Audit, Risk & Assurance Committee

Tue 02 August 2022, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:40
10 min

1. Preliminary Matters

1.1. Apologies for Absence

Verbal *Chair*

1.2. Declarations of Interest

Verbal *Chair*

1.3. Draft Minutes of the Meeting held on 13 June 2022

Attachment *Chair*

1.3 Draft Minutes Audit Committee 13.06.22 RM SB approved.pdf (6 pages)

1.4. Committee Action Log

Attachment *Chair*

1.4 Audit Committee Action Log - Aug.pdf (4 pages)

09:40 - 10:30
50 min

2. Corporate Governance, Risk and Assurance

2.1. To receive the Committee Annual Programme of Business 2022/23

Attachment *Director of Corporate Governance*

2.1 ARAC Work Plan August2022.pdf (4 pages)
2.1a ARA_Committee Work Programme 2022-23_Final.pdf (6 pages)

2.2. To receive an update on the Audit Recommendations Tracker

Attachment *Director of Corporate Governance*

Due to the size of the spreadsheets, the supporting appendices (A-F) were distributed with the agenda. This is to ensure that the documents are legible.

2.2 AuditTracker_Cover Report_Aug22.pdf (9 pages)

2.3. To review the Board Assurance Framework (BAF) 2022/23

Presentation *Director of Corporate Governance / Head of Risk & Assurance*

2.4. To receive the Committee Risk Report

Attachment *Director of Corporate Governance / Head of Risk & Assurance*

2.4 Strategic Risk Report ARACJul2022docx.pdf (6 pages)
2.4a Final Master Risk Profiles July 2022.pdf (6 pages)
2.4b Appendix 1 Corporate Risk Register OverviewJune2022.pdf (8 pages)

10:30 - 10:45
15 min

3. Financial Governance and Control

3.1. To Receive the Report of the use of Single Tender Waivers and other Financial Governance Matters

Attachment *Assistant Director of Finance, Corporate*

- 3.1 Governance Report -02 August 2022-v3.pdf (5 pages)
- 3.1c Appendix 3 Financial Control Procedures Status Aug 22.pdf (1 pages)
- 3.1d Appendix 4 - STA - Summary 25th March 1 page- .pdf (1 pages)

10:45 - 11:10
25 min

4. Anti-Fraud

4.1. To Receive a Quarterly Report on Counter Fraud Activity

Attachment *Head of Counter Fraud*

- 4.1 Counter Fraud Audit Committee report 2 August 2022.pdf (2 pages)
- 4.1a Counter Fraud Progress Report .pdf (8 pages)

4.2. To Receive the Post Payment Verification (PPV) Annual Report

Attachment *PPV Manager*

- 4.2 PPV End of Year Report 21-22.pdf (4 pages)
- 4.2a ABuHB Annual PPV Report 2021-22 Anonymised key .pdf (1 pages)
- 4.2a ABuHB Annual PPV Report 2021-22 Anonymised GMS .pdf (1 pages)
- 4.2a ABuHB Annual PPV Report 2021-22 Anonymised. GMS%2.pdf (1 pages)
- 4.2a ABuHB Annual PPV Report 2021-22 Anonymised. GOS%2.pdf (1 pages)
- 4.2a ABuHB Annual PPV Report 2021-22 Anonymised GOS .pdf (1 pages)

11:10 - 11:25
15 min

5. Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services

5.1. To receive the Internal Audit Plan Progress Report

Attachment *Head of Internal Audit and Director of Audit & Assurance, NHS Wales SSP*

- 5.1 AB Internal Audit FINAL Assurance Progress Report August 2022 ARA Committee.pdf (8 pages)

5.2. To receive the Internal Audit Reports

Attachment *Head of Internal Audit and Director of Audit & Assurance, NHS Wales SSP*

Reasonable Assurance

- 5.2 ABUHB Waste Management Final Report v2.pdf (27 pages)

11:25 - 11:40
15 min

6. External Audit

6.1. To receive the External Audit Progress Report 2021-22

Attachment *Audit Wales*

- 6.1 Audit Risk & Assurance Committee Update_Aug 2022.pdf (14 pages)
- 6.1a Structured Assessment 2022 Briefing Note FINAL.pdf (7 pages)

6.2. To note Audit Wales' Review of Quality Governance Arrangements

Attachment *Audit Wales*

6.2 ABUHB_Quality_Governance_Report_final_0.pdf (44 pages)

11:40 - 11:45
5 min

7. For Information

Verbal *Director of Corporate Governance*

The following informational items are included in the Supporting Appendices pack:

- Audit Wales Assure, Explain, Inspire 2022-2027 Strategy
- Letter from Audit Wales to the Chair of the Public Accounts and Public Administration Committee - The Welsh Community Care Information System
- Audit Wales Report - Tackling the Planned Care Backlog in Wales

11:45 - 11:50
5 min

8. Close of Meeting

Verbal *Chair*

Date of Next Meeting:

6th October 2022 - 09:30 – 12:30

Microsoft Teams

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Audit, Risk & Assurance Committee held on Monday 13th June 2022 at 13:00pm via Microsoft Teams

---

Present:

Shelley Bosson	-	Independent Member (Chair)
Richard Clark	-	Independent Member (Vice Chair)
Katija Dew	-	Independent Member
Paul Deneen	-	Independent Member (left at 13:55)

