of the contingency project, for which we observed a robust framework and good governance. However, there is a risk that the Pathology Directorate has not captured all risks, and therefore by default, corresponding actions have not been considered. Consequently, we have concluded **reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Directorate Risks (Operation)		**Impact**
Following the Board's approval of the new agreement term, CRR045 was de-escalated from the Corporate Risk Register to the divisional risk register for continued management and oversight. We reviewed the Pathology Directorate's Risk Register, and whilst the risk is included (ID 8791), it has not been updated since October 2023 and does not reflect the current position. Two additional risks related to the LINC programme are recorded; ID 7672 and 7092. Whilst risk 7672 has been appropriately updated and is subject to regular review, risk 7092 has not been updated since October 2023 and does not reflect the current position. We consider there to be an overall lack of detail within the risk register regarding the impact of the delay of the LINC programme on Pathology services, which could potentially lead to unexpected issues and missed opportunities that could negatively affect the LIMS 2.0 project.		Potential risk of: • Inaccurate and outdated risk information which could lead to missed opportunities and/or unexpected issues.
Recommendations		**Priority**
1.1	Management should ensure that risks 8791 and 7092 are reviewed, updated, and managed accordingly.	**High**
1.2	Management should ensure that all risks in relation to the delay of the LINC programme on Pathology services have been considered and are reflected within the Directorate Risk Register. Current risks should be appropriately detailed in order to inform effective mitigating actions.	**High**

Agreed Management Action		Target Date	Responsible Officer
1.1	8791 and 7092 are duplicate risks. 8791 has been closed. 7092 remains on the directorate risk register and has been reviewed and updated and will be subject to monthly reviews and updates.	May 2024	Pathology Directorate Manager
1.2	A risk workshop will be scheduled to ensure all digital risks are appropriately defined and logged on the Directorate risk register. A full review of existing risks will be undertaken to ensure they are appropriately detailed with associated mitigating actions logged.	Oct 2024	Pathology Directorate Manager / Assistant Director of Digital Programmes.

Matter Arising 2: Pathology Directorate Meeting (Operation)			**Impact**
Directorate risks are overseen within the Pathology Directorate Meeting, however, we note from the papers provided that meetings have not taken place since August 2023 and only brief overviews of the highest scoring risks were presented. Minutes from February, May and August 2023 indicate that limited to no discussion was had regarding the LINC programme and associated risks.			Potential risk of: • Inaccurate and outdated risk information which could lead to missed opportunities and/or unexpected issues.
Recommendations			**Priority**
2.1	Management should ensure that directorate risks are appropriately overseen, regularly reviewed, and actioned.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	There is a monthly meeting held to review the directorate risk register. Following the risk workshop (referenced in management response 1.2), the Terms of reference for this meeting will be reviewed and aligned with digital project governance to ensure all risks, digital or otherwise and reviewed and regularly updated.	December 2024	Pathology Directorate Manager / Assistant Director of Digital Programmes

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Intra-site Patient Transfers
Final Internal Audit Report

July 2024

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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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement

NHS Wales Audit & 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

This internal audit has been undertaken to provide an opinion over the management of intra-site patient transfers within Aneurin Bevan University Health Board (the 'Health Board').

Overview

We found that the recommendations of previously issued reports were progressing, but had yet to be fully implemented and were continuing to be reported as overdue. Whilst this is being managed via the Audit Recommendation Tracker process we raised recommendations over ensuring the Flow Centre is achieving its objectives and that any further extension of the recommendations is by exception only.

We also completed a review of a patient transfer that would not be managed by the Flow Centre Team. In particular, maternity patient transfers from the Birthing Unit at Ysbyty Ystrad Fawr (YFF) to the Grange University Hospital (GUH) were sampled and we commented on opportunities to further improve the recording and performance management. These have since been implemented.

All findings are detailed in matters arising in Appendix A.

Report Classification

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	Follow up the audit recommendations made in Internal Audit Reports ABU 2021-40 Clinical Futures – Transport and AB 2122-22 - Flow Centre, and an assessment of the level of implementation of agreed management actions	Reasonable
2	Review of the transfer of patients and babies from the Health Board Birthing Unit at Ysbyty Ystrad Fawr (YFF) to the Grange University Hospital (GUH), antenatally, intrapartum and postnatally, to assess controls over transfer activity	Substantial

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Flow Centre Internal Review	1	Operating Effectiveness	Medium
2	ARAC Recommendation Tracking	1	Design	Medium
3	YYF to GUH Maternity Transfers - Sample Testing	2	Operating Effectiveness	Medium
4	YYF to GUH Maternity Transfers - DATIX Entries	2	Operating Effectiveness	Low

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

1. Introduction

1.1 As part of Aneurin Bevan University Health Board's (the 'Health Board') Audit Plan for 2023-24, an audit was undertaken of the arrangements in place to ensure the appropriate internal transfer of patients between sites within the Health Board.

1.2 Two internal audits were completed over patient transfers in recent years. In 2020-21 an audit report was issued on Clinical Futures - Transport that commented on the Flow Centre system implemented throughout the Health Board to manage the transfer of patients. In 2021-22 a second audit report was issued on the Flow Centre. These two audits commented on patient transfers managed by the Flow Centre, including step up, and step down transfers. As we examined this process within the last two audits, we did not retest the management of such transfers in this audit, but rather the progress made on recommendations raised within those reviews.

1.3 The Flow Centre has been under the management of the Urgent Care Division since March 2022.

1.4 The risks considered in the review included:

- intra-site transfers are not undertaken in a safe manner;
- despatching, in-transfer and receiving sites/clinicians are not all fully informed of nature of each transfer and local requirements;
- transfers are not effectively communicated to patient / patient's family or representatives;
- transfers are not subject to agreed approval process before actioning; and
- transfer performances are not recorded and assessed by ABUHB with any issues and actions to improve services not being tracked.

2. Detailed Findings

Objective 1: Follow up the audit recommendations made in Internal Audit Reports ABU 2021-40 Clinical Futures – Transport and AB 2122-22 - Flow Centre, and an assessment of the level of implementation of agreed management actions

2.1 A review of the Audit Recommendation Tracker (the 'Tracker') reported to the Audit, Risk and Assurance Committee (ARAC) meetings from February 2023 to February 2024 has identified that management actions from the previous reviews, including those commenting on KPIs and business continuity planning have yet to be fully implemented. Recommendations are being reported as overdue, despite due dates having been extended multiple times.

2.2 We have raised matter arising 2 in Appendix A, stating that management actions should be extended by exception and that any amendment of the date has appropriate justification provided.

2.3 An internal review of the Health Board's Flow Centre operations was performed during 2023 to ensure it remains fit for purpose. A Flow Centre Review Paper

(the 'review paper') was issued in 2023 in the form of an SBAR (Situation, Background, Assessment, Recommendation) document.

2.4 We noted that the terms of the reference detailed within the review paper were not specifically addressed. In particular, whether the Flow Centre is delivering its key aims and objectives, as originally commissioned. Whilst the review paper provided a current (2023) assessment of operations, it did not refer to an overarching assessment of the delivery of the original key aims and objectives. We have raised this finding in matter arising 1 in Appendix A.

2.5 However, the review paper did comment on the progress towards implementing the recommendations from the Flow Centre audit report. This included narrative that five of the six areas reported as requiring improvement had not yet been completed and have remained outstanding since May 2022.

2.6 The review paper was presented to the Divisional Management Team (DMT) and referred onto the Chief Operating Officer to provide a definitive guide / position regarding the recommendations made in the paper. We have raised this in matter arising 1 in Appendix A.

Conclusion:

2.7 We found that the recommendations and agreed management actions from the previous internal audit reports have not been fully implemented in a timely manner. Whilst actions have been implemented and are planned, based on infrastructure developments, it is evident that initial focus has been on the external patient transfer process, that comprises the majority of all patient transfer activity, rather than the lower volume intra-site patient transfers. We have raised two matters arising on the need to improve the tracking of, and to progress the implementation of agreed actions. Therefore, we have provided **reasonable assurance** over this area.

Objective 2: Review of the transfer of patients and babies from the Health Board Birthing Unit at Ysbyty Ystrad Fawr (YFF) to the Grange University Hospital (GUH), antenatally, intrapartum and postnatally, to assess controls over transfer activity

2.8 The All Wales Guideline for Transfers from Community and Freestanding Midwifery Units is employed by YYF midwives when transferring patients from YYF to the GUH, as YYF is a free-standing maternity unit. Whilst the scope of the guideline is predominantly for instances where a transfer is required during labour or shortly after birth, the principles can be used in all cases for a YYF to GUH transfer.

2.9 In addition, YYF midwives utilise the All Wales Clinical Pathway for Normal Labour Booklet (the 'booklet'). The booklet comprises three parts including: Part one, record of telephone conversations and decisions; Part two, initial assessment; and Part three, active labour pathway. A multipart Situation, Background, Assessment, Recommendation (SBAR) document is also included at the back of the booklet that allows the midwife to record the SBAR and record any intra-site transfer, i.e. from YYF to GUH.

2.10 YYF is a midwifery led facility and all staff receive continuous training provided via on the job training that is supported via four mandatory training days allocated each year. We noted that training is in support of continuing professional development and as a requirement of all midwives' revalidation.

2.11 A sample of patient transfers from YYF to GUH was selected and the scanned patient records were reviewed. We found that transfers sampled were actioned in accordance with the process and consistent with the guidance detailed above. However, we identified two matters that have been raised in matter arising 3 in Appendix A, notably:

- Medical notes reviewed on screen did not always reflect the engagement of patients and partners etc. in the transfer decision. Whilst we were informed that discussions were held, they were not evidenced within the record.
- The scanning of medical records reviewed identified that they are not always filed in a chronological order and that individual multi-page documents are not always scanned in sequential order. Since the initial audit, Maternity Services have now moved to digital records and are paper light – all records therefore no potential for loss of records or a lack of chronology.

2.12 Transfer review meetings are held regularly, where all intra-site patient transfers from YYF to GUH are discussed. This is an opportunity to review the patients' medical records, discuss performance, and identify any personal or YYF-wide training needs.

2.13 However, we noted that these meetings do not automatically capture any related DATIX incident reporting, associated with such patient transfers. This has been raised in matter arising 4 in Appendix A

Conclusion:

2.14 We have raised two matters arising under this objective relating to the inclusion of evidence in the patients' medical records of patients' and representatives' engagement with transfer decisions and the improvement of the scanning of the medical record. In addition, there is a need to capture relevant DATIX reporting of patient transfer matters as part of the periodic review meetings held.

Maternity service has a high rate of DATIX reporting and the department follows the RCOG trigger list for reportable incidents. Any woman that was involved in a clinical incident in accordance with the trigger list would have a Datix submitted and a MDT review. Transfer of care to GUH would not automatically result in a DATIX as this forms part of safe care and is supported by the all-Wales transfer guidelines.

These matters represent opportunities for further enhancement to existing processes and therefore, we have provided **substantial assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Flow Centre Internal Review (Operating Effectiveness)	Impact
An internal review of the ABUHB Flow Centre operations was performed in 2023 to ensure it is achieving its objectives. The terms of reference of the review included the following objectives that the review would be expected to address. • whether the Flow Centre is delivering to the key aims and objectives as originally commissioned; • if the key aims and objectives should be updated; • if the Flow Centre has processes and controls to assure high standards of delivery and provides value for money; and • whether the Flow Centre is operating appropriately by balancing organisational priorities with respect to patient flow. The review team included key individuals from the Urgent Care Division, Flow Centre staff, Operational Site Management Team, other Divisional staff and colleagues from WAST. A Flow Centre Review Paper (the ' review paper') was issued in 2023 in the form of an SBAR (Situation, Background, Assessment, Recommendation) document. The paper was delivered to the Executive Management Team. Whilst the paper provided a current (2023) assessment of operations, it did not provide an overarching assessment commenting on the above objectives. The review paper commented on progress on implementing the recommendations from the Flow Centre internal audit report and noted that five of the six areas reported as requiring improvement had not yet been completed and have remained outstanding since May 2022. The review paper recommended that areas of the May 2022 audit requiring improvement should be completed within an agreed timeframe, with appropriate resource allocated to the tasks and that progress is reported monthly at the Urgent Care Divisional Management Team meeting. The review paper was presented to the Divisional Management Team (DMT). Minutes of the DMT were reviewed and they indicated that the paper was subsequently referred to the Executive Team to provide a definitive guide / position regarding the recommendations made within the review paper.	Potential risk of: • Ineffective processes and controls for the transfer of patients; • Lack of value for money; and • Strategic objectives not met.

Recommendations		Priority
1.1	We recommend that the Health Board ensure that the Flow Centre Review Paper recommendations are delivered in a timely manner, with progress updates provided to the Chief Operating Officer.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	The Urgent Care Division is in contact with the Chief Operating Officer to resolve outstanding recommendations that may require additional funding. The recommendations are discussed formally in a wider group at the weekly Urgent Care Enhanced Monitoring Meeting chaired by the COO or Deputy COO.	March 2025	General Manager

Matter arising 2: ARAC Recommendation Tracking (Design)	Impact
A review of the Audit Recommendation Tracker (the 'Tracker') reported to the Audit, Risk and Assurance Committee (ARAC) meetings from February 2023 to February 2024 has identified that management actions from the previous reviews, including those commenting on KPIs and business continuity planning have yet to be fully implemented. Recommendations are being reported as overdue, despite due dates having been extended multiple times. At the November 2023 meeting it was noted that a number of the recommendations in the two reports were either overdue or had had due dates extended, thereby removing them from overdue status. The number of fully implemented recommendations was limited.	Potential risk of: Potential risk of: • Ineffective processes and controls for the transfer of patients; • Lack of value for money; and • Strategic objectives not met.

Recommendations		Priority
2.1	We recommend that the Health Board only consider further extensions of the Flow Centre related recommendations by exception only, and that any intent to further amend an already revised due date is specifically explained and supported.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	As part of the Urgent Care Enhanced Monitoring, this will be actioned as required.	July 2024	General Manager

Matter arising 3: YYF to GUH Maternity Transfers - Sample Testing (Operating Effectiveness)	Impact
A sample of maternity transfers from the midwifery-led birthing unit at the Ysbyty Ystrad Fawr (YYF) site to the Grange University Hospital (GUH) site in the period August 2022 to August 2023 was selected. Scanned medical records in support of each transfer were reviewed and discussed in detail with the Senior Midwifery Manager. We noted that the medical notes reviewed on screen did not always document the engagement of patients and partners in the decision for transfer. That is not to say there were not discussions held but that they are not effectively detailed in the patient notes. In addition, we noted that the scanning process did not result in a logical, sequential record being retained. From the samples reviewed it was evident that the patients' records consisted of many pages and that the ability to review the processes followed was labour intensive and required midwifery expertise to locate all the documents and interpret the record. For the sample selected all relevant documentation was located, but the process was not efficient.	Potential risk of: • Patient transfers are not effectively communicated to patient / patient's family or representatives. • The effectiveness of patient transfer records retained for YYF to GUH transfers is adversely impacted by the inefficient scanning of patient records.