In Attendance:

Glyn Jones	-	Interim CEO
Rani Mallison	-	Director of Corporate Governance
Rob Holcombe	-	Interim Director of Finance
Iwan Jones	-	Independent Member
Gareth Lewis	-	Finance
Susan Gauntlett	-	Finance
Simon Cookson	-	Interim Head of Internal Audit
Stephen Chaney	-	Deputy Head of Internal Audit
Martyn Lewis	-	Internal Audit, IT
Gwen Kohler	-	Assistant Director of Finance, Corporate
Richard Harries	-	Audit Wales
Neall Hollis	-	Audit Wales
Bryony Codd	-	Head of Corporate Governance
Peter Carr	-	Director of Therapies & Health Science
Lucy Windsor	-	Secretariat

Apologies:
None

AC 1306/01	**Welcome and Introductions and Apologies for Absence**
	The Chair welcomed everyone to the meeting. Apologies for absence were noted.
AC 1306/02	**Declarations of Interest** There were no Declarations of Interest to record.
AC 1306/03	**Draft Minutes of the Meeting held on 7th April 2022** Item 1705/06 Iwan Jones, Independent Member, requested that the management response to the Care After Death Audit be reviewed to ensure it appropriately captured the action required to procure an appropriate replacement software system that was fit for purpose. **Action: Deputy Head of Internal Audit**

	The Committee accepted the minutes as a true and accurate reflection of the meeting.
AC 1306/04	**Action Sheet** The Committee noted the 3 outstanding actions as in progress, as outlined within the paper.
AC 1306/05	**Counter Fraud Functional Standard Return Declaration 2021/2022** The Committee received the Counter Fraud Functional Standard Return Declaration 2021/2022 for information. Iwan Jones, Independent Member, questioned whether more investment in resources would result in a higher return on fraud recovery and more opportunities to be more proactive in prevention and deterrent work for the Health Board. Rob Holcombe, Interim Director of Finance, stated that the Health Board had an acceptable team size in relation to the size of the organisation but agreed to pursue benchmarking against other Health Boards. In addition, he would request a briefing on benefits realisation from the Head of Counter Fraud. **Action: Interim Director of Finance** The Committee NOTED the Counter Fraud Functional Standard Return Declaration 2021/2022.
AC 1306/06	**Internal Audit Reviews from the 2021/22 Internal Audit Plan** Simon Cookson, Interim Head of Internal Audit, referred to the Committee's receipt of an abridged version of the Audit Cycle via email. He offered to share the complete document with the Director of Corporate Governance to assist with recommendations and implementation tracking. Action: Interim Head of Internal Audit It was noted that the Waste Management Review had not been formally reported to the Committee; this would be available at the next meeting. Stephen Chaney, Deputy Head of Internal Audit, presented the Audit reviews included within the meeting papers. The Committee accepted the reasonable assurance rating for the six audits listed below and took note of the recommendations and corresponding action plans: a) Flow Centre b) Corporate Governance c) Operational Plan for Resumption of Services

	d) Financial Sustainability e) Medicines Management (Including Controlled Drugs) f) NIS Directive Committee Members raised queries regarding the Medicines Management Audit in terms of policy adherence and the frequency of required stocktakes. A Report of the Controlled Drugs Officer was noted as an annual requirement and the Director of Corporate Governance, suggested that the Internal Audit report be presented to the Patient Quality, Safety, and Outcomes (PQSO) Committee so that the appropriate individuals could respond to the queries. **Action: Director of Corporate Governance** The Medical Equipment and Devices Audit was discussed; the Committee and the Lead Executive, Peter Carr (Director of Therapies and Health Science) agreed this review remained as 'Limited' assurance until a full audit could be completed. The Chair requested that the Committee be informed and that any changes to audit assurance ratings be approved by the Committee. The Committee noted the significant risk in documenting equipment and equipment location, as well as staff training compliance/recording in medical devices, and requested that regular updates on action plan implementation be provided to the Committee prior to the next scheduled audit. The Director of Therapies & Health Science agreed to review the action plan dates and contact Internal Audit to determine the best time to re-audit. **Action: Secretariat - Include regular updates in the forward work programme.** The Committee noted the revised assurance rating in respect of the NIS Directive Audit from "limited" to "reasonable." Internal Audit confirmed that this was due to new information about the overall cyber security action plan being received. This was in line with the approach taken for other organisations in Wales. The Audit Reviews from the 2021/22 Internal Audit Plan were NOTED by the Committee.
AC 1306/07	**Final Head of Internal Audit Opinion 2021/22** Simon Cookson, Head of Internal Audit, presented the Final Head of Internal Audit Opinion for 2021/22, noting that the only substantive change in the final iteration was the change in assurance rating for the NIS Directive Audit.