Recommendations		Priority
3.1	We recommend that ABUHB management ensure that the patient records of maternity transfers from YYF to GUH are improved to ensure that informed engagement of patient and representatives in the transfer decision is noted in the patient record.	**Medium**
3.2	We recommend that the Health Board review the current scanning process regarding YYF to GUH patient transfer records to ensure that multiple pages of each patient record are scanned in a consistent, logical sequence.	**Low**

Agreed Management Action		Target Date	Responsible Officer
3.1	Digital end to end clinical records implemented 2023. Choice for place of birth and transfer information mandated, women provided with portal app to support shared care. Midwives to be reminded of the importance of documenting shared decision making.	Complete	Head of Midwifery & Gynaecology
3.2	Digital end to end clinical records implemented 2023. Provides real time data of clinical care resulting in detailed chronology of care and significant reduction in scanning. Since this audit the process for midwifery records has changed and they have moved to a digital end to end system. Part 1 of the pathway remains in paper form as cannot be adapted for digital use. The remainder of the pathway of care is in digital format. Any transfer to GUH would be recorded in the digital records Within the new digital records that has been rolled out 2023/2024 choice for place of birth is mandated this includes information in relation to transfer. Women have access to a portal app detailing their care and are very much shared partners in care of records.	Complete	Head of Midwifery & Gynaecology

Matter arising 4: YYF to GUH Maternity Transfers - DATIX Entries (Operating Effectiveness)	Impact
Patient transfer performance is reviewed as part of a regular periodic review of all maternity YYF transfers from YYF to GUH. Review meetings held are attended by the Senior Midwifery Manager, YYF midwifery staff, and the Governance Midwife. We noted that the patient records and the relevant YYF midwives are able to provide and comment on each patient transfer individually at the review meetings. However, there was no direct linkage to any DATIX reported incident that may have been raised on a patient transfer. The regular, periodic review meetings do not include DATIX events that have been reported. We recognise that a DATIX incident may be raised by persons other than YYF midwifery staff, but it is important that midwifery management are aware of all transfer related incidents reported for completeness and consistency of approach.	Potential risk of: • Midwifery management are not aware of all DATIX reported incidents relating to maternity patient transfers from YYF to GUH and are unable to assess and monitor DATIX reported events from a midwifery perspective.

Recommendations		Priority
4.1	We recommend that ABUHB management ensure that where a YYF to GUH maternity patient transfer has given rise to the reporting of an incident in DATIX that there is an ability to identify the event and discuss and monitor the DATIX record as part of the existing regular periodic review meetings held of all maternity patient transfers.	**Low**

Agreed Management Action		Target Date	Responsible Officer
4.1	Maternity service has a high rate of DATIX reporting with the service following the RCOG trigger list for reportable incidents. Any woman that was involved in a clinical incident in accordance with the trigger list would have a Datix submitted and a MDT review. Transfer of care to GUH would not automatically result in a DATIX as this forms part of safe care and is supported by the all-Wales transfer guideline.	Complete	Head of Midwifery & Gynaecology

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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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*
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Theatre Stocks
Final Internal Audit Report

July 2024

Aneurin Bevan University Health Board

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Auditors:	Stephen Chaney, Acting Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Leanne Watkins, Chief Operating Officer
Distribution:	Julie Poole, interim General Manager Scheduled Care Arvind Kumar, General Manager Clinical Support Services Stephen Gingell, Business Support Manager & Omnicell System Manager
Committee:	Audit, Risk and Assurance Committee

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Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the effectiveness of the Health Board's processes to manage and monitor theatre stock.

Overview

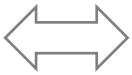
We noted the Health Board manages with a commercial stock management system (Omnicell) an extensive range of items used in its operating theatres.

We identified one high priority issue related to the risk of stock loss or misappropriation, as there is currently no review of potential stock losses within the 'discrepancies' figures captured.

Other medium priority issues are identified and recorded in the body of the report relating to stock access; access management controls; and non-compliance with the Health Board's year-end stocktake instructions.

Matters arising are summarised in the table at the beginning of the next section and all of these are referenced in the main body of the report and detailed further in the matters arising and management actions table in Appendix A.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 Limited in 2019/20

Assurance summary[1]

Assurance objectives		Assurance
1	Stock availability	Reasonable
2	Stock security	Reasonable
3	Stock records	Limited
4	Stock management information	Reasonable

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Regular review of staff granted access to theatre stocks	2	Design	Medium
2	Operation of open stores	2	Design	Medium
3	Distinguishing between stock discrepancies and losses	3	Design	High
4	Compliance with year-end stocktake instructions	3	Operation	Medium

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

1. Introduction

1.1 The review of Theatre Stocks was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2023/2024 Internal Audit Plan.

1.2 The scope of the audit covered the five main sites of the Health Board where there are Theatres in operation, but the audit examined these on a sample basis.

1.3 Omnicell devices are used to store medical equipment and devices for use within theatres to:

- improve workflow and patient care by ensuring supplies are readily available;
- keep high-cost supply items secure; and
- provide effective and accurate management of the inventory.

1.4 Under Health Board policies, theatre stocks are subject to controls to prevent loss or misappropriation. These include the following requirements:

- establishing maximum and minimum levels of equipment/ device to be held;
- maintaining records of volumes/ counts of equipment/ device usage, replenishment, waste; and
- performing regular stock takes to confirm physical volumes/ counts in the store match records.

1.5 The review examined controls around the safekeeping, storage and use of medical equipment and devices held for theatre use in Omnicell machines.

2. Detailed Findings

Objective 1: stock is available at the point of need

2.1 We sought to establish the model adopted by the Health Board for storing theatre consumables and other equipment such as implants for ready use during theatre operations and the processes in use to maintain these stocks at appropriate levels to ensure they are always available when needed.

2.2 Equipment (Omnicell cabinets) and related systems (SupplyX) have been provided in locations linked to theatre suites and these stores may serve single or multiple theatres according to site configuration. Cabinets store consumables and equipment from which they can then be drawn for the operations scheduled.

2.3 In addition to cabinets, in some theatre suites, stocks are also held in open stores. These locations operate in a similar manner to the cabinets, but with open shelving rather than secure cabinets. Items held in both cabinets and open stores are controlled within the Omnicell SupplyX stock management system.

2.4 Theatre clinical staff specify what items are held in theatre suite cabinets and storerooms based on the mix of operations that they are responsible for. Designated staff have ready access to the items held in cabinets and stores and will access these both before and during operations.

2.5 **Periodic Automatic Replacement (PAR) process**

A Periodic Automatic Replacement (PAR) automated re-order processes operates to provide item availability at all times.

2.6 PAR is an inventory control system that details the level of inventory required to fulfil demand. The PAR level sets the optimum amount of inventory stock needed on hand after each order delivery and triggers automatic stock re-orders.

2.7 **Stock-outs**

'Stock-outs' of items are an indication of the suitability of PAR levels and are continuously monitored. Stock outs prompt a review of PAR levels, which may then be adjusted to reduce/ avoid further occurrences.

2.8 We noted that item stock-out levels reported across the months of 2023/24 ranged from a low of 4% of the global item catalogue (9,960 different items) to a high of 9%.

2.9 **Manual orders**

The majority of stock lines are managed through a default auto-replenishment process, triggered by the PAR level parameter for each item in each cabinet.

2.10 We noted an exception to this is 'noncat' stock lines, where the items involved are not listed in the Oracle procurement catalogue. This results in the automated order routines stalling at the Oracle interface feed. As these are legitimately initiated by the Omnicell PAR framework, this category of manual orders does not increase stock item levels above design. However, there is a cost impact as a result of Oracle procurement purchase order raising and approvals workflows.

2.11 The Health Board has set and monitors a volume target to reduce manual orders to below 5% of all stock replenishment orders raised. However, we noted that levels of automated orders (target 95%) reported across the months of 2023/24 ranged from a low of 79% to a high of 86% of all orders raised, falling short of target (we were advised that there is ongoing work to improve this).

Conclusion:

2.12 We noted that stock-out levels are not insignificant, but adjustments are made to PAR levels where required and that these are monitored and are declining. We noted efficiency gains are still available from reducing further the level of manual ordering of replenishment stocks and that the Health Board has set and are pursuing a target to do so. We have raised no matters arising concerning the availability of stock (the subject of this objective), but recognise that further progress is still underway. Therefore, we have provided **reasonable assurance** over this area.

Objective 2: stock is securely held within the Omnicell system

2.13 We sought to establish the means by which consumables and other items are held securely within the locations concerned.

2.14 **Omnicell cabinets**

Omnicell cabinets contain consumables and regularly used devices. These are secure units and items can only be physically taken from them by persons granted system access.

2.15 Access to Omnicell cabinets is controlled by the issue of system user ids to appropriate staff and restricting their use to those specific individuals by employing fingerprint readers or access passwords.

2.16 Omnicell users are allocated to a user group where system functionality is assigned. User group functionality is designed to only allow group members access to the system functions, appropriate for their role.

2.17 We noted there are 535 active users of the Omnicell system currently listed across a number of user groups, under review at the time of the audit:

User Group	Number	Notes on user access and functionality
Regular Nurse	456	Limited access. Can issue, return and cycle count stock on handsets and cabinets, cannot make any changes
Nurse Manager	14	Can do all the above, but with extra permissions to add fingerprints for staff
Omnicell Tech	62	These are for stock controllers; clinical staff where there are no stock controllers; senior clinical staff requiring this access; or Omnicell tech personnel for remote access. This access provides additional server access on SupplyX via a PC, but they cannot make changes. Instead, they undertake stock control functions using SupplyX instead of via the handsets or cabinets like cycle counting, receipting, stock enquiries. These 62 users have different variations of access control, for example, the Stock Controllers will have a more access than clinical staff or local Stock Controllers not part of the central team, and the main system admin team will have full access to all functions on SupplyX, OmniCentre, Dyane RFID software and server access.
Pharmacy Technician B	2	Fully read only for national reporting. These two individuals are NWSSP external staff.
Pharmacist B	1	Read/write access. This is used for limited access to mainly reports or stock enquiries.
Total	**535**	

2.18 We were advised that user ids are automatically deleted after six months of inactivity but beyond that, there is no periodic review / validation process in place (see **Matter Arising 1**).

2.19 Regular counting of cabinet contents is relied upon to identify discrepancies between the recorded and actual stock levels (examined further under objective three).

2.20 **Open stores**

Open stores are used at some locations, instead of cabinets. We noted that at St Woolos Hospital, one of our two sample theatre suites, there are no Omnicell cabinets in use. Instead, stock is stored in an open store environment. A similar range of items for orthopaedic operations are found stored exclusively in cabinets at the Royal Gwent Hospital.

2.21 The store room was situated within the restricted access theatre suite, but the store itself was not further protected by keypad or other door security device.

2.22 We noted the workflow is designed for theatre staff to freely take items from the store room shelves, without making any record of the withdrawal. For expensive orthopaedic prostheses, which are individually identified by codes and references, following an operation, theatre staff advise the stock controller of stock utilised. This is reconciled using the item's serial number. The stock controller will then log in and update the Omnicell system to record the issue of the item and the system will

update the item 'Quantity on Hand' (QOH). For other items, use is only identified when remaining stock levels are identified within the next physical count.

2.23 The retrospective recording model used here may increase the risk of error or misappropriation. However, we were informed that the use of the full Omnicell cabinets was suitably considered, but due to both the limited physical space at St Woolos and the cabinet availability, a decision was taken by senior management to repurpose the cabinets at higher risk sites, notably GUH. We have not been able to review the information utilised within this decision-making process that took place some years ago, but the rationale is consistent with our findings from our previous audit work completed. We recommend that Health Board revisit the current approach to determine if it is still suitable for the location (see **Matters Arising 2**).

2.24 Generally, regular counting of shelf contents against item QOH is relied upon to identify any differences between book and actual stock levels (examined further under objective three).

Conclusion:

2.25 We have raised two matters arising against this objective relating to a review of user access and the use of an open store at St Woolos. However, with the latter point, we recognise that this risk was considered by senior management and theatre access is limited, together with stock reconciliation taking place on high value items. However, notwithstanding that, there is an increased inherent stock control risk. Therefore, we have provided **reasonable assurance** over this area.

Objective 3: Omnicell maintains an accurate record of stock movements

2.26 We sought to establish the means by which theatre sites maintain accurate records of stock movements and balances.

2.27 Stock holdings of all theatre consumables and items used in operations and other theatre-based patient procedures are held within the Health Board's Omnicell systems.

2.28 Every access to a cabinet is recorded in a comprehensive system transaction log that captures date, time, user id, item removed / replenished etc. but once a cabinet door is opened there is access to all the items on the shelves of the cabinet, where they are free standing.

2.29 The staff member is required to indicate what they have taken by pressing a button on the shelf, but the open design of the cabinet means this is not enforceable, and any number of items can be taken from any shelf section without being recorded. Anecdotally, there have been instances where theatre staff forget to accurately indicate items taken using the shelf section buttons.

2.30 Stocks are replenished by stock controllers from both automated re-order cycles and manual order raising. Omnicell keeps a running record of QOH at item level in both cabinets and open stores.

2.31 **Discrepancy monitoring and reporting**

Cabinets record and will display on their console the QOH for every item they hold at any time. The cabinet QOH value for an item is updated with each movement in and out of the cabinet but relies upon operators accurately recording the movements as they are made. Where this fails, discrepancies arise between the cabinet QOH and the number of items in the cabinet. The retrospective recording of withdrawals from open stores where the Omnicell system is updated as a separate activity increases the risk of discrepancies.

2.32 **Cycle counting**

Stock controllers perform item 'cycle counts' in the cabinets and open stores daily and are required to cover 95% of the stock items held in cabinets and open stores across the course of each month (we were advised SupplyX reporting issues had affected report accuracy and as a result were unable to determine with certainty the percentage of stock lines that had been counted over the 11 months reported in 2023/24).

2.33 In the process of cycle counting the stock controller enters the number of items on the shelf against the QOH that is displayed for that item. Cycle count reports then record the differences ('discrepancies') that the count has revealed.

2.34 We noted a weakness in the stock management model in operation in that there is no means of distinguishing between stock discrepancies and losses when encountering differences during the monthly 'cycle count' between the number of items on cabinet or stores shelves and the system record of Quantity on Hand (QOH) for that item. This is a limitation of the system, mainly observed where an open store structure is in use. The differences described are currently collectively identified by the system as 'Discrepancies'.

2.35 Legitimate discrepancies are those differences which can be accounted for by poor compliance by staff, taking more or less items from cabinets or opens stores than they record in the system, or not booking them out/not booking in items being returned etc. The practice of retrospective posting of withdrawals of items from open stores will also give rise to legitimate discrepancies in item count and QOH, corrected when the issue is retrospectively posted by the stock controller.

2.36 Losses, on the other hand, are unexplained differences where misappropriation could be a cause.

2.37 Currently, all differences are assumed legitimate, and because they are too numerous to investigate individually, are classed as discrepancies and not investigated further.

2.38 For the reasons outlined above, discrepancies are frequent, but at present there is no process for analysing or investigating these (see **Matter Arising 3**).

2.39 In practical terms, cycle counting is used to correct cabinet/ store actual item QOH values and through that, the re-ordering cycles (because of the PAR cycles, mis-stated QOH levels lead to stock holdings above or below design). However, as mentioned above, there is no process in action for analysing or investigating the discrepancies that the cycle counting reveals.

2.40 **Year end stock valuation**

Cycle counts conducted at the end of February each year are submitted for the annual accounts stock valuation.

2.41 Omnicell maintains a running record of QOH at item level, in both cabinets and open stores, but we note there is no interface with the Oracle main accounting system that shares these values. Only at year end, an aggregate Omnicell stock valuation is provided, for inclusion within the Health Board's year end accounts (£4.003m at 31st March 2024).

2.42 We noted that the requirement for an individual, independent of those conducting stock line counts, to sample check the accuracy of the count records prescribed in the Annual Stocktaking Guidance was not met for the 2023/24 year-end count (see **Matter Arising 4**).