	The Committee was pleased to note that for 2021/22, the Board could take reasonable assurance that arrangements to secure governance, risk management, and internal control within the areas under review were appropriately designed and effectively implemented. In most audits, the Committee identified training as an area for improvement and would like to see a stronger governance process built into training. Rani Mallison, Director of Corporate Governance, stated that a work programme involving a more integrated approach to policy compliance and management would begin in the coming months and would be linked to the Board Assurance Framework (BAF). Furthermore, Internal Audit would keep training under review and pick up at a future Committee meeting. The Chair thanked the Head of Internal Audit and colleagues for their hard work during 2021/22 and for the comprehensive final report. The Committee ENDORSED the Final Head of Internal Audit Opinion 2021/22 for submission to the Board.
AC 1306/08	**Final Audit of Accounts 2021/22 (ISA260)** Richard Harries, Audit Wales, assisted by Neall Hollis, Audit Wales, presented the Final Audit of Accounts 2021/22, confirming that an unqualified opinion would be issued. The key points of note were as follows; - • The level of materiality for this year's audit was set at £17 million. • The regularity opinion would be qualified due to the financial statements including a provision (and corresponding expenditure) of £756,155 for the Health Board's estimated liability because of a Ministerial Direction in 2019. The Direction instructed those payments be made to clinical staff to restore the value of their pension benefit packages if they made a claim. The Committee recognised that this issue affected all Welsh Health Boards, not just Aneurin Bevan University Health Board. • Corrected misstatements had not adversely affected the audit opinion. However, one misstatement in the financial statements remained uncorrected, relating to the full revaluation of NHS land and buildings. • Corrected statements – the bottom line reported to the Committee in May had not changed

	• Verifying Asset Existence – assets that had not been stated had been identified, resulting in a potential £6 million misstatement. To avoid material misstatement, it was suggested that annual verification of asset existence be completed. The Director of Finance stated that he would form a Task & Finish Group to determine the existence of all assets. • The process for completing the disclosure reports required improvement. • There were no recommendations made. Iwan Jones, Independent Member, asked if pensions should be included in the Remuneration Report in terms of total remuneration and benefits paid. Audit Wales took note of the comment and agreed to consider it as a note in future reports. Following the close of the annual accounts, Audit Wales and management agreed to hold a debriefing session to inform learning and improvement for future years. The Committee welcomed the opportunity for reflection and continuous improvement. The Committee ENDORSED the Final Audit of Accounts 2021/22 (ISA260) for submission to the Board.
AC 1306/09	**Final Draft Annual Report 2021/22** The Director of Corporate Governance presented the Committee with the final Performance Report and Accountability Report for 2021/22. It was noted that since the Committee discussed the draft reports on May 17th, both documents had been reviewed by Audit Wales and Welsh Government, and the final versions had been amended to reflect the comments and feedback received, as well as the points raised by members at the previous meeting. The Performance and Accountability Report was APPROVED by the Committee for submission to the Board. The Committee thanked the Director of Corporate Governance and the Interim Director of Finance, as well as their respective teams, for their efforts and thorough reports.
AC 1306/10	**Review of the Draft Financial Statements 2021/22 (Part 3)** The Interim Director of Finance, who was assisted by the Assistant Director of Finance, Corporate, presented the Draft

	Annual Accounts. The Committee was informed that none of the changes made since the draft report was received on May 17th had changed the bottom line. The Committee thanked the Interim Director of Finance and his team for a comprehensive report and ENDORSED its submission to the Board.
AC 1306/11	**Final Letter of Representation for 2021/22** The Committee NOTED the final letter of Representation for 2021/22.
AC 1306/12	**Recommendation to the Board in respect of the Annual Report and Accounts 2021/22** The Audit, Risk and Assurance Committee RECOMMENDS to the Board that it: • RECEIVES the Audit of Accounts Report (2021/22) of External Audit (Audit Wales) • APPROVES the Annual Report and Accounts 2021/22, which includes: 1. The Performance Report; 2. The Annual Accountability Report; and 3. The Financial Statements • APPROVES the Letter of Representation; and • AUTHORISES the Chair, Chief Executive Officer and Director of Finance, Procurement and VBH, to sign these documents where required.
AC 1306/11	**Date of Next Meeting**
	Tuesday 2nd August 2022 09:30am

Audit, Risk & Assurance Committee
Action Sheet

All actions in this log are currently active and are either part of the Committee's forward work programme or require an update against the action.

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2022	**AC 0302/07**	Produce an outcomes report outlinng ways that the Health Board could streamline the termination/new starter process for managers.	**Director of Finance & Procurement & VBHC Head of Counter Fraud**	**6th October 2022**	In progress
June 2022	**AC 1306/03** Action Sheet	**1705/06 -** The management response to the Care After Death Audit be reviewed to ensure it appropriately captured the action required to procure an appropriate replacement software system that was fit for purpose	**Deputy Head of Internal Audit**	**30th June 2022**	**Completed** The Facilities Team is working closely with Informatics to implement their new software, and the Assistant Director of Informatics is heavily involved in the process to ensure information governance risks are addressed. This action is therefore deemed closed at 2nd August 2022
June 2022	**AC 1306/05** Counter Fraud	Benchmark the Health Boards counter-fraud resources against those of other Health Boards.	**Interim Director of Finance**	**TBA**	Due to higher priorities, a briefing paper has yet to be developed. At the meeting, an interim verbal update will be provided.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

June 2022	**AC 1306/05** Counter Fraud	Request a benefit realisation briefing from the Head of Counter Fraud. The briefing from the Head of Counter Fraud will cover whether investing in resources will result in a higher return on fraud recovery and provide more opportunities to be more proactive in prevention and deterrent work.	**Interim Director of Finance** **Head of Counter Fraud**	**30 June 2022**	**Completed.** The current LCFS recruitment drive will result in 3 wte LCFS on the ABUHB Fraud Team. The HofCF would suggest that this is the appropriate compliment of staff on the team, which is supplemented by admin support. This number is already an increase on the 2.8 wte LCFS initially shown on the corporate structure. This is consistent with other HB's in Wales, the highest being SBUHB at 3.2 wte LCFS.
June 2022	**AC 1306/06** Internal Audit Reviews from the 2021/22 Internal Audit Plan	Take the Medicines Management Internal Audit report to the Patient Quality, Safety, and Outcomes (PQSO) Committee so that the appropriate people can respond to the following concerns;- • Policy adherence • Frequency of required stocktakes	**Director of Corporate Governance**	**31 July 2022**	**Completed** The PQSO Committee workplan will take into account this action. Committee workplans will be presented to the Board for approval in July 2022. This action is therefore deemed closed at 2nd August 2022.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

June 2022	**AC 1306/06** Internal Audit Reviews from the 2021/22 Internal Audit Plan	Schedule regular progress updates against the Internal Audit recommendations and Management Plan for Medical Equipment and Devices.	**Secretariat**	**30 June 2022**	**Completed.** This action has been factored into the Committee workplan.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk and Assurance Committee 2nd August 2022 Agenda Item: 2.1

Aneurin Bevan University Health Board

AUDIT RISK AND ASSURANCE COMMITTEE WORK PLAN

Executive Summary

The Audit Risk and Assurance Committee is asked to receive the draft Committee work plan appended to this report. The work plan has been developed with due regard to guidance set out in NHS Wales' Audit Committee Handbook (June 2012), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board (March 2022);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

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

Executive Sponsor: Rani Mallison, Director of Corporate Governance

Report Author: Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**X**	**Committee of the Board**	

Date of the Report: 25th July 2022

Supplementary Papers Attached:
Appendix 1 – Committee Work Plan

Purpose of the Report
The draft Committee work plan outlines the key items for business, legislative requirements as outlined within Health Board Standing Orders which enables the Audit, Risk and Assurance Committee to discharge its responsibilities appropriately and on behalf of the Board.

Background and Context
The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report. In line with good governance practice, a committee work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting function.

Assessment and Conclusion
The Committee is requested to approve the Committee work plan as outlined in **Appendix 1** noting that the work plan will be presented at each Committee meeting for oversight and noting. The work plan will be used to inform Committee business alongside the Board Assurance Framework which would seek to highlight areas of limited or reduced gap in assurance.

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence.
Equality and Diversity Impact Assessment	This report has no Equality and Diversity impact.

(including child impact assessment)	
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering how the business of the Committee aligns to the WBoFG Act.
Glossary of New Terms	Not required.
Public Interest	Report to be published.

AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2022/23

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

This Annual Programme of Business has been developed with due regard to guidance set out in NHS Wales' Audit Committee Handbook (June 2012), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board (March 2022);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓	✓	✓	✓
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG				✓			
Review of Committee Programme of Business	Standing Item	Chair					✓	✓	✓
Annual Review of Committee Terms of Reference 2022/23	Annually **(April)**	Chair & Director of CG							
Annual Review of Committee Effectiveness 2022/23	Annually **(April)**	Chair & Director of CG							
Committee Annual Report 2022/23	Annually **(April)**	Chair & Director of CG							
Corporate Governance, Risk & Assurance									
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	Quarterly	Director of CG					✓		✓
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG						✓	
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG						✓	
Compliance with Ministerial Directions	Bi-Annually	Director of CG			✓		✓		

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			✓		✓		
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG							✓
Review of Audit Recommendation Tracking Procedure	Annually	Director of CG	✓						
Audit Recommendations Tracking Report	Standing Item	Director of CG	✓			✓	✓	✓	✓
Annual Review of Risk Management Strategy	Annually	Director of CG					✓		
Report on the Implementation of the Risk Management Strategy Realisation Plan	Bi-Annually	Director of CG					✓		
Annual Review of the Board Assurance Framework Process	Annually	Director of CG							✓
Review of the Board Assurance Framework	Bi-Annually	Director of CG				✓			
Committee Risk Report	Standing Item	Director of CG	✓			✓	✓	✓	✓
Financial Governance and Control									
Report of the use of Single Tender Waivers	Standing Item	Director of FPV	✓	✓		✓	✓	✓	✓
Report of Losses and Special Payments	Bi-Annually	Director of FPV		✓			✓		
Reviewed and Updated Financial Control Procedures	As Required	Director of FPV	✓			✓			
Annual Report and Accounts									
To consider the approach and timelines for the Annual Report and Accounts	Annually	Director of FPV & Director of CG	✓						
Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)	Annually	Director of CG		✓	✓				

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)	Annually	Director of CG		✓	✓				
Review Draft/Final Annual Accounts and Financial Statements (Part 3)	Annually	Director of FPV		✓	✓				
Audit Enquiries to those charged with Governance and Management	Annually	Director of FPV		✓					
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	Annually	External Audit			✓				
Final Annual Accounts Memorandum	Annually	External Audit						✓	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	Annually	Internal Audit			✓				
Agree a recommendation to the Board in respect of the audited annual report and accounts	Annually	Chair			✓				
Anti-Fraud									
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (2023)	Director of FPV							
Receive the Counter Fraud Annual Report	Annually	Head of CF		✓					
Agree the Counter Fraud Annual Workplan	Annually	Head of CF		✓					
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	Head of CF				✓		✓	
Agree the Counter Fraud Functional Standard Return Declaration	Annually	Head of CF			✓				
Receive the Post Payment Verification Annual Report	Annually	PPV Manager				✓			
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager							