Conclusion:

2.43 We have raised two matters arising under this objective relating to the analysis and investigation of stock line discrepancies and annual stocktake protocol omissions and therefore have provided **limited assurance** over this area.

Objective 4: the system provides accurate, timely and relevant management information

2.44 We sought to establish the extent of management information provided by the Omnicell systems and assess its adequacy.

2.45 Management oversight of theatre stocks is provided at a divisional level by the Scheduled Care Divisional Management Board and at an operational level by the Omnicell Programme Board (OPB).

2.46 The latter are a group that meet monthly to examine and resolve Omnicell configuration and systems issues. Meetings are formal with agendas, minutes and actions which we reviewed over the months of 2023/24.

2.47 Reports of inventory value, non-moving stock, manual versus automated Omnicell ordering volumes, cabinet null transaction volumes, over par value stock holdings, stock out volumes and non-catalogue ordered item volumes are currently provided to the OPB at their monthly meetings. Absent from this at present is discrepancy reporting (referenced earlier under objective three above), although minutes and actions of recent OPB meetings indicate this is an area being considered.

2.48 Meeting minutes indicate the area of management oversight over theatre stocks is continuing to evolve and a process of building management information into a framework of informative KPIs to aid decision making is under development.

Conclusion:

2.49 We have raised no findings relating to this objective but, noting that there are open OPB actions to develop management reporting further, have provided **reasonable assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Regular review of staff granted access to theatre stocks (Design)	Impact
We noted at the time of the audit there were 535 active users of the Omnicell system currently listed across a number of user groups. We were advised that user ids are automatically deleted after 6 months inactivity, but beyond that, there is no periodic review/ validation process in place and this is considered a control weakness.	Potential risk that inappropriate individuals have access to theatre stocks.

Recommendations	Priority
1.1 We recommend that the Health Board implement a periodic Omnicell system user id review activity. During this exercise all users and their access, functionality, permissions etc. are reviewed and confirmed/ amended by an appropriate staff member.	Medium

Management Responses	Target Date	Responsible Officer
1.1 Since the audit, we have reduced the automated user removal time from six to two months. Furthermore, enquires have been made to Workforce and OD around staff leaver reporting to enable a system update. However, upon staff leaving their swipe badge access is removed and therefore, they are unable to access these stock control areas.	Complete	Business Support and Omnicell System Manager / Service Manager PACCT

Matter arising 2: Operation of open stores (Design)	Impact
We noted that currently one of the theatre sites serving orthopaedic patients operates using exclusively open stores. This contrasts with other sites where the same orthopaedic items are stored in Omnicell cabinets. Open stores have obvious inherent control weaknesses over restricted access cabinets where withdrawals are strictly controlled and recorded, restricted and traceable to a small number of listed individuals. However, we were informed that the use of the full Omnicell cabinets was considered, but due to both the limited physical space at St Woolos and the limited number of cabinets available, the cabinets were utilised at a higher risk site instead, i.e. GUH. Furthermore, we confirmed within previous audit work completed, over the use of Omnicell cabinets, that the lack of physical space at St Woolos was a barrier to the full rollout of the cabinets. The current workflow at St Woolos is designed that theatre staff take items from the store room shelves as they are needed, but without making any record of the withdrawal. Following the operation the stock controller is advised of what has been used in order that the withdrawals can be posted into the Omnicell records. We confirmed that this was taking place as expected. However, whilst we recognise the challenges in utilising a finite resource, we consider that the retrospective recording model that is in use increases the risks of stock error or misappropriation.	Potential risk that misappropriation of theatre stocks go undetected or unauthorised withdrawals are untraceable.

Recommendations	Priority
2.1 We recommend that the Health Board review the stock management arrangement at St Woolos to ensure the current approach remains the most appropriate.	Medium

Management Responses	Target Date	Responsible Officer
2.1 We are currently restricted with the site layout and appropriate space available, but this is considered regularly. Therefore, the current approach remains the most appropriate, although this will always remain under review.	Complete	Business Support and Omnicell System Manager / Service Manager PACCT

Matter arising 3: Distinguishing between stock discrepancies and losses (Design)	Impact
We noted a weakness in the stock management model in operation in that there is no means of distinguishing between stock discrepancies and losses when encountering differences during the monthly 'cycle count' between the number of items on cabinet or stores shelves and the system record of Quantity on Hand (QOH) for that item. These are currently collectively identified by the system as 'Discrepancies'. Legitimate discrepancies are those differences which can be accounted for by poor compliance by clinical staff, taking more or less items from cabinets or opens stores than they record in the system, or not booking them out/not booking in items being returned etc. The practice of retrospective posting of withdrawals of items from open stores will also give rise to legitimate discrepancies in item count and QOH, corrected when the issue is retrospectively posted by the stock controller. Losses, on the other hand, are unexplained differences where misappropriation could be a cause. Currently, all differences are assumed legitimate, and because they are too numerous to investigate individually, they are classed as discrepancies and not investigated further.	Potential risk that misappropriation of theatre stocks remain undetected.

Recommendations	Priority
3.1 We recommend that workflows are redesigned to enable the stripping out of legitimate discrepancies from reported QOH differences ('Discrepancies') and that the remainder are individually investigated further to determine their cause.	**High**

Management Responses	Target Date	Responsible Officer
3.1 Investigation of discrepancies is time consuming and complex. We detail the null transactions made by staff via reporting, this is shared with the Senior Theatre Team to improve clinical team practices. There are limitations in further development due to the time required to investigate this to the level of detail required, particularly against competing demands and expanding workload. However, we are currently reviewing the level of stock control resource and assessing the risk further. Following the review we will be in the position to reassess and if required prioritise workstream/resource demand.	End of September 2024	Business Support and Omnicell System Manager / Service Manager PACCT

Matter arising 4: Compliance with year-end stocktake instructions (Operation)	Impact
We noted year end stocktaking instructions require that item-by-item count records, made on the day of the year end stock take, are sample tested by a supervisor to assure their accuracy. However, this was not included for the 2023/24 year end process.	Potential misstatement of the Health Board's year end theatre stocks valuation.

Recommendations	Priority
4.1 We recommend that relevant staff are reminded of the Health Board's year end stocktaking process and if required, guidance notes updated accordingly.	**Medium**

Management Responses	Target Date	Responsible Officer
4.1 Options are being explored to involve additional support, including an independent person for the year end stock taking validation e.g. financial support.	End of February 2025	Business Support and Omnicell System Manager / Service Manager PACCT

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Financial Controls
Internal Audit Report

May 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the effectiveness of the Health Board's treasury financial controls.

Overview

We reviewed the monthly financial controls cycle of a sample of treasury functions within the Health Board. Overall, we found good arrangements and raised no recommendations.

Further detail is included within the main body of the report.

Report Classification

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	No recent comparative report

Assurance summary[1]

Assurance objectives		Assurance
1	Control design adequacy	Substantial
2	Control operation	Substantial
3	Addressing control lapses	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 Financial Controls was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2023/2024 Internal Audit Plan.

1.2 Financial controls are internal processes put in place to prevent or detect accounting errors. Their main purpose is to keep accounting records accurate and reliable. A robust network of internal controls also acts as a safety net to catch and deter fraudulent activity.

1.3 The overall objective of the audit was to assess the controls in place over treasury activities within the Health Board, through sample testing.

1.4 The risks considered in this review included:

- Misappropriation of funds.
- Loss or misappropriation of assets.
- Mis-statement of accounting records.

2. Detailed Findings

Objective 1: controls in place in the areas examined adequately address and mitigate the risks present

2.1 We sought to establish the range and scope of key treasury financial controls that operate within the Health Board, to determine if risks are suitably mitigated.

2.2 The Finance Team undertake a broad range of controls which are carried out each month covering accounting processes, journal postings and account balance reconciliations.

2.3 The controls are performed and documented by finance officers assigned according to the area of activity.

2.4 These are then monitored through a monthly checklist, currently listing 73 controls, spanning a range of control themes including:

- delegation of financial duties in a segregated and hierarchical fashion (e.g. 'Prepared by/ reviewed by');
- reconciliations – including, fixed assets, debtors and creditors control accounts, bank, cash;
- approval authority limits;
- budget oversight; and
- updating and production of financial records.

2.5 We examined specifically the following treasury related monthly controls in this audit:

Area of reconciliation	Description of control
1.Main bank account	Cash book reconciliation with Oracle general ledger
2.Main bank account	Cash book reconciliation with bank statement
3.Charitable funds	Cash book reconciliation with Oracle general ledger
4.Charitable funds	Cash book reconciliation with bank statement
5.Patient monies	Cash book reconciliation with Oracle general ledger
6.Patient monies	Cash book reconciliation with bank statement
7.Exeter income accounts	Reconcile all Exeter primary care income accounts
8.Revenue (funding)	Review revenue resource limit with cash draw down

2.6 We examined the working papers supporting and evidencing the operation of these controls across periods P01 – P12 2023/24.

2.7 Control themes of, *'Reconciliation'*, *'Delegation of financial duties in a segregated and hierarchical fashion'* and *'Timely updating of records'* are employed in these Treasury related areas, which we assess as an effective method of identifying error or anomaly which can then be investigated further.

2.8 We noted that for the first seven control records listed above they are held in the following form:

- a spreadsheet with evidence of the reconciliation of the linked balances (e.g. cashbook reconciliation to Oracle general ledger); and
- pdf copies of the latter signed and dated by the officer preparing the reconciliation, and the officer reviewing the reconciliation.

All reconciliations examined were dated shortly after the month end: a random sample of 35 across these indicated on average they were prepared and approved 2.6 and 4.4 days after the month end respectively.

2.9 We noted control seven 'Revenue (Funding)' is not a conventional reconciliation, but rather a review of the cumulative funding drawdown from an annual allocation to monitor each month the remaining balance available to the Health Board.

Conclusion:

2.10 We have raised no matters under this objective and therefore have provided **substantial assurance** over this area.

Objective 2: controls operate to an appropriate frequency, are evidenced and cannot be circumvented

2.11 We sought to establish that the financial controls examined operate to an appropriate frequency and that there is a mechanism in place that ensures they cannot lapse or be over-looked. We did not test any automated processes e.g. systems matching of purchase orders, invoices and payments, as these were not applicable to the treasury related controls, which were the focus of this audit.

2.12 The control framework operates to a strict monthly cycle and for each control there are completion targets that drive the review activity.

2.13 We noted that for each of the control entries a target and actual completion date of the control process are recorded. Where there are cases of incomplete or late completed controls, these are examined, challenged, explained and assessed for impact using both RAG ratings and, where applicable, a monetary measure of potential impact of the delay.

2.14 We reviewed the control framework for any treasury related controls that had been assigned an 'amber' or 'red' RAG rating and confirmed that there were none.

Conclusion:

2.15 We have recorded no matters arising under this objective. Consequently, we have provided **substantial assurance** for this objective.

Objective 3: non-compliance, errors or irregularities that the periodic control review cycles identify are examined and appropriate action is taken to address.

2.16 We sought to establish the process adopted to investigate and address errors or irregularities that the periodic control review cycles identify.

2.17 Performance of the control is used to do the following:

- identify differences between the balances of reconciling entities;
- account for these differences by identifying the components that they are comprised of (e.g. listing unpresented cheques); and
- identify and investigate any residual balance that cannot be accounted for.

2.18 The reconciliation process is reviewed and signed off only when differences between balances of the reconciling entities have been analysed fully, accounted for and all elements have been explained (e.g. not documented within the sign-off documentation).

2.19 We reviewed the control sign-off schedules for evidence of issues identified during the monthly process and as noted above, control completion delays were encountered, usually because of the late input of month end journals by divisions or corporate teams, impacting the areas in question, but not significantly so.

2.20 We noted that completed monthly checklists are presented at the Corporate Finance Senior Manager Team meeting, where there is a standing agenda item to address this.

2.21 The meeting is attended by appropriate financial staff from throughout the Health Board.

2.22 We reviewed meeting minutes and actions that emerged from the meeting cycle across the period April 2023 to March 2024 and noted a number of actions had been recorded to address delays in completing some of the monthly controls.

Conclusion:

2.23 We have raised no matters arising under this objective and therefore have provided **substantial assurance** over this area.

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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Flexible Working

Final Advisory Report

July 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement

NHS Wales Audit & 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 report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed advisory review brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Advisory reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose of the Review

The purpose of this review was to determine if the requirements of the Flexible Working Policy and Guidance are being applied consistently across the organisation.

This is an advisory review and so, although management actions have been raised the review has not been given an assurance rating.

Summary of Health Board Position

	Area of consideration	Health Board position
1.	Application of the Flexible Working Policy and Guidance	Strengthen

Key:

No concern	No risks or issues identified / recommendations identified for enhancing existing process
Strengthen	Management attention needed to address medium to low risk matters
Escalate	Urgent management attention needed to address matters of high risk with potential substantial impact

Overview of Findings

What's Working Well

- A Flexible Working Group (the 'Group'), with many different representatives, including clinical staff groups, is in operation. Within this Group, we observed sharing of good practice, problem solving and focus on 'hot spot' areas that require support.
- We found that the Workforce Team advise and offer support to the divisions to assist with the implementation of the Flexible Working Policy (the 'Policy').
- Team and self-rosters pilots are being reviewed and implemented to enable staff to select preferred shifts, whilst ensuring all establishment levels are covered.

Areas to Further Strengthen

- Communication and awareness on the Health Board's intranet / SharePoint should be updated to assist with staff's awareness of the process and guidance.
- The Health Board should ensure links and documentation are correct, to enable staff to access the relevant guidance.
- Training for managers to help embed / implement the flexible working process.

Areas of Concern

- Staff are typically completing the form contained within the Health Board's guidance 'Flexible Working Policy: Balancing Working & Personal life, which is hosted on the intranet / SharePoint. The form includes a section requesting the reasons for the flexible working request, which does not conform to the legislation that commenced in April 2024. However, the 'All-Wales Flexible Working Policy' form does not include this section.
- We found that ESR requests for flexible working are still outstanding even though legislation states a decision should be made on the request within two months of receiving it, except where otherwise agreed with the employee. However, we were unable to determine if the respective employee had agreed to the extension.
- The 'Decision Required By' date on ESR is still set to the default timeframe of three months, instead of two months, as required by legislation since April 2024.

1. Introduction

1.1 The advisory review of flexible working was completed in line with 2023/24 Internal Audit Plan.

1.2 Flexible Working is a term used to describe any type of working arrangements that gives some degree of flexibility on how long, where and when an employee works. According to the Royal College of Nursing, since September 2021 all NHS employees in England and Wales have the right to request flexible working from day one of their employment. The Welsh Health Circular WHC (2024) 017: *Implementation of the non-pay elements of the 2022-24 collective agreement* issued in March 2024 is key in ensuring NHS organisations implement the all-Wales flexible working policy and the principle of it becomes the default position across the workforce.

1.3 Flexible working arrangements help create a healthy work life balance for employees and in turn employers recognise the benefits of flexible working, which include recruiting and retaining the best and reducing absenteeism and work-related stress. Some of the flexible working options available are part time working, flexi time, compressed hours, job-share, term time working and career breaks.

Associated Risks

1.4 The main risk considered in this review was the inability to attract, recruit and retain qualified staff in order to deliver services and the organisation's aims and objectives.

Advisory Review

1.5 Further details of the scope of the review and the work undertaken are included in Appendices One and Two.

1.6 This is an advisory review therefore we have **not provided an assurance rating**. We have identified learning and provided recommendations to strengthen and improve controls around agile delivery. Our recommendations are set out in Appendix Three.