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Bi-Annually	PPV Manager							
Clinical Audit									
Ratify the Clinical Audit Plan to be overseen by the PQSO Committee	Annually	Medical Director					✓		
Receive an Annual Report on Clinical Audit Activity	Annually	Medical Director							✓
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services									
Agree the Internal Audit Annual Workplan	Annually	Head of Internal Audit			✓				
Receive Internal Audit Progress Reports	Standing Item	Head of Internal Audit	✓	✓	✓	✓	✓	✓	✓
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Head of Internal Audit Plan							
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	Annually	Head of Internal Audit with Chair			✓				
External Audit – Audit Wales									
Receive the External Audit Annual Audit Report	Annually	Audit Wales						✓	
Agree the External Audit Annual Plan	Annually	Audit Wales		✓					
Receive the 2022 Structured Assessment	Annually	Audit Wales						✓	
Receive External Audit Progress Report 2021-22	Standing Item	Audit Wales	✓	✓		✓	✓	✓	✓
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues	As Scheduled	Audit Wales							

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
identified, ensuring that they are acted upon	within Annual Work plan								
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Ad-hoc	Audit Wales							
Audit, Risk and Assurance Committee Members to meet Independently with:									
External Audit Team	Bi-Annually	Chair					✓		
Internal Audit Team	Bi-Annually	Chair				✓			✓
Local Counter Fraud Team	Bi-Annually	Chair	✓					✓	

KEY	
D of CG	Director of Corporate Governance
D of FPV	Director of Finance, Procurement and Value
Head of CF	Head of Counter Fraud
PPV	Post Payment Verification

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Risk and Assurance Committee
Tuesday 2nd August 2022
Agenda Item: 2.2

Aneurin Bevan University Health Board

Internal and External Audit Recommendations Tracking

Purpose

The paper presents the Audit, Risk and Assurance Committee with an overview, as of 30th April 2022, against all identified internal and external audit recommendations and implementation status. The tracker has also been updated to reflect all Internal and External Audit Reports that have been received to date. The Committee is asked to note that the most up to date reports will have deadlines associated that are not yet due.

The paper presents the Audit, Risk & Assurance Committee with a position since the last reporting period on recommendations that have progressed, where there has been a revised deadline proposed, recommendations that remain outstanding and an overview of the management action plans that have now been completed in totality.

The Committee is asked to:	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Rani Mallison, Director of Corporate Governance

Report Author: Rani Mallison, Director of Corporate Governance/Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by:

Executive Team	✓	**Committee of the Board**	N/A

Date of the Report: 24th July 2022

Supplementary Papers Attached:

- **Appendix A** - Master Internal and External Audit Recommendations Tracker (inclusive of overdue, not yet due and completed/closed actions)
- **Appendix B** - Internal Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix C –** Internal Audit Recommendations that are overdue and have a revised deadline proposed for the Audit, Risk and Assurance Committee's consideration and approval
- **Appendix D –** Internal Audit Recommendations that have been completed/closed since the previous report (March 2022)
- **Appendix E –** Internal Audit and External Audit Recommendations that are Not Yet Due for Implementation (as of 30 April 2022)
- **Appendix F -** External Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix G –** External Audit Recommendations that are overdue and have a revised deadline proposed for the Audit, Risk and Assurance Committee's consideration and approval.

Detailed Assessment

Procedure for the Management of Internal and External Audit Recommendations

As agreed at the April 2022 Committee meeting, a revised and adopted approach has been operational in relation to internal and external audit recommendations management. It is intended for the Procedure to support a structured approach to the management of internal and external audit recommendations, with clearly defined actions that will enable the Health Board to have a comprehensive oversight of its internal and external audit activity.

The procedure does not extend to the management of improvement actions arising from Regulatory Inspections or Independent Reviews (such as those undertaken by the Community Health Council). The nature of which are dealt with under a separate process and overseen by the Board's Patient Quality, Safety and Outcomes Committee.

Scope of the Audit Recommendations Tracker and Role of the Committee

The Audit, Risk and Assurance Committee will focus its attention at each meeting on those recommendations that are overdue past the original agreed timeframe for completion, those that have been closed during the last reporting period which require noting and the number of audit recommendations that are not yet due for implementation.

The Director of Corporate Governance will ensure that all completed actions are retained for any potential future reference.

Internal and External Audit Recommendation Tracking, 30 April 2022

Since the last reporting period further work has been undertaken to update the master tracker to reflect all Internal and External Audit Reports that have been considered by the Audit, Risk and Assurance Committee (in-line with the agreed procedure). The Master Tracker is attached at **Appendix A** (inclusive of overdue, not yet due and completed/closed actions).

Following the last report to the Audit, Risk and Assurance Committee, the Executive Team was asked to review and update progress in implementing internal and external audit recommendations. The position reported in this paper is therefore reflective of the position as of 30th April 2022. Further updates will be requested from the Executive Team, for those items due and overdue, over the summer period in readiness for reporting to the Committee in October 2022.

Internal Audit
The position reported to the Audit, Risk and Assurance Committee, as of 30th April 2022, in respect of overdue (passed the original agreed implementation date) internal audit recommendations is:

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017/18 2018/19 2019/20 2020/21	11	6	6	16	39
2021/22	1	12	6	0	19
				Grand Total Overdue at 30/04/2022	58*

The position reported in March 2022, confirmed that there were 86 recommendations overdue past the agreed deadline. This demonstrates an improved position.

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017/18 2018/19 2019/20 2020/21	13	12	6	23	54
2021/22	4	18	10	0	32
				Grand Total Overdue at 31/03/2022	86

Of the 58 recommendations that are overdue for implementation passed the original agreed implementation date, there are several proposed revised timescales for implementation. These proposed revisions relate to the following Internal Audits:

- Medical Equipment & Devices (2017/18)
- Clinical Audit Follow-up of actions from 2016/17 (2018/19)
- Covid-19: Reducing Nosocomial Transmission (2020/21)
- Gifts, Hospitality and Declarations of Interest (2021/22)
- Occupational Health (2021/22)

The Audit, Risk and Assurance Committee is asked to **consider and approve**, if appropriate, the revised timescales for implementation as provided in Appendix C (column J [original agreed date for implementation] and column K [proposed revised date for implementation).

The detail provided at **Annex 1** of this paper provides the Audit, Risk and Assurance Committee with an overview of progress in implementing the totality of audit recommendations arising from internal audit reviews; demonstrating the number of actions implemented, overdue and not yet due at an individual audit review level. It is proposed that this oversight is provided to the Audit, Risk & Assurance Committee with each audit tracking report to enable the Committee to focus its attention on those actions overdue for implementation as well as being able to take assurance that action plans are being completed.

The detail provided now includes all Internal Audit Reviews that have been reported in 2021/22 to the Audit, Risk and Assurance Committee. The Internal Audit Reviews

reported to the Audit, Risk & Assurance Committee on 2nd August 2022 will be added into the Master Tracker thereafter (in-line with the agreed procedure).

The following appendices are attached to support the Audit, Risk & Assurance Committee's review of internal audit recommendations tracking:

- **Appendix B** - Internal Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix C –** Internal Audit Recommendations that are overdue and have a revised deadline proposed for the Audit, Risk and Assurance Committee's consideration and approval
- **Appendix D –** Internal and External Audit Recommendations that have been completed/closed since the previous report (March 2022)
- **Appendix E –** Internal Audit and External Audit Recommendations that are Not Yet Due for Implementation (as of 30 April 2022)

External Audit

The position reported to the Audit, Risk and Assurance Committee, as of 30th April 2022, in respect of overdue (passed the original agreed implementation date) external audit recommendations is:

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017 2018 2019 2020	5	0	0	2	7
2021 & 2022	3	1	0	1	5
Grand Total Overdue at 30/04/2022					12*

The position reported in March 2022, confirmed that there were 13 recommendations overdue past the agreed deadline.

Date	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2017 2018 2019 2020	7	0	0	3	10
2021 & 2022	1	1	0	1	3
Grand Total at 31/03/2022					13

Of the 12 recommendations that are overdue for implementation passed the original agreed implementation date, there are some proposed revised timescales for implementation. These proposed revisions relate to the following External Audits:

- Structured Assessment 2018
- Structured Assessment 2021

The Audit, Risk and Assurance Committee is asked to **consider and approve**, if appropriate, the revised timescales for implementation as provided in Appendix C (column J [original agreed date for implementation] and column K [proposed revised date for implementation).

The detail provided at **Annex 2**, provides the Audit, Risk and Assurance Committee with an overview of progress in implementing the totality of audit recommendations arising from external audit reviews; demonstrating the number of actions implemented, overdue and not yet due at an individual audit review level. As with Internal Audit, it is proposed that this oversight is provided to the Audit, Risk and Assurance Committee with each audit tracking report to enable the Committee to focus its attention on those actions overdue for implementation as well as being able to take assurance that action plans are being completed.

The following appendices are attached to support the Audit, Risk & Assurance Committee's review of external audit recommendations tracking:

- **Appendix D –** Internal and External Audit Recommendations that have been completed/closed since the previous report (March 2022)
- **Appendix E –** Internal Audit and External Audit Recommendations that are Not Yet Due for Implementation (as of 30 April 2022)
- **Appendix F -** External Audit Recommendations that are Overdue (passed the original agreed implementation date)
- **Appendix G –** External Audit Recommendations that are overdue and have a revised deadline proposed for the Audit, Risk and Assurance Committee's consideration and approval.

Next Steps

The master tracker will be updated as and when internal and external audit reports are reported to the Audit, Risk and Assurance Committee.

Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **DISCUSS** and **NOTE** the position in respect of overdue audit recommendations; and
- **CONSIDER** and **APPROVE** proposed revised dates for implementation in respect of several audit recommendations outlined.