2. Advisory Review Findings

Objective: To determine if the requirements of the Flexible Working Policy and Guidance are being applied consistently across the organisation

2.1 We reviewed the government legislation on flexible working, and noted the changes that took effect from April 2024. Employees can now make a statutory request to undertake permanent changes to their contract from their first day of employment and make two requests in any twelve-month period rather than one. Alongside this, there is no longer a requirement for the employee to explain or justify reasons for the request (except in the case of requests in line with the Equality Act 2010).

2.2 The All-Wales Flexible Working Policy (the 'Policy') was approved by the Welsh Partnership Forum, with an issue date of December 2023. The Policy documents the main principles and process for flexible working, including requests. A form is included within the appendix for staff to complete or alternatively, details on how to undertake the request via ESR. The supporting guidance states flexible working requests will be accepted unless "there is a legitimate business reason for refusal".

2.3 Alongside the Policy the Health Board maintains a local policy, Flexible Working Policy & Guidance – Balancing work with personal life. This was issued during July 2022 with a review date of July 2025. The policy and guidance document provides examples of good practice principles and guidelines. However, the form included is out of date, with a required step asking for reasons for the request. Whilst we observed examples of this form being completed and the section being omitted by staff submitting the request, there is still a risk that some staff may be detracted from applying for flexible working if they must document such information. This has been raised within **management action one.**

2.4 The Welsh Health Circular WHC (2024)017: Implementation of the Non-pay elements of the collective agreement 22-24 sets out that the Health Board must provide assurance confirming that the relevant measures are in place. This information was to be reported to the Welsh Government by May 2024, but we are unsure whether this has been reported. We requested a copy of the information submitted, but this has not been received.

2.5 We reviewed the intranet for guidance over flexible working and found some different searches contained incorrect information; had little relevance on the guidance; was incorrect documentation; or the corresponding links to the information were not operating correctly. This has been raised within **management action two**.

2.6 Currently there are no training or awareness sessions in place for employees and managers, but we understand this is in the process of being developed and rolled out by the Health Board. However, we confirmed that the Flexible Working Group (the 'Group') meets every six weeks to discuss requests, issues arising and elements of good practice. Clinical and non-clinical representatives from divisions attend the Group and we observed useful discussion taking place. We also

observed discussion over how managers can be supported with the processing of requests.

2.7 Within this forum ESR reports are discussed, including acceptance rates and issues arising throughout the organisation. Overall, within our testing, we typically found that the process in place was consistent with the requirements.

During March 2023 – April 2024, 78 requests have been inputted on ESR, with the following status for each of them:

Accepted	Pending	Rejected – alternative accepted	Rejected – alternative rejected	Withdrawn	Blank (change in working days / shifts, increase in hours and other)
43	23	1	1	1	9

We found that at least 10 of the 23 identified as 'pending', have been outstanding for more than two months. We are not aware if the process has been progressed outside of ESR and thus, they are all still pending. However, there is a concern that these requests are still outstanding because the managers are not aware of or not sure how to action them. However, as a decision should be completed within two months there is a risk that either ESR is displaying out of date figures or employees have not received a decision within the required timeframe. We have queried this further, but have not received any further information over the status of the requests. This has been raised within **management action three**.

2.8 In addition, the 'Decision Required By' date within ESR is still set to the default timeframe of three months, instead of two months, as required since April 2024. This has also been raised within **management action three**.

2.9 We observed regular updates and discussions taking place at the People and Culture Committee, along with relevant analysis concerning requests accepted and declined. We also noted that c. 360 staff attended a 'retention chat café' and one of the themes discussed for leaving the Health Board was flexible working. However, we have not noted any data to support this. During these sessions, the Workforce Team advised staff of the process and assisted managers with this.

2.10 We are aware of pilots being undertaken regarding self and team roster, where staff submit their requests and roster rules are added which is then agreed by the divisional nurse. This enables staff to take ownership of their working pattern, but also highlight the importance of ensuring patient care and skill mix are maintained. Once the pilots have been completed and the analysis reviewed the intention is to roll this out more widely within the Health Board.

Conclusion:

2.11 Overall, we generally observed adherence to the requirements of the Policy, except for the points raised above. In almost all instances, flexible working changes are agreed upon. Furthermore, where the initial decision does not agree with the

proposal, we observed further processes initiated to engage with staff and agree on alternative arrangements. Typically, for the requests recorded, we found that the default position is to grant flexible working requests.

2.12 We also found a range of guidance in place, but this requires a review and refresh – particularly the hosting on the intranet. Whilst we did not test for the completeness of the flexible working requests (as some may not be processed via ESR and these are not reported centrally), within our testing we found a good level of understanding of the arrangements. We also confirmed that they were regular steps / initiatives in place to expand upon that knowledge and embedding throughout the Health Board.

2.13 However, the Health Board should ensure that ESR is up to date for flexible working requests; legislative requirements are fully met (in this instance, decisions are made within the required timeframe); the correct documentation is used; and the promotion / raising awareness of the process continues.

Appendix One: Terms of Reference

Scope	An advisory review to determine if the requirements of the Flexible Working Policy and Guidance are being applied consistently across the organisation
Associated risks	The main risk in this review was the inability to attract, recruit and retain qualified staff in order to deliver services and meet the organisation's aims and objectives.
Limitations to scope	As this is an advisory review, no assurance rating has been provided.
Approach	As this is an advisory review, the assignment has not been allocated an assurance rating. Advice and recommendations have been provided to facilitate change and improvement.

Appendix Two: What We Did

Our approach was to:

a. undertake a desk-top review of key documents;

b. review and assess ESR reports; and

c. interview key staff involved in flexible working across the Health Board.

To achieve this, we undertook the following review activity:

Interviews with key Health Board staff:

- Deputy Head of HR
- Senior Organisational Development Practitioner
- Divisional Nurse
- Senior Nurse
- Senior Nurse Manager

High-level review of:

- Gov.uk legislation on Flexible Working;
- Welsh Health Circular: WHC (2024)017: Implementation of Non-Pay elements of the 2022-24 Collective Agreement;
- All Wales Flexible Working Police;
- Health Board Flexible Working Policy;
- Relevant papers and minutes eg Flexible Working group action logs and attendance, People and Culture Committee agenda and minutes, Board agenda and minutes, Audit and risk Committee agenda and minutes;
- Health Board SharePoint;
- ESR reports;
- Workforce & Organisational Development People Plan: Putting People first 2022/25;
- CIPD Website;
- NHS England guidance; and
- RCN: Work flexibly to support work life balance.

Appendix Three: Recommendations and Management Actions

	Para.	Risk / Potential Impact	D/O[2]	Recommendation	Priority[3]	Agreed Management Action
1		The correct policy, guidance and documentation is not being adhered to i.e. incorrect flexible working request form is being used. Staff are giving reasons for the request which is not in line with legislation and the All-Wales Flexible Working Policy.	D	The Health Board should ensure that the correct policy and documentation is hosted on the intranet / SharePoint for staff to refer and adhere to.	**High**	Whilst we removed the previous policy from the intranet/sharepoint, we were unaware that another version still existed (when searching) and this has now been removed. A follow up review of all historical documents available on the intranet will be carried out (in conjunction with the HB communications team) by Q3.
2		Without links that are correct, alongside appropriate information held on SharePoint, staff may not complete the correct process when requesting flexible working arrangements.	O	Whilst the All-Wales Flexible Working Policy and Guidance is clearly hosted on the intranet, there is no ongoing promotion of the benefits of utilising this to managers and other staff. For example listed under staff benefits. Therefore, the Health Board should: • Periodically advertise / promote the Policy and associated process / form to all staff throughout the Health Board;	**Medium**	As part of our programme of work in support of flexible working and retention, during the audit, we have already started rolling out flexible working awareness and training sessions to managers. The flexible working group will include the development of communication strategy to promote flexible working and will include recruitment and retention metrics to inform the hot-spot areas. We are aiming to complete a full roll-out of this work by Q4.

	Para.	Risk / Potential Impact	D/O[2]	Recommendation	Priority[3]	Agreed Management Action
				• Promote further details and scenarios to managers to where the options may be utilised; and • Target service areas with recruitment or retention concerns and identify how flexible working can assist with staff numbers.		
3		Requests submitted via ESR are left pending and a decision is not being made within two months of receiving it as per government legislation.	D / O	The Health Board should ensure Managers are aware of the process for processing requests via ESR and ensuring flexible working requests are actioned and decisions made within two months, except where a documented extension agreement has been made with the staff member. The Health Board should also update the default timeframe for the 'Decision Required By' date within ESR, which is currently calculating the period as three months, instead of two.	**High**	As the ESR functionality is managed centrally via the Digital Solutions Team at NWSSP, we have asked that the "Decision Required By" field is amended to reflect the two-month timescale (as opposed to three months). In the interim, we are advising all managers of the two-month deadline and preferably, confirming a response sooner. This action is now complete, but we will continue to follow up on the changes required to the system. We will continue to review all outstanding requests on a bi-monthly basis and the HR team contact relevant managers to provide advice and update ESR accordingly. The HR team are also monitoring declined requests and contact with managers to advise on the process and adherence.

2. C = Control Design weakness: a gap in the design of the system or process giving rise to increased risk.
   O = Operating Effectiveness issue: non-compliance(s) with the laid down system / process giving rise to increased risk.

3. Recommendation priority rating definitions can be found here.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report presents the Audit, Risk and Assurance Committee (the Committee) with an assessment of the strategic risks related to the Board's strategic priorities and provides assurance that these risks are being effectively managed.

It also aims to provide reassurance regarding the advancements being made in enhancing risk management within the Health Board.

Cefndir / Background

The Strategic Risk Register last presented to the Committee in April 2024, consisted of **eight** principal risks and **20** sub-risks. **One** of those risks, **SRR 001I**, had not been subjected to a comprehensive risk assessment due to the committee's timing and identification and the time necessary to evaluate and assess the risk.

Since April, the strategic risk register has been reviewed and reported to the Board at its meeting in May. The Board was assured that the current controls and mitigating actions were sufficient to mitigate the likelihood and impact of one sub-risk (SRR 001D).

SRR 001D - **The Health Board is at risk of being unable to provide and sustain high-quality, safe, and sustainable services that are responsive to the evolving needs of the population, *due to the threat of Industrial Action during ongoing national disputes and negotiations*.**

The British Medical Association (BMA) has agreed to suspend all industrial action in Wales in order to resume negotiations with the Welsh Government over the 2023/24 pay award. Consequently, the probability of the risk occurring has been reduced from 'Likely' (score of 4) to 'Possible' (score of 3). It is also important to mention that the dispute has been resolved in England.

The Strategic Risk Register remains unchanged as at the end June 2024, with **eight** principal risks and **20** sub-risks. The Board has delegated responsibility to various committees to receive and scrutinise assurances against specific strategic risks in accordance with the Committee's agenda.

Asesiad / Assessment

In accordance with risk management best practices, all strategic risks have been reviewed to ensure that the control environment is adequate to manage the risk. If it is not adequate, the implementation of additional controls has been documented, and action is being taken to address the gaps. Similarly, assurances are evaluated to ensure that there is sufficient assurance across all three lines of defence to ascertain the efficacy of the controls in place. If not, gaps in assurance are identified, and the control environment is reassessed.

In in line with the agreed-upon review period for the severity of the risk, all risks have been updated as necessary and have been subjected to focused scrutiny by the delegated Committee (Table 1).

Appendix A contains the full Strategic Risk Register, while **Appendix B** contains the individual risk assessments for the **20** sub-risks.

The table does not include **SRR 003** and **SRR 009**, as they are no longer considered strategic risks and have been deescalated to either the corporate or divisional risk register for oversight.

Table 1

Overarching Strategic Risk Description	Number of Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (9 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**9 (A-I)**	3	1	People	People and Culture Committee
		2	1	Service Delivery	Partnerships, Public Health & Planning Committee
		-	1	Financial Sustainability	Finance and Performance Committee
		-	1	Compliance and Safety	Finance and Performance Committee

SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**2 (A -B)**	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**1**	1	-	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	**1**	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**3 (A – C)**	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	**2 (A – B)**	2	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	**1**	-	1	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	**1**	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
Total	**20**	**12**	**8**		

As previously stated, the Strategic Risk Register contains **eight** principal risks and **20** sub-risks. Since the last presentation of this report to the Committee, and the subsequent review of all strategic risks, the strategic risk environment has remained reasonably stable. However, the Committee should be aware of **six** sub-risks that exceed the risk threshold for their domain, as shown below (Table 3). The Board has been informed of this, and discussions with executive leads and responsible officers are ongoing to determine what additional mitigation is required to reduce the likelihood or impact of the potential threat.

Table 3

Overarching Strategic Risk Description	Sub-Risk Description	Risk Profile	Current Risk Score & Level

			Likelihood x Impact =
SRR 001 There is a risk that the Health Board will be unable to deliver and maintain high-quality quality safe and sustainable services which meet the changing needs of the population	**g)** Due to long-term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes.	**Theme** Financial Sustainability **Appetite** Minimal - Score 8 and below	**5 x 4 = 20** **Extreme**
	i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**4 x 4 = 16** **Extreme**
SRR 002 There is a risk that there will be significant failure of the Health Board's estate	**a)** Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**3 x 5 = 15** **Extreme**
	b) Due to significant levels of backlog maintenance and Structural Impairment		**3 x 4 = 12** **High**
SRR 004 There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**a)** Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**3 x 5 = 15** **Extreme**
SRR 010 The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	**b)** Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**3 x 4 = 12** **High**

The infographic below depicts the Health Board's current risk exposure to the 20 strategic sub-risks, demonstrating that the majority of the strategic risks are in the upper right quadrant of the risk matrix, indicating a high level of risk exposure, and as previously stated in the report, five of those risks fall outside the Board's agreed-upon appetite level.

Risk Scoring Matrix					
Likelihood/ Frequency	**Consequence/Impact**				
	1. Negligible	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**

5. Almost Certain (91%)				**1 x (Extreme)**	
4. Likely (61-90%)				**3 x (Extreme)**	
3. Possible (41-60%)			**1 x (High)**	**9 x (High)**	**3 x (Extreme)**
2. Unlikely (11-40%)				**3 x (Moderate)**	
1. Rare (1-10%)					

The Corporate Governance Directorate continues to work with risk owners to evaluate and improve controls and assurances, as well as to increase transparency about the work being undertaken to implement mitigation in the short, medium, and long term. This will be demonstrated by a revised risk assessment template that places a greater emphasis on the high-level actions being taken to implement additional controls to bring the risk within appetite or to a level at which the Board is willing to tolerate the risk. The revised template will be considered at an Executive Time Out Session in July, which is a half-day session focused on risk management, specifically the strategic and corporate risk portfolio.

The closing position as at the end of Quarter 1 2024/25 (April – June) the Strategic Risk Register includes **eight** high-level strategic risks and **20** sub-risks, **six** of which are managed outside of their predefined risk appetite level.

Corporate Risk Register

Initial meetings with Directors have been held to discuss any potential high-level operational risks in their areas of responsibility that need to be supported and managed by the Executive Team through the Corporate Risk Register. The draft corporate risk portfolio will be discussed at the July Executive Time Out session, which will include a focused assessment of these risks, as well as strategic risks, to ensure they are reflective of the operating environment and are recorded and reported at the appropriate level. A comprehensive report, including the status of strategic and corporate risks, will be presented to the Board at its next meeting in September to determine the Board's position on current risk exposure and management.