Internal Audits Outstanding from:

- **2017/18**
- **2018/19**
- **2019/20**
- **2020/21**

ABUHB Ref	Audit Title	Lead Director	Assurance Rating: Substantial / Reasonable / Limited / No	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due (at 31/04/22)				All Audit Recs Implemented
					H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
TBC	Health & Safety, (2017/18)	DoTHS	Limited	**5**	2	3			0	3			2	0							×
TBC	IT Service Management (2017/18)	DoPPD&IT	Limited	**11**	4	7			3	7			1	0							×
TBC	Medical Equipment & Devices (2017/18)	DoTHS	Limited	**5**	2	3			0	3			2*	0							×
TBC	Wellbeing of Future Generations Act (Wales) 2015 (2018/19)	DoPHSP	Reasonable	**3**	1	2			0	2			1	0							×
TBC	Management of Balance Sheet Assets (2018/19)	DoFPV	Reasonable	**12**	1	9	2		0	9	2		1	0	0						×
TBC	Clinical Audit Follow-up of actions from 2016/17 (2018/19)	MD	Limited	**3**	3				1				2*								×
TBC	Job Planning (2019/20)	MD	Limited	**5**	3	2			3	2			0	0							✓
TBC	Pay Incentives (2019/20)	DoWOD	Limited	**7**	2	4	1		0	4	1		2	0	0						×
TBC	IM&T Control and Risk Assessment (2020/21)	DoPPD&IT	Advisory	**14**				14								13				1	×
TBC	High Voltage Electrical Systems Management, (2020/21)	DoOps	Reasonable	**6**		3	3			0	0			3	3						×
TBC	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	DoOps	Reasonable	**7**		7				7				0							✓
TBC	Clinical Futures – Workforce (2020/21)	DoPPD&IT	Substantial	**1**		1				0				1							×
TBC	Clinical Futures – Transport (2020/21)	DoPPD&IT	Reasonable	**4**		2	2			0	0			2	2						×
TBC	Mass Vaccination Programme	DoPHSP	Substantial	**1**		1				1				0							✓
TBC	Mental Health and Learning Disabilities Divisional Review	DoPCCMH	Reasonable	**4**		2	2			2	1			0	1						×
TBC	(2020/21) Staff Experience	DoWOD	Advisory	**3**				3				2				1					×
TBC	Covid-19: Reducing Nosocomial Transmission (2020/21)	DoCG	Advisory	**7**				7				5				2*					×
TOTAL				**98**	18	46	10	24	7	40	4	7	**11**	**6**	**6**	**16**	0	0	0	1	
													**** indicates that a revised deadline has been proposed/agreed***								

2021/22 Internal Audits

ABUHB Ref	Audit Title	Lead Director	Assurance Rating: Substantial / Reasonable / Limited / No	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review			Audit Recs Implemented to-date			Audit Recs Overdue (against original agreed timescale)			Audit Recs Not Yet Due			All Audit Recs Implemented
					H	M	L	H	M	L	H	M	L	H	M	L	
2021.06	Mental Capacity Act	DoPCCMH	Reasonable	**5**	1	3	1	1	3	1	0	0	0				✓
2021.01	Gifts, Hospitality and Declarations of Interest	DoCG	Reasonable	**2**		2			0			2*					×
2021.03	Clinical Negligence Costs	DoFPV	Substantial	**2**		1	1		1	1		0	0				✓
2021.02	Putting Things Right	DoN	Reasonable	**2**		2			2			0					✓
2021.04	Charitable Funds	DoFPV	Substantial	**1**		1			0			1					×
2021.12	IT System Controls (WRIS)	DoPPDIT	Reasonable	**10**	1	9		0	2		0	4		1	3		×
2021.05	Pathology	DoTHS	Reasonable	**9**		3	6		0	0		3	5			1	×
2021.07	Occupational Health	DoWOD	Substantial	**2**			2			1			1*				×
2021.10	Tredegar Health and Well Being Centre	DoPPDIT	Reasonable	**12**	4	6	2	3	6	2	1	0	0	0	0	0	×
2021.08	GUH: Financial Assurance (Follow-up)	DoPPDIT	Substantial	**0**													
2021.09	GUH: Technical Assurance	DoPPDIT	Substantial	**1**			1			1			0			0	✓
2021.11	GUH: Equipment Procurement Assurance Follow-up	DoPPDIT	Reasonable	**2**		2			2			0			0		✓
2021.17	Corporate Governance: BAF	DoCG	Reasonable	**4**	0	2	2		0	0		0	0		2	2	×
2021.12	Risk Management	DoCG	Reasonable	**3**		3						1			2		×
2021.18	Financial Sustainability	DoFPV	Reasonable	**8**		2	6								2	6	×
2021.13	Continuing Healthcare MH&LD	DoPCCMH	Limited	**6**	4	2		1				1		3	1		×
2021.16	Flu Immunisation	DoPHSP	Reasonable	**2**		1	1								1	1	×
2021.19	Medical Equipment and Devices[1]	DoTHS	Not Rated														
2021.20	Medicines Management (including Controlled Drugs)	DoOps	Reasonable	**5**		4	1								4	1	×
2021.15	Falls Management	DoTHS	Reasonable	**6**	5	1								5	1		×
2021.21	Datix	DoTHS	Not Rated	**0**													
2021.22	NIS Directive	DoPPDIT	Reasonable	**6**		5	1								5	1	×
2021.23	Operational Plan for Resumption of Services	DoOps	Reasonable	**2**		2									2		×
2021.24	Flow Centre	DoOps	Reasonable	**7**		4	3								4	3	×
2021.26	Facilities Care After Death	DoOps	Reasonable	**4**		1	3								1	3	×
TBC	Waste Management	DoOps	Not yet Reported														
2021.14	GUH: Quality	DoN	Reasonable	**3**		3									3		×
2021.25	Follow-up on Previous Recommendations	DoCG	Not Rated	**0**													
TOTAL				**104**	15	59	30	5	16	6	**1**	**12**	**6**	9	31	18	
											**** indicates that a revised deadline has been proposed/agreed***						