Risk Management

The Head of Corporate Risk and Assurance continues to work with directorates to integrate the risk management framework and ensure cleansing of Datix. Datix serves as the Health Board's digital risk management system, enabling it to effectively assess risk exposure and provide valuable intelligence for decision making and resource prioritisation. In addition, the Head of Corporate Risk and Assurance is working closely with key areas such as patient quality and safety, health and safety, estates and capital to ensure effective management of significant risks and to ensure the escalation process outlined in the framework is implemented.

This report aims to provide reassurance regarding the efforts being made to enhance the Health Board's risk maturity.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **NOTE** the Strategic Risk Register and Risk Assessments for the 20 sub-risks; and,
- **CONSIDER** whether it has sufficient assurance that strategic risks are being assessed, managed, and reviewed appropriately and effectively;
- **NOTE** the risks outside of the agreed-upon appetite for the risk domain; and,
- **NOTE** the continued work to mature risk management within the Health Board.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

Parties / Committees consulted prior to University Health Board:	

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

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
	People & Culture Committee	People	Director of Workforce and Organisational Development		a)Due to an inability to recruit and retain staff across all disciplines and specialities.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reliance on agency and bank staff •Litigation & Financial Penalties	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Staff Attendance: Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work., "Hot spot" areas identified and plans in place to support. Recruitment: Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor, Annual programme of Apprentice recruitment, Overseas Nursing (All Wales), Nursing Workforce Strategy, Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) , Partnerships with employability schemes such as Kickstart and Restart, Actively working with Local Authorities to promote joint recruitment activities and Registration – Temporary register extended for 2 years to enable staff to return to practice. Retention: Development of career pathways (e.g., non-clinical to clinical), Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR, Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts, Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return, Agency reduction and Plan in place to monitor and review all agency, bank pay incentives supply and demand. E-Systems: Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff, Development of alternative and new roles , Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP, Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. and Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. Training: The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies, HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy, Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 Staff: Vacancy Numbers and establishment control Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies and Development of ESR establishments commenced on a national basis w/c 03/09/23.	Medium	3	2	6	Low	01/06/2024	01/07/2024
					b) Due to a deterioration in, and a failure to improve, the well-being of our staff	•High absence levels, with some sustained long periods •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reputational damage to the health board as an employer •Work-related industrial injury claims •Moral injury	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars)., Increase wellbeing initiatives: Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites, Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders), Train Mediators so there is team and organisational resilience and network, Regular Schwartz rounds arranged across the Health Board, Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. Close links with the Arts in Health programme, Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. Chaplaincy service for staff , Re-launching Chill out in the Chapel, Recruitment of staff counsellors, Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being , Scope, design and deliver a programme of research 'Healthy Working Day', Enhanced our financial well-being offer. Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management, Drafting of a 10-year plan focusing on optimising the employee experience of work , The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. Occupational Health Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes, Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted, Support equality and diversity of workforce Review of staff diversity networks, Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. Other Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC, Reducing fatigue poster developed	Medium	3	3	9	Moderate	01/04/2024	01/07/2024

SRR 001				There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	c) Due to insufficient and ineffective leadership levels throughout the organisation.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Poor levels of accountability and delivery •Reputational damage to the health board as an employer •Adverse impacts on staff recruitment and retention	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Talent and Succession Planning lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. Development leadership capabilities Designing learning journeys and access to Gwella Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Medium	3	2	6	Low	01/04/2024	07/07/2024
					d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Litigation & Financial Penalties •Reputational damage to the health board and loss of public confidence	3	4	12	High	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Services Business continuity plans in place. All Wales training sessions provide by legal and risk to support industrial action. Ensure early identification of mandated Statutory, and core critical clinical services. Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. Reducing impact on patients - Support for early supported discharge prior to industrial action. Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). Establish WOD hub with emergency planning to stand up as required Ensure early identification of mandated Statutory, and core critical clinical services. Review of business continuity plans Map services and staff provision and impacts of industrial action. Assess variable pay usage in case of work to rule applies. Assess current vacancies. Working with partners in Gwent on a system wide basis. Implementation of business continuity plans. Communication plans. Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	Medium	2	4	8	Moderate	01/04/2024	01/07/2024
	Partnerships, Public	Service	Director of Strategy		e)Due to inadequate strategic plans which respond to population health and socio-economic needs	•Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to train teams in multi-morbidity management •Failure to comply with the Wellbeing of Future Generations Act (Wales) •Reputational damage and loss of public confidence	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	Medium	2	3	6	Low	01/04/2024	01/07/2024

	Health & Planning Committee	Service Delivery	Strategy, Planning and Partnerships.		f) Due to unsustainable service models	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes • Failure to deliver health board priorities, required improvements and achieve sustainability • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	Medium	2	3	6	Low	01/04/2024	01/07/2024
	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	• Breach of statutory duty to breakeven over 3 years • Instigation of NHS Wales Escalation & Intervention Arrangements • Non – delivery of health board priorities, required improvements and achieve longer-term sustainability • Prioritisation and possible disinvestment in service delivery • Reputational damage and loss of public confidence	5	4	20	Extreme	Above Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	Medium	2	4	8	Moderate	01/06/2024	01/07/2024
	Partnerships, Public Health & Planning Committee	Service Delivery			h) Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Unable to substantially improve the health of the population ➢ Reputational damage and loss of public confidence ➢ Multi-year CIP calculated on non-recurrent funding ➢ Major grants subject to funding cuts 24/25 ➢ No determined staffing establishment ➢ Possible at-risk TUPE posts ➢ £1.5 million temporary staff funding (RIF + EYP) majority on permanent contracts ➢ Government grants focused on particular risk factors	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Business cases being written for PIP to increase core funding to deliver objectives. Through Pip process work towards a funded establishment reduce risks associated with permanent staff being funded through temporary funding which impacts on the ability to plan long term.	Negative	2	3	6	Moderate	01/06/2024	01/07/2024
		Compliance and Safety	Director of Public Health and Strategic Partnerships		I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications	4	4	16	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Performance Management and Assurance Framework Executive Accountability letters – to be issued by the end of May 2024 Divisional Directors Accountability letters – to be issued by the end of May 2024 Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reporting through to the Finance and Performance Committee via Executives Specific areas of focus are discussed at the Value & Sustainability Board System-wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. Embed in the regional programmes of work i.e. ophthalmology, diagnostics, and orthopaedics.	Medium	2	4	8	Moderate	01/06/2024	01/07/2024
					a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Non-compliance with Health & Safety legislation • Litigation & Financial Penalties	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	At this stage, the controls in place are appropriate and practicable to monitor the issues and prepare medium-term responses in line with the timelines within the expert report.	Medium	1	2	2	Very Low	01/06/2024	01/07/2024

SRR 002	Partnerships, Public Health & Planning Committee	Compliance and Safety	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	b) Due to significant levels of backlog maintenance and Structural Impairment	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.	Medium	3	2	6	Low	01/04/2024	01/07/2024
SRR 004	Partnerships, Public Health & Planning Committee		Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Harm or injury to patients and/or staff •Health Board breaches statutory duties under the Civil Contingencies Act 2004 •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Testing programme of business continuity plans. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. Joint planning with PH response in response to infection disease and public health incidence. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. Continue to promote awareness in a timely manner. Continue to promote awareness of the requirement for BC across the Health Board. A tabletop BC exercise is planned for the 10th of October 2023. Continuing participation in multi-agency exercises. Programme plan to be developed to address the weaknesses in business continuity planning. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Development of Pandemic Plan.	Medium	2	3	6	Low	01/05/2024	01/08/2024
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	01/04/2024	01/07/2024

SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a)Due to the full or partial failure of existing digital infrastructure and systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Implement the recommendations from Templar report: • Outline a step by step process of how the proposed risk treatments need to be implemented. This should include the activities to be performed, who is responsible and deadlines for completion. • Complete any outstanding policy and process development, ensuring there is engagement with non ICT teams including the SIRO and board • Ensure ICT disaster recovery policies are complete and refer to any system specific recovery processes. • Ensure non ICT teams are aware of disaster recovery policies and processes and engaged in developing system breach/failure response definition. • Complete a policy and process review after each incident to identify if anything could be improved in detection, resolution or prevention of a cyber security incident. Also, ensure the same is done whenever there are significant system changes. • Develop the policy and processes for identity and access management to ensure that privileged and critical system accounts are reviewed periodically e.g. 6 to 12 months, with other accounts reviewed through joiners/starters, movers and leavers processes. • Investigate circumstances where dedicated devices can be used for critical system access • Consider plans for certification of users and devices and how those certifications can be used. • Consider how to monitor privileged accounts e.g. with additional logs managing not just by exception but random and planned audits • Assess whether MFA can be implemented for privileged user accounts • Review any critical system logs that are created • Update systems or request updates to create additional logs where possible and include creation of logs on user devices in any investigation • Investigate a means of alerting for specific log conditions • Consider collective identification of appropriate tools and working with other OES within NHS Wales to identify appropriate tools.	Medium	2	4	8	Moderate	01/06/2024	01/07/2024
					B)Due to an adverse impact on service delivery in the implementation of new digital systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success	Medium	2	3	6	Low	07/04/2024	01/07/2024
					c)Due to a failure to develop digital solutions that are sustainable and fit for the future	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities	Medium	2	4	8	Moderate	07/04/2024	01/07/2024
				There is a risk	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	•Unmet patient need resulting in harm •Ineffective use of combined resources •Delayed decision making •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach. .	Medium	2	2	4	Low	10/04/2024	10/07/2024

SRR 007	Partnerships, Public Health & Planning Committee	Transformation and Partnership Working	Director of Strategy, Planning and Partnerships.	that the Health Board will be unable to deliver truly integrated health and care services for the population	b) Due to the impact of fragile services across the regional and supra regional geography	Changes of regional flow in an unplanned way Additional demand on UHB workforce to support fragile services Unmet patient need resulting in harm Ineffective use of combined resources Delayed decision making Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence	3	3	9	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a recent review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with recognition that these need to be 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions. Discussion to be had at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	Reasonable	2	2	4	Low	16/04/2024	16/07/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	Medium	2	2	4	Low	01/04/2024	01/07/2024
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Safety of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	01/05/2024	01/07/2024

Reference				Risk Score Matrix
				2 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff	
			c) Due to insufficient and ineffective leadership levels throughout the organisation.	
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	
			f) Due to unsustainable service models	
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	
	Director of Public Health & Strategic Partnerships		h) Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants	
			I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	
			b) Due to significant levels of backlog maintenance	
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	
			b) Due to an adverse impact on service delivery in the implementation of new digital systems	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future	
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	
			b) Due to the impact of fragile services across the regional and supra regional geography	
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

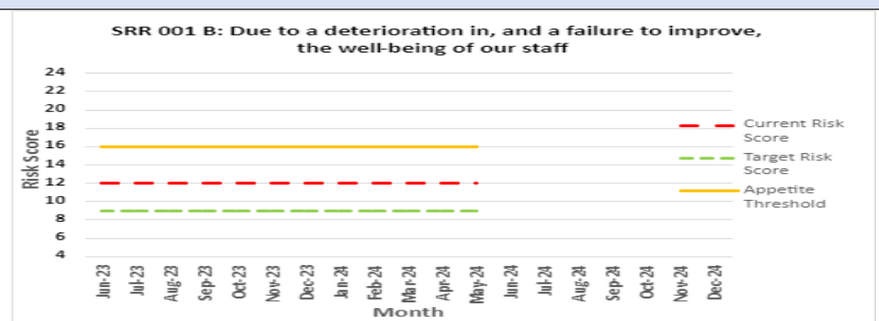
Key	
Current Score	●
Target Score	×
Appetite Threshold	◊
Current to target	◄—

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**a)** Due to an inability to recruit and retain staff across all disciplines and specialties.	**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reliance on agency and bank staff ➢ Litigation & Financial Penalties			**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **Outside** of target level but **WITHIN the** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*	
Last Reviewed	01 June 2024	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*	
Next Review Monthly based On current score	01 July 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing and HCSW). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Workforce planning supported by Compendium of new roles to support innovative workforce models. • Recruitment KPI's. • IMTP (Integrated Medium-Term Plan) Educational Commissioning. • Workforce Establishment controls national working group has been instigated. • Value and Sustainability Board. **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales Recruitment programme)	**Retention** • Development of career pathways (e.g., non-clinical to clinical). • Talent management and succession planning framework in process of internal assurance. Presented to TUPF through a development session and going to Exec Committee on 06 June 2024. • Career conversations and succession planning resources designed, will be available on intranet from 07 June 2024. • Career conversation workshops designed, plans in place to advertise dates post 06 June 2024. • All Wales self-assessment retention tool being completed at organisational level for Nursing and Midwifery to provide a baseline. **E- Systems** • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Workforce reports to the Nurse Strategic Workforce Group. • Monthly sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls. • Occupational Health and Wellbeing dashboards report KPIs. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. • Measurements of Wellbeing through the ABUHB	**Gaps in Assurance** **Action to Address Gaps in Assurance**	**Positive Assurance**

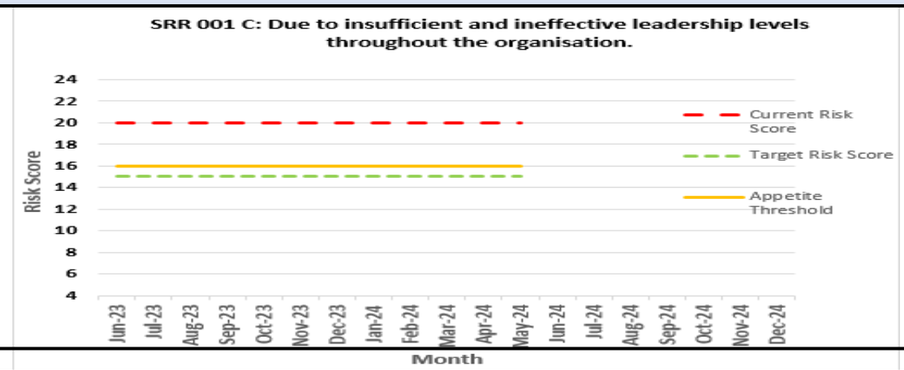
• Nursing Workforce Strategy agreed • Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) • Partnerships with employability schemes and FE/HE to widen access. • Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. **Retention:** • Retention lead appointed with programme action plan in place for the next two years. • Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. • Week of events planned to support retention agenda in June 2024. This will include a mixed method of online webinars, videos and retention materials. • Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. • Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return. **Variable pay reduction.** • Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. **E- Systems** • Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. eLocum Bank, eJob Planning, eAgency systems are all 'live' and rolled out within the Health Board. eRostering is planned to go live shortly following ESR interface testing. **Development of alternative and new roles** • A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent, and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care • The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management. **Training** • The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2024 and beyond which are required to support turnover and existing vacancies**.** • HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience. • RN/HCSW Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (6 supported this year)	• Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. • Looking to increase assistant band 4 in Community/Mental Health • Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. • Increasing consultant therapy and nurse practitioners • Nurses with skills to support chronic disease management in Primary Care • RCN introduction of Registered Nurse Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027. • Development of new roles and career pathways to support hard to fill roles in Health Visiting. **Training** • HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy • Workforce planning within new competency framework commencing June 2024. • Development opportunity being scoped for Business support staff and Masterclasses being launched across the organisation for key business critical themes.	• (Aneurin Bevan University Health Board) Staff Survey. • Routine Reporting against nurse staffing levels. • Variable Pay Programme Board reporting to Value and Sustainability Board **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Reviews 2023 -24 • Long Term Sickness Absence Management (Q4) • Flexible Working (Q4) • External quarterly vacancy reporting to WG • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

• Cadet Nursing programme in place (20 candidates last year) • K102 bridging model now being offered to support HCSW pathways into registered nursing. • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) is in its second year. Similar program developed for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group which commenced 23 April 2024. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff. **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period December 2024 there were circa 619 WTE vacancies. Reduction 109 WTE from March 2023. Next reporting update is due mid-May 2024. • Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan has been developed and approved by Executive Committee in April 2024. Project workstream established and work commenced. **Staff attendance** • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • “Hot spot” areas identified and plans in place to support.				

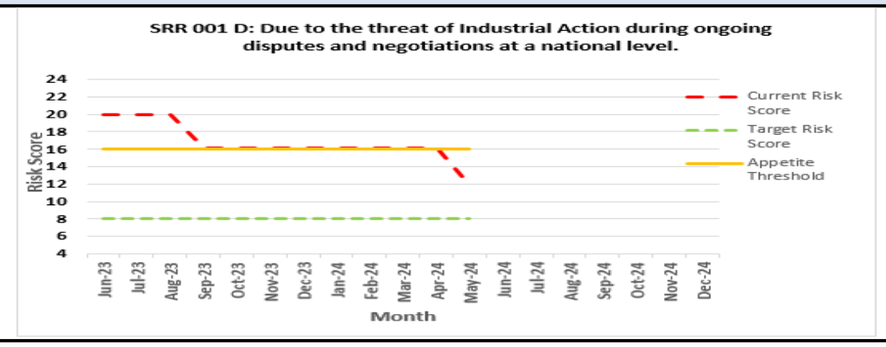
RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**b)** Due to a deterioration in, and a failure to improve, the well-being of staff.	**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ High absence levels, with some sustained long periods ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reputational damage to the health board as an employer ➢ Work-related industrial injury claims ➢ Moral injury			**Risk Appetite Threshold – Open Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*	
Next Review Due Quarterly based on current score	01 August 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Monitoring Framework to support roll out of the People Plan. • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance. • Staff related policies. • National Staff Survey and Health Board Employee Experience Survey • External Employee Assistance Programme • Speaking up Safely action plan • Race/LGBT groups. • Wellbeing resources • Occupational Health Service • Staff diversity networks • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Chaplaincy service for staff	• Increase wellbeing initiatives: • Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders). • Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. • Trained mediators so there is team and organisational resilience and network. • Scope, design and deliver a programme of research 'Healthy Working Day'. • Enhanced our financial well-being offer. • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales. **Occupational Health**.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and Facilities **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter • Sickness Absence Audit 2023/24	**Gaps in Assurance** • Understand if support is reaching all staff **Action to Address Gaps in Assurance** • Meetings with Divisions ongoing to ensure all areas are aware of what's available.	**Positive Assurance**

• Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales. • The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. This workstream began in October 2023 and will be developed over the next 12 months with a strong emphasis on evidence analysis and culture. The initial SUS Steering group was held on 14 March 2024, and an externally commissioned SUS hotline will be piloted in April 2024. • An external Employee Assistance Programme (Vivup) has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. **Occupational Health** • Additional occupational health resources secured to reduce waiting times. • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. **Support equality and diversity of workforce.** • A part time Disability Inclusion Officer has been seconded to the EDI Team (December 2023 – December 2024). • Band 5 EDI Officer appointed and commence in post at the end of March 2024. • Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. • Reverse Mentorship Programme launched February 2024. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC • Reducing fatigue poster developed.	• Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. **Support equality and diversity of workforce.** • Review of staff diversity networks. • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing.			

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**c)** Due to insufficient and ineffective leadership levels throughout the organisation	**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Failure to deliver health board priorities, required improvements and achieve sustainability; ➢ Poor levels of accountability and delivery; ➢ Reputational damage to the health board as an employer; ➢ Adverse impacts on staff recruitment and retention			**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	2 *(Minor)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*	
Next Review Due Quarterly based on current score	01 August 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Talent and Succession Planning • Monitoring Framework to support roll out of the People Plan- focus on Talent and Succession Planning • Monitoring frameworks with HEIW • Lead appointed in July 2023 on a secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify, and develop talent for critical roles across ABUHB. • HEIW schemes • 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. **Development leadership capabilities** • Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Leadership development offer now available for entry level leaders and managers, Clinical Directors, Directorate Manager development programme (DMx) to launch Q1 2024/25, Senior Nurses and multi-disciplinary teams. • Learning Masterclasses have been designed and developed for the organisation addressing key themes such as giving feedback, developing teams, and having courageous conversations. • Leading People Programme (starting cohort 8 May 2024) • 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	**Talent and Succession Planning** • Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. **Development leadership capabilities** • Currently exploring leadership funding options with USW in order to maximise Governmental Grants and utilisation of the apprentice levy. • Continued commitment to NHS graduate schemes.	Level 1 Operational *(Implemented by the department that performs daily operation activities)* • WOD Divisional reporting • Evaluation of internal leadership programmes and regular review of our internal offer Level 2 Organisational *(Executed by risk management and compliance functions.)* • Reporting to People and Culture Committee - progress against People Plan 22-25 **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Review • Talent and Succession Board	**Gaps in Assurance** **Action to Address Gaps in Assurance**	**Positive Assurance**

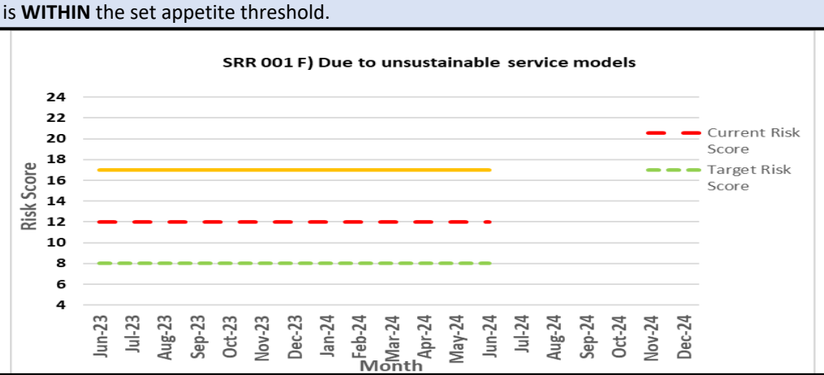
RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**d)** Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Litigation & Financial Penalties ➢ Reputational damage to the health board and loss of public confidence			**Risk Appetite Threshold – Open Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	*3 (Possible)* *x*	**2** *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**4** *(Major)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review Due Quarterly based on current score	01 August 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• All Wales Industrial Action Planning Group • Local Health Board planning arrangements • Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture • Effective derogation processes including Christmas Day cover definition. • Local Negotiating Committee (LNC) • Services Business continuity plans in place. • Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. • Command and control structure and leads established. • Derogation test completed. • Executive and Senior Manager leads established links with national planning cells. • All Wales training sessions provide by legal and risk to support industrial action. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Picketing guidance supported and agreed	• Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. • Issue of WHC AFC non pay elements of collective agreement 2022-24. Response to WG on immediate assurance by end May 2024 • Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). • Communication plans- public, stakeholders and partners • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. • Consideration of further additional national legal advice	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) • Trade Union Partnership meetings **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • All Wales IA group and Welsh Government planning group. • Debriefing session planned to reflect and capture learning for any potential future action	**Gaps in Assurance** • Further industrial action **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic Risk: SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	e) Due to inadequate strategic plans which respond to population health and socio-economic needs.	**Publication Status**	**Public**	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes	➢ Failure to train teams in multi-morbidity management ➢ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➢ Reputational damage and loss of public confidence		**Risk Tolerance Level - OPEN SCORE 17 AND BELOW** Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the set appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

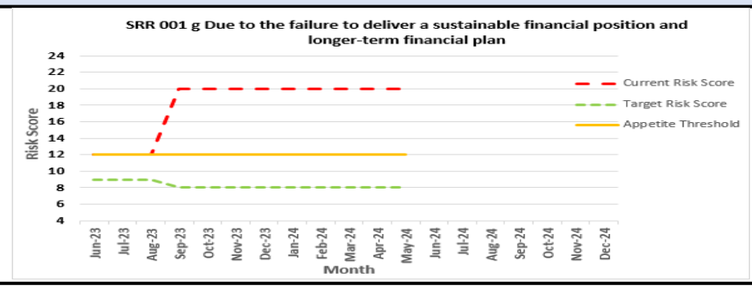
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)*	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 (*Major)*	3 *(Moderate)*
Last Reviewed	01 May 2024	**Risk rating**	**= 8** *(Moderate)*	**= 6** *(Moderate)*
Next Review Due Bi-annually based on current score	01 August 2024			

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Qliksense – performance information • SFN – performance information **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal Audit Reviews 2023-24 1. IMTP Planning (Q1) Outcome – Reasonable Assurance	**Gaps in Assurance** • Effectiveness of the plans in delivering improvements **Action to Address Gaps in Assurance** • Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan	**Reasonable Assurance**

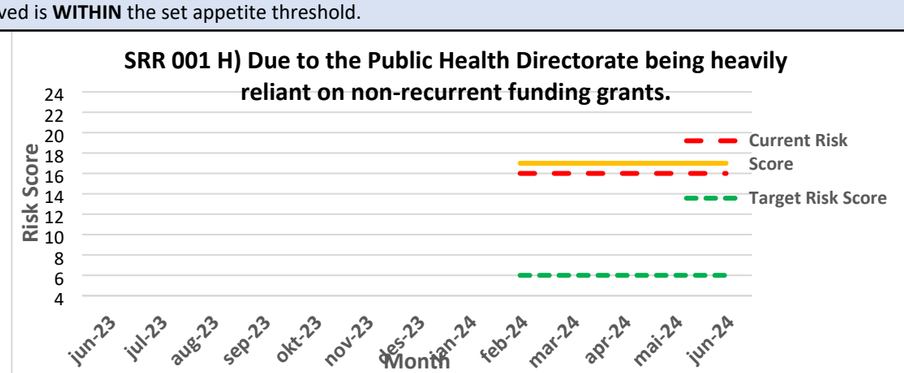
RISK THEME	SERVICE DELIVERY				
Strategic Risk: SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**				
Strategic Threat	f) Due to unsustainable service models		**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased demand ➢ Increased patient acuity levels	➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Reputational damage and loss of public confidence			**Risk Tolerance Level - OPEN SCORE 17 AND BELOW** Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the set appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review Due Quarterly based on current score	01 August 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• The Health Board IMPT and associated KPIs • Clinical Futures Transformation programmes. • Public Health Wales surveillance data – Covid, flu and other communicable diseases. • Qliksense – performance information. • Population needs assessment and area plan development by the RPB. • Southeast Wales Plan for fragile services.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy – to launch Summer 2024.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023-24** **1.** IMTP planning Q1. **Outcome – Reasonable Assurance.** **Internal Audit Reviews 2024-25** 2. IMTP – Service Plans (Q2)	**Gaps in Assurance** • Evidence of individual arrangements in place to deliver service plans. **Action to Address Gaps in Assurance** • Recommendations from the Internal Audit of IMTP – Service Plans (Q2)	**Reasonable Assurance**

RISK THEME	FINANCIAL SUSTAINABILITY				
Strategic Risk: SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	**Publication Status**	Public	**Risk Appetite Level - Cautious.** Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 12 and below** Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies. **SUMMARY** The current risk level is **OUTSIDE** of the target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target**	
Monitoring Committee	Finance & Performance Committee	**Likelihood**	5 *(Almost certain)* x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*	
Last Reviewed	11 June 2024	**Risk rating**	**= 20** *(Extreme)*	**= 8** *(Moderate)*	
Next Review Monthly based on current score	01 July 2024				



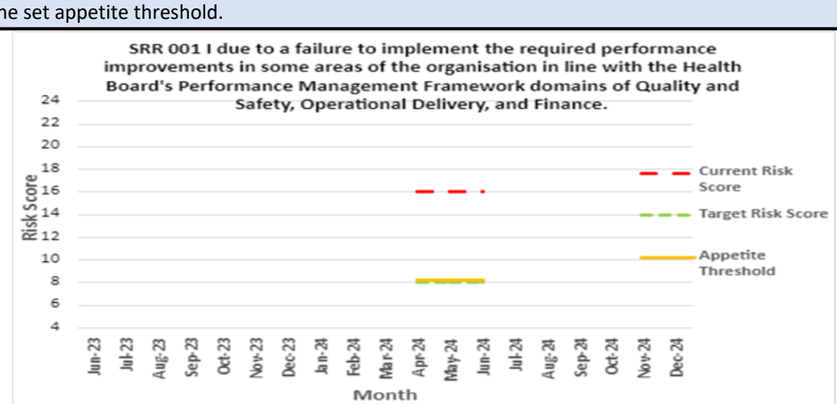
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training • Cost intervention procedures • 23/24 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance.	Control mechanisms evaluated favourably by Audit. Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 - 24** 1. Savings Programmes Q3 - Not yet undertaken. Report expected Q1 2024/25 2. Financial Controls Q2 – Not yet reported. Report expected Q4 2023/24 3. Asset Management Q3 – Reasonable Assurance reported to ARAC April 2024 **External Audit Reports 2023 -24** 1. Efficiency Review Q3/Q4 – Not yet reported. 2. Structured Assessment - Received at ARAC November 2023. 3. Audit of Financial Statements Q4 2023/24 – Not yet reported. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring meetings with Welsh Government – monthly	**Gaps in Assurance** • Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of 3 year recovery plan. **Action to Address Gaps in Assurance** • 2024/25 IMTP plans focussed on 'living within' budget levels. • 2024/25 savings plans to be delivered. • Final budget delegation approved by Board - delegations to be issued Q1. • Work underway to develop a 3-year recovery plan.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY				
Strategic Risk: SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population.**				
Strategic Threat	**h)** Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants		**Publication Status**	Public	**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure**.**
Impact	➢ Avoidable harm ➢ Increased patient acuity levels ➢ Worsening health inequalities ➢ Worsening health outcomes ➢ Unable to substantially improve the health of the population. ➢ Equity of care to patients across Gwent	➢ Reputational damage and loss of public confidence ➢ Staff impact - Possible redundancies as less roles available over the health board for redeployment ➢ Long-term financial implications – due to reduced prevention activity			**Risk Appetite Threshold – SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy
					SUMMARY The current risk level is **WITHIN** the risk appetite threshold but **OUTSIDE** of the target level. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Director of Public Health & Strategic Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Population Health, and Planning Committee	**Likelihood**	**4** *(Likely)* *x*	**2** *(Unlikely)* *x*	
Initial Date of Assessment	01 December 2023	**Impact**	**4** (*Major)*	**3** *(Moderate)*	
Last Reviewed	01 June 2024	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*	
Next Review Due Monthly based on current score	01 July 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Organisational Change Process (OCP) instigated which will enable change to the ways of working and moving to a fully funded permanent structure. • Meetings with finance to determine TUPE level and CIP calculation. • Local public health risk register. • Business cases been through PIP for preventative adverse deaths, Health Protection, and other public health areas, additional information required. This has been submitted; awaiting a date for Exec scrutiny and decision. • SMT meetings to discuss progress on delivery of objectives linked to the available budget. • £11.2M recurrent funding has been agreed and received for Health Protection and vaccination. (*Just to highlight that this money will <u>not</u> be retained in public health and the majority of it will transfer out to primary care for vaccination delivery, microbiology and Local Authority (LA). This leaves circa £1.2m of the £7.3m being retained in public health and much of the remaining funding is temporary grant funding. The fund substantive budget for public health is £3, 751, 000)* • Work has commenced transferring operational delivery of the vaccination service to Primary Care with oversight from Public Health to ensure effective delivery of programmes (funded by the new recurrent funding from WG to fund Health Protection and vaccination locally)	• Through the PIP process work towards a funded establishment to reduce risks associated with permanent staff being funded through temporary funding which impacts the ability to plan long-term. • Establish a Health Protection offer within the core Public Health Team to do strategic planning and mitigation and assurance around vaccination delivery.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monthly finance meetings in place with the Director and Assistant Director • Monthly reporting on finance levels **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Escalation to the Strategic Risk Register for Board oversight • Highlighted and discussed at Corporate Review **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* • Report delivery of local progress against the national public health strategy through the Public Health Peer Group • Public Health finance to be reviewed as part of the Annual Financial sustainability Internal Audit	**Gaps in Assurance** • Unable to assess the full impact of gaps in delivering the Public Health offer against the prevention agenda • Outcome of PIP Business Case to determine the future structure of the PH Directorate **Action to Address Gaps in Assurance** • Through the OCP process we will be able to establish the appropriate areas to place Public Health business for efficient and effective health protection and vaccination delivery. • Developing a clear evidence base to understand population need for long-term public health planning. •	**Negative Assurance**

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population			
Strategic Threat	**i)** Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**Publication Status**	Public	**Risk Appetite Level - MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work	➢ Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications		**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is **OUTSIDE** of target and **OUTSIDE** of the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

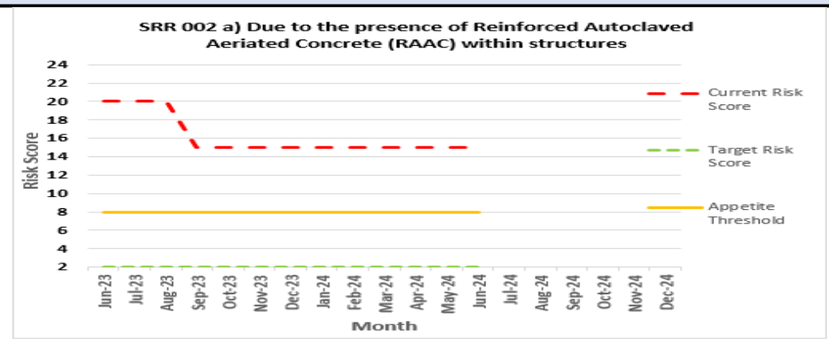
Lead Director	Director of Strategy, Planning & Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance and Performance Committee	**Likelihood**	*4 (Likely)* **x**	2 *(Unlikely)* x
Initial Date of Assessment	19 April 2024	**Impact**	***4** (Major)*	4 *(Major)*
Last Reviewed	01 June 2024	**Risk rating**	***= 16 (Extreme)***	***= 8 (Moderate)***
Next Review Monthly based on current score	01 July 2024			



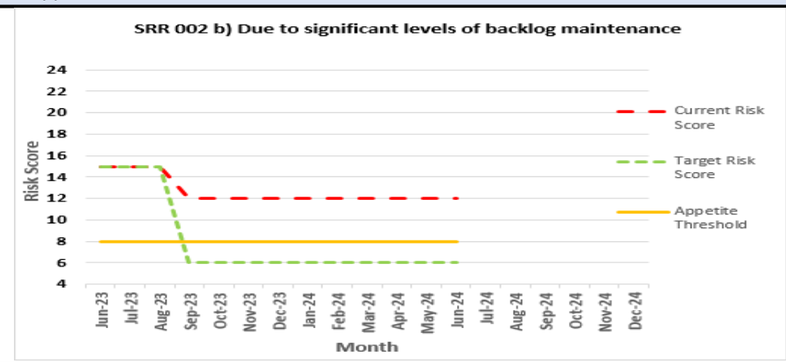
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Performance Management and Assurance Framework Executive Accountability letters – to be issued by end of June 2024 Divisional Directors Accountability letters – to be issued by end of June 2024 Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reporting through to Finance and Performance Committee via Executives Specific areas of focus are discussed at V&S Board System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc.	6-month review of Performance Management and Assurance Alignment of internal mechanisms to national escalation Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. Standardised Divisional Assurance Templates (pre-populated) Commission external reviews to support improvements where required. Review of JD to explicitly include in Assistant Director of Planning and Performance role Appropriate Business Partnering Support and analytical support	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety Committee • Established reporting to the Board • Routine reporting through the IQPD process **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit 2024/25 Plan ○ Directorate Review - Mental Health and Learning Disabilities (Q2) ○ Divisional Governance Arrangements (Q2) • HIW Inspections • Llais for feedback	**Gaps in Assurance** Capacity to run the performance framework. If Business Partnering Support and analytical support is in the appropriate areas **Action to Address Gaps in Assurance** Realign capacity and/or redefine roles to provide explicit support **Internal Audit 2024/25 Plan** ○ Review Divisional Governance Arrangements (Q2) ○ Divisional Governance Arrangements (Q2)	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk: SRR 002	**There is a risk that there will be significant failure of the Health Boards Estates.**			
Strategic Threat	**a)** Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.	**Publication Status**	Public	**Risk Appetite Level - MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Loss of estate ➢ Litigation and financial penalties			**Risk Appetite Threshold - SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold

		Risk Exposure	**Current Level**	**Target Level**
Lead Director	Chief Operating Officer			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare*) x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	01 June 2024	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*
Next Review Due Monthly based on current score	01 July 2024			

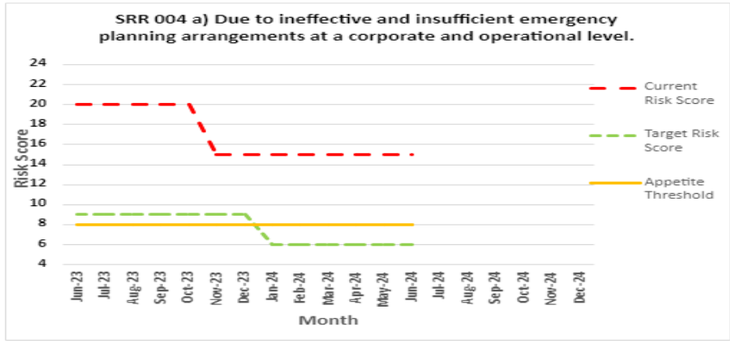


Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Work to assess the risk has been undertaken with expert external surveyor advice and repeat surveys have recently been completed. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas • Controlled access to roof areas • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. *Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations* • Links with NHS England and other Health Boards in Wales for shared learning. • Fortnightly dialogue with Welsh Government and Shared Services Estates.	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Fortnightly checks in place for the props in place • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) scheduled for June 2024 **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment • Formal reporting to the Board • Formal update to the PPHPC in July with full SOC end of Q3. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal Audit 2024/25 Plan • Nevill Hall RAAC (Q1) – In progress	**Gaps in Assurance** • Ongoing management of the issues. **Action to Address Gaps in Assurance** • Repeat surveys have been completed and additional more specific and technical surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues. Internal Audit 2024/25 Plan • Nevill Hall RAAC (Q1)	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY				
Strategic Risk: SRR 002	**There is a risk that there will be a significant failure of the Health Board Estates.**				
Strategic Threat	b) Due to significant levels of backlog maintenance and structural impairment.		**Publication Status**	Public	**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties. ➢ Loss of estate				**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** *(Minor)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*	
Next Review Due Quarterly based on current score	01 August 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Asbestos reinspection programme (over the next 3 years) • Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation • HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants • A clear approach to compliance monitoring and escalation of AE reports has been implemented.	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • Outcome of the Asbestos reinspection programme **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023- 24** Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and Finance and Performance Committee **Internal Audit Plan 2024-25** Estates Assurance – Energy Management (Q4) • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	**Gaps in Assurance** • If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration. **Action to Address Gaps in Assurance** • Performance reporting	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk: SRR 004	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.**			
Strategic Threat	**a)** Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.	**Publication Status**	Public	**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls**.**
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Harm or injury to patients and/or staff; ➢ Staff absence (injury, wellbeing) ➢ Financial implications due to staff absence	➢ Loss of infrastructure; ➢ Health Board breaches statutory duties under the Civil Contingencies Act 2004; ➢ Litigation & Financial Penalties; ➢ Reputational damage and loss of public confidence		**Risk Appetite Threshold – SCORE 8 AND BELOW.** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Director of Strategy, Planning and Partnerships			
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Risk Exposure**	**Current Level**	**Target Level**
Initial Date of Assessment	01 June 2023	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Last Reviewed	01 May 2024	**Impact**	5 (Catastrophic*)*	3 *(Moderate)*
Next Review Due Monthly based on current score	01 August 2024	**Risk rating**	**= 15** *(Extreme)*	**= 6** *(Moderate)*



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Major Incident • Major Incident Plan • Local/Divisional action cards are in place. • Training undertaken service-specific relating to local response. **Business Continuity (BC) /Critical Incident** • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents. • EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. • Awareness raising of the requirement for BC across the Health Board through various training programmes **Infectious Diseases** • Joint plan with PH in response to infectious diseases and public health incidence response. **Overall** • Internal strategic on call training • Executive Team attending 2-day strategic training.	• Major Incident Exercise 'Euclid' planned for 20th June 2024 – Faculty in place to plan scope and detail of exercise. • Testing programme of business continuity plans. • Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Develop further training programmes to support staff preparedness to response to an incident. • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. (as this is not fully implemented,	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Departmental debrief following an incident to inform learning and enhance controls. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Debrief with key stakeholders following an incident to inform learning and enhance controls. • Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Review(s)** • Business Continuity Planning 2023-24 (Q2) outcome report published – Reasonable Assurance • Outcome and feedback from national exercises	**Gaps in Assurance** • Robustness of service business continuity plans within Divisions **Action to Address Gaps in Assurance** • Recommendations for strengthening resilience following testing of service business continuity plans	**Reasonable Assurance**

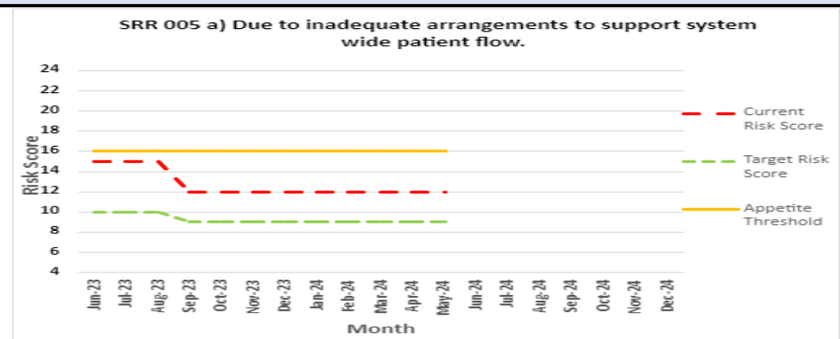
• Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	it is still being worked through thus would make it additional control until in place)			

RISK THEME	SERVICE DELIVERY			
Strategic Risk: SRR 005	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	a) Due to inadequate arrangements to support system-wide patient flow	**Publication Status**	Public	
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3 *(Minor)*
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*
Next Review Due Quarterly based on current score	01 July 2024			

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

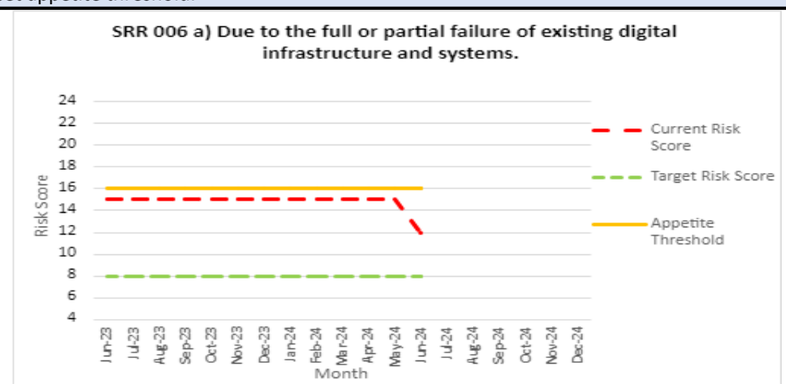
Risk Appetite Threshold – Open SCORE 17 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Workshops in diary. • Improve regional acceptance of flow processes with neighbouring Health Boards.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews** 1. Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY				
Strategic Risk: SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				
Strategic Threat	**a)** Due to the full or partial failure of existing digital infrastructure and systems.	**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 17 and below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*	
Last Reviewed	01 June 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review Due Quarterly based on current score	01 September 2024				

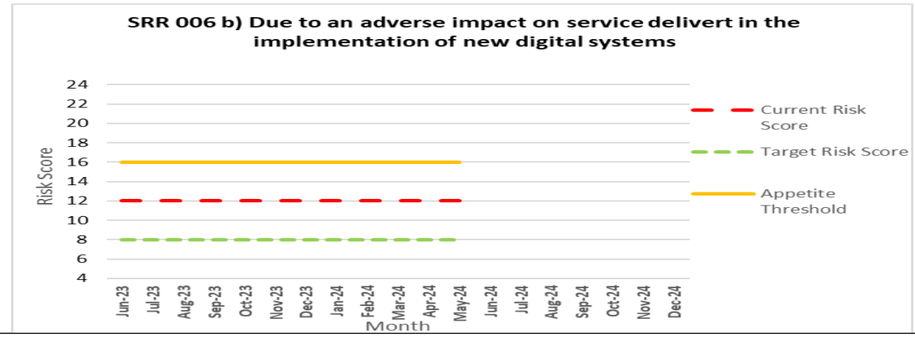


Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. • This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Following the CRU Assessment in Jan 24, the action plan has been revised and updated to capture further recommendations against NIS CAF. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are	Implement the recommendations from Templar report: Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting on progress to the Finance & Performance Committee on our cyber security action plan. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal audit • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance** • An assessment against CAF was undertaken by CRU in January '24 and the report along with its recommendations has been circulated to key stakeholders.	**Reasonable assurance**

held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. Implement the recommendations from Templar report: Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. Level 1 Operational (Implemented by the department that performs daily operation activities) Gaps in Assurance Reasonable assurance · Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. · Oversight from NHS Wales Cyber Resilience Unit. Level 2 Organizational (Executed by risk management and compliance functions.) Action to Address Gaps in Assurance · Regular reporting on progress to the Finance & Performance Committee on our cyber security action plan. An assessment against CAF was undertaken by CRU in January '24 and the report along with its recommendations has been circulated to key stakeholders. Level 3 Independent (Implemented by both auditors internal and external independent bodies.) • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · Cyber has maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · Cyber has begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. · Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.				

RISK THEME	SERVICE DELIVERY			
Strategic Risk: SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	**b)** Due to an adverse impact on service delivery in the implementation of the new digital systems.	**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 17 and below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold

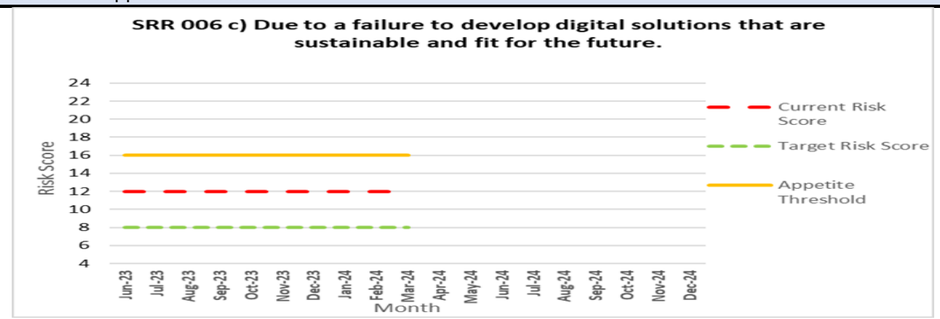
		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital			
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* *x*	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due Quarterly based on current score	01 July 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required. • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Project Boards meet monthly and report into the quarterly Digital Portfolio Progress Group • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit **Action to Address Gaps in Assurance**	**Reasonable assurance**

• Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success. • Information Governance Sub Committee and Cyber Security Subgroup established		• Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit** • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance		

RISK THEME	SERVICE DELIVERY				
Strategic Risk: SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				
Strategic Threat	**c)** Due to failure to develop digital solutions that are sustainable and fit for the future.	**Publication Status**	Public	**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 17 and below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*	
Last Reviewed	07 April 2024	**Risk rating**	**= 12** (High)	**= 8** *(Moderate)*	
Next Review Due Quarterly based on current score	01 July 2024				



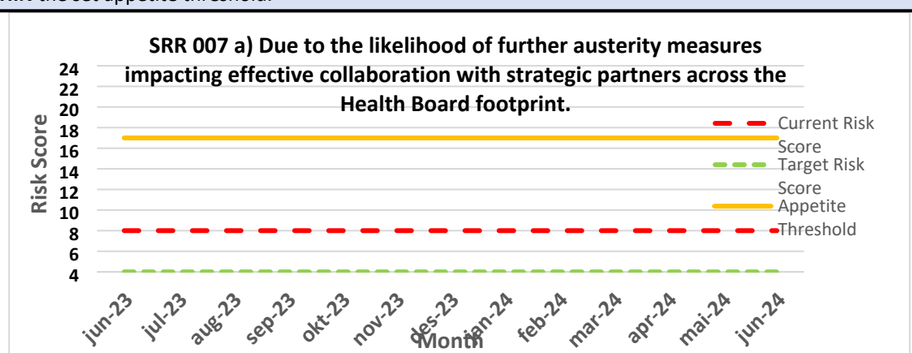
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• New Digital Service Request process in place which provides governance in several key areas: • Information Governance – ensuring new services have appropriate controls to keep patient information safe. • Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. • Patient Safety – ensuring services do not introduce any patient safety risks. • Records – ensuring new systems comply with the requirements of records management. • Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. • Business change function which ensures implemented systems are effective and deliver the benefits required. • Formal framework in place for the adoption of new digital services and best practice guidance followed. • Operational delivery aligned to ITIL standards • Annual operational plan completed and aligned with IMTP • New governance structures to be put in place	• Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee • Automation of request process via ‘Seren’ the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities • Prioritisation & Optimisation Framework redrafted pending ratification •	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Quarterly reporting to DDAT sub-committee **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit** • LINC Programme 23/24 – Not yet undertaken. • Network Infrastructure (VPN) 23/24 Q3 - Outcome **reasonable assurance**	**Gaps in Assurance** • If there NDSR process delivers anticipated improvements **Action to Address Gaps in Assurance** • Monitor the performance of the NDSR process	**Reasonable assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk: SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			
Strategic Threat	**a)** Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	**Publication Status**	Public	
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	01 April 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Low)*
Next Review Due Bi-annually based on current score	01 July 2024			

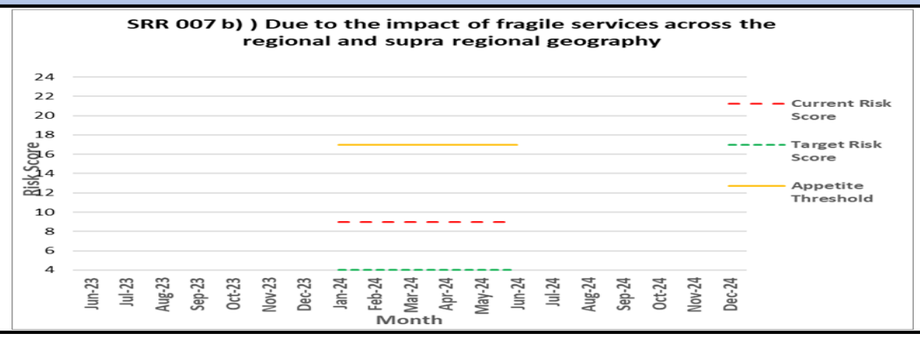
Risk Appetite Level - OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold - **SCORE 17 AND BELOW**
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: 1. **The Gwent Public Services Board (Gwent PSB)** brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. 2. **The Gwent Regional Partnership Board** As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal Audit Plan 2023/24 • RPB Governance Review (Q2) – due to be reported to the Audit, Risk & Assurance Committee in July 2024.	**Gaps in Assurance** • Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements **Action to Address Gaps in Assurance** • Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach.	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
Strategic Risk: SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population**				
Strategic Threat	b) Due to the impact of fragile services across the regional and supra regional geography	**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	04 January 2024	**Impact**	*3 (Moderate)*	2 *(Minor)*	
Last Reviewed	01 April 2024	**Risk rating**	***= 9*** *(High)*	**= 4** *(Low)*	
Next Review Due Quarterly based on current score	01 July 2024				

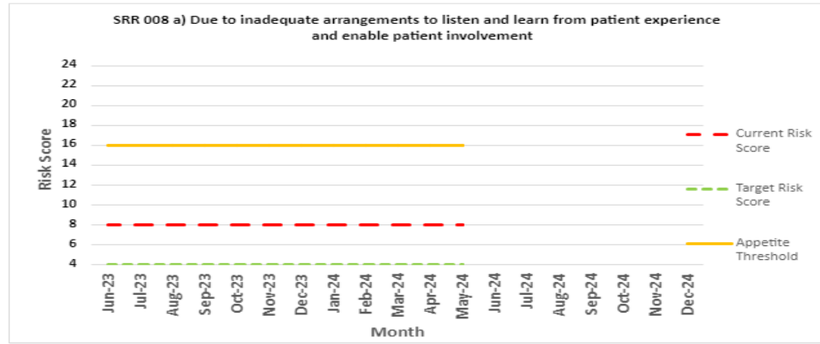
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these formal arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with these 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions (collaborative work has been undertaken in March with a parallel WG review of fragile services across south Wales, to ensure alignment of assumptions and priorities) • A further workshop (to include Chairs, Executives and clinicians) has been arranged for June Discussion ongoing at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Service Divisions reporting to the Chief Operational Officer **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. • Regular touchpoint meetings of all key players to review progress and issues arising **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Plan 2024/25** • Partnership Arrangements Review (Q1)	**Gaps in Assurance** • Alignment and effectiveness of partners to deliver integrated services **Action to Address Gaps in Assurance** **Internal Audit 2024/25** Recommendations from the Partnership Arrangements Review (Q1)	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk: SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**			
Strategic Threat	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Publication Status**	Public	
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	01 April 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*
Next Review Due (Bi-annually based on current risk score)	01 July 2024			

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

Risk Appetite Threshold – Open SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.



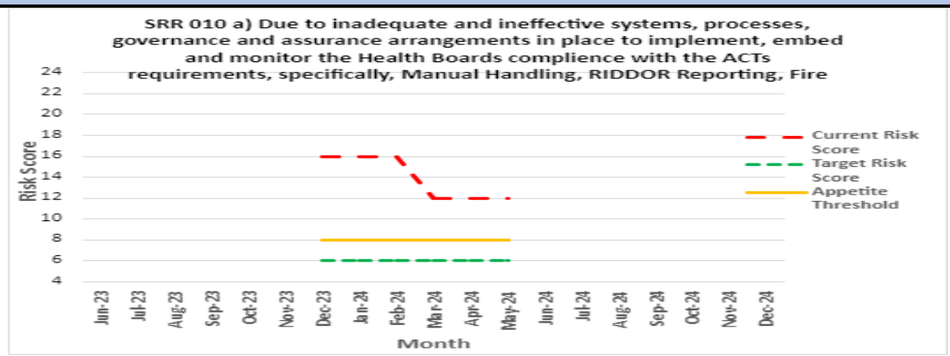
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision.- Discussions with VBHC to pilot SMS in ED through DrDoctor • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation • Immediate feedback and escalation to clinical teams following PALS queries and concerns **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • LLais Reports • HIW inspections • Advocacy reports	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. • Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.	**Reasonable Assurance**

RISK THEME	COMPLIANCE & SAFETY			
Risk No: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**			
Strategic Threat	**a)** Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**Publication Status**	Public	
Impact	➢ Unintended physical harm; ➢ Punitive actions from the Health and Safety Executive (HSE); ➢ Increased levels of staff sickness; ➢ Loss of estate due to unsafe environments;	➢ Financial implications; ➢ Adverse publicity; and, ➢ Reputational damage		
Lead Director	Director of Therapies & Health Science	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (*possible*) **x**	**2** (*Unlikely*) **x**
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*
Date Reviewed	01 May 2024	**Overall Risk Rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Date of Next Review Quarterly based on current score	01 August 2024			

Risk Appetite Level - MINIMAL.
Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.

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

SUMMARY
The current risk level is **OUTSIDE** of the appetite threshold and target score. The target level to be achieved is **WITHIN** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Attendance at Divisional Quality & Patient Safety meetings provide a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training / Development (delivered on 24 Apr 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern	• Health and Safety Governance and reporting arrangements (Health and Safety Committee) • Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Health and Safety compliance data extracted from ESR and Datix and reported **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Performance reviews at All Wales Health and Safety Management Steering Group • Internal Audit – H&S processes Review to be included in 2024/25 Plan. • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	**Gaps in Assurance** • Effectiveness of the health and safety plan • Compliance on completion of risk assessments and mitigating actions **Action to Address Gaps in Assurance** • Implement health and safety performance reporting • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	**Reasonable Assurance**

Agenda Item: 3.13

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 July 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit, Risk and Assurance Committee – Review of Committee Forward Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit, Risk and Assurance Committee (the Committee) is asked to review the agreed Committee Forward Work Plan (FWP) appended to this report. The FWP has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committee's terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with the principles of good governance, the Committee has an established FWP to ensure that the statutory requirements for Committee business are scheduled throughout the year. Therefore, the FWP can be utilised to inform and

anticipate committee business, as well as to assist in the agenda-setting process.

The FWP is designed to assist the Committee in the review of its programme of business. It captures the timing of the submission of reports, identifies items that have been deferred, captures new requests for reports, and allows the Committee to monitor and review its business at each meeting.

Argymhelliad / Recommendation

The Committee is requested to: -

- **NOTE** progress against the Committee Forward Work Plan.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	N/A

Parties / Committees consulted prior to University Health Board:	

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

ANNUAL PROGRAMME OF BUSINESS 2024/25

AUDIT, RISK & ASSURANCE COMMITTEE

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The discharge of the business needs of the individual Directorates
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee self-assessment for 2023 and the Structured Assessment 2023 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings.

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

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

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Preliminary Matters								
Attendance and Apologies	**SI**	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2024/25	**An**	Chair & DofCG	√**R**					
Review of Committee Programme of Business	**SI**	Chair	√**R**	√**R**	√**R**	√	√	√
Annual Review of Committee Effectiveness 2023/24 to include a review of the Terms of Reference	**An**	Chair & DofCG				√		
Committee Annual Report 2023/24	**An**	Chair & DofCG		√**R**				
Corporate Governance, Risk & Assurance								
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	**BI**	DofCG				√		√
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	**An**	DofCG					√	
Receive full report of all offers of gifts and hospitality as declared	**An**	DofCG					√	
Compliance with Ministerial Directions	**BI**	DofCG				√		√
Compliance with Welsh Health Circulars (WHCs)	**BI**	DofCG				√		√
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	**An**	DofCG						√
Compliance with regulatory requirements	**An**	DofCG						√
Audit Recommendations Tracking Report	**SI**	DofCG	√**R**		√**R**	√	√	√
Annual Review of Risk Management Framework	**An**	DofCG						√
Report on the Implementation of the Risk Management Framework	**BI**	DofCG				√		
Committee Risk & Assurance Report	**SI**	DofCG	√**R**		√**R**	√	√	√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Financial Governance and Control								
Report of the use of Single Tender Action	**SI**	DofF&P	√**R**			√	√	√
Report of Losses and Special Payments *(May report will be included in the Accounts)*	**BI**	DofF&P		√**R**			√	
To Approve Reviewed and Updated Financial Control Procedures	**Ad hoc**	DofF&P	√**R**		√**R**			
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	**An**	DofF&P & DofCG						√
Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	**An**	DofCG		√**R**	√**R**			
Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	**An**	DofCG		√**R**	√**R**			
Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	**An**	DofF&P		√**R**	√**R**			
Audit Enquiries to those charged with Governance and Management	**An**	DofF&P		√**R**				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	**An**	AW			√**R**			
Final Annual Accounts Memorandum	**An**	AW					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	**An**	HofIA			√**R**			
Agree a recommendation to the Board in respect of the audited annual report and accounts	**An**	Chair			√**R**			
Counter-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy *(Feb 2026)*	**3-Yearly**	DofF&P	-	-	-	-	-	-
Receive the Counter Fraud Annual Report	**An**	HofCF		√**R**				√
Agree the Counter Fraud Annual Workplan	**An**	HofCF	√**R**	√**R**				
Receive a Quarterly Report on Counter Fraud Activity	**Quarterly**	HofCF				√		√
Agree the Counter Fraud Functional Standard Return Declaration	**An**	HofCF			√**RR**			

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2024-25	**An**	PPV Manager			**√R**			
Receive a Mid-Year update in respect of Post-Payment Verification Activity	**An**	PPV Manager					√	
Clinical Audit								
Receive the Clinical Audit Activity Annual Report 2023 - 2024	**An**	Medical Director		**√R**				
Agree the Clinical Audit Plan 2024 - 2025	**An**	Medical Director		**√R**				
Mid-year Report on the delivery of the Clinical Audit Plan	**An**	Medical Director				√		
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	**An**	HofIA	**√R**					
Receive Internal Audit Progress Reports	**SI**	HofIA	**√R**	**√R**	**√R**	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**SI**	HofIA	**√R**	**√R**	**√R**	√	√	√
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**An**	HofIA with Chair		**√R**				
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	**An**	AW		**√R**				
Agree the External Audit Annual Plan	**An**	AW	**D**	**√D**				
Receive the draft external auditor's opinion on the quality account	**An**	AW						
Receive the 2024 Structured Assessment	**An**	AW					√	
Receive External Audit Progress Report 2024-25	**SI**	AW	**√R**	**√R**	**√R**	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**Ad hoc**	AW						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Ad hoc**	AW						

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			**10**	**15**	**15**	**14**	**13**	**16**
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	**BI**	Chair			√			√
Internal Audit Team	**BI**	Chair		√			√	
Local Counter Fraud Team	**BI**	Chair	√			√		

Lead Officer Key	
DofCG	Director of Corporate Governance
DofF&P	Director of Finance and Procurement
HofCF	Head of Counter Fraud
PPV	Post Payment Verification
HofIA	Head of Internal Audit
AW	Audit Wales
Chair	Chair

Frequency of Inclusion Key	
SI	Standing Item
AN	Annually
BI	Biannually
Quarterly	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
√**R**	Received at the Scheduled meeting
D	Deferred from this agenda
√ **D**	Deferred Scheduled agenda item Received
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

DRAFT