KEY:	
MD	Medical Director
DoN	Director of Nursing
DoTHS	Director of Therapies & Health Science
DoPPDIT	Director of Planning, Performance, Digital & IT
DoPHSP	Director of Public Health & Strategic Partnerships
DoPCCMH	Director of Primary, Community Care & Mental Health
DoFPV	Director of Finance, Procurement & Value
DoOps	Director of Operations
DoCG	Director of Corporate Governance

[1] This audit refers to the audit recommendations arising from the 2017/18 and so are not double counted in the 2021/22 numbers

ABUHB External Audits Outstanding from:

- **2017**
- **2018**
- **2019**
- **2020**

ABUHB Ref	Audit Title	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
			H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
TBC	Structured Assessment 2017	**7**	7				4				3								×
TBC	Structured Assessment 2018	**5**	5				2				2				1*				×
TBC	Structured Assessment 2019	**4**				4				2				2					×
TBC	Structured Assessment 2020	**0**																	
TOTAL		**16**	12			4	6			2	**5**			**2**	1				
											**** indicates that a revised deadline has been proposed/agreed***								

ABUHB External Audits 2021 & 2022

ABUHB Ref	Audit Title	Lead Director	Total Number of Audit Recs Arising from Review	Audit Recs Arising from Review				Audit Recs Implemented to-date				Audit Recs Overdue (against original agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
				H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	H	M	L	Not rated	
202101	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	**DoFPV**	**5**	2	2	1		0	1	0		1	1	0		1	0	1		×
202102	Radiology Services – Follow-up of 2017 recommendations	**DoOps**	**1**				1				0				1					×
202103	Audit of Accounts Report – ABUHB Charitable Fund and Other Related Charities (Dec 2021)	**DoFPV**	**1**		1				0				0				1			×
202104	Taking Care of the Carers (Oct 2021)	**DoWOD**	**6**				6				5				0				1	×
202105	Structured Assessment 2021	**DoCG**	**5**	4			1	1			0	2*			0	1			1	×
TBC	Quality Governance Arrangements	**DoN**	**Not yet Reported**																	
TBC	Orthopaedic Follow Up of Recommendations Made in 2015	**DoOps**	**Not yet Reported**																	
TBC	Arrangements for Securing Efficiencies	**DoFPV**	**Not yet Reported**																	
TBC	Unscheduled Care Arrangements	**DoOps**	**Not yet Reported**																	
TOTAL			**18**	6	3	1	8	1	1	0	5	**3**	**1**	**0**	**1**	2	1	1	2	
												**** indicates that a revised deadline has been proposed/agreed***								

KEY:	
MD	Medical Director
DoN	Director of Nursing
DoTHS	Director of Therapies & Health Science
DoPPDIT	Director of Planning, Performance, Digital & IT
DoPHSP	Director of Public Health & Strategic Partnerships
DoPCCMH	Director of Primary, Community Care & Mental Health
DoFPV	Director of Finance, Procurement & Value
DoOps	Director of Operations
DoCG	Director of Corporate Governance

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk and Assurance Committee 2nd August 2022 Agenda Item: 2.4

Aneurin Bevan University Health Board

AUDIT RISK AND ASSURANCE COMMITTEE -STRATEGIC RISK REPORT

Executive Summary

This report provides an overview of all **26** strategic risks described on the Corporate Risk Register.

Response to the COVID-19 pandemic, through front line service delivery, restart and recovery plans, Primary and Secondary Care demand increase and associated risks continue to have the greatest impact on service delivery. This sustained response continues to represent the most significant risk to the Health Board's delivery of its non-COVID-19 services and the achievement of the objectives outlined within the IMTP 2022/23.

The Committee is asked to note and receive updates within this report on the continued development of the Once for Wales (OfW) RL DATIX risk management module. An update on the Risk Management Benefits Realisation Plan will be presented to the Committee in October 2022 alongside a review of the Risk Management Strategy.

The Committee is also requested to note the overview of the Corporate Risk Register at ***Appendix 1*** and note the updates on the risk profiles that receive oversight from this Committee at ***Appendix 2***.

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

Executive Sponsor:	**Rani Mallison, Director of Corporate Governance**		
Report Author:	**Danielle O'Leary, Head of Corporate Services, Risk and Assurance**		
Report Received consideration and supported by :			
Executive Team	**X**	**Committee of the Board**	
Date of the Report: 22nd July 2022			
Supplementary Papers Attached: **Appendix 1 – Dashboard of Corporate Risk Register** **Appendix 2 – Committee Risk Profiles**			

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks which encompass the Corporate Risk Register and form the strategic risk profiles for the Health Board.

Background and Context

This report provides the Audit, Risk and Assurance Committee with an opportunity to review the organisational strategic risks which receive oversight across all Committees and the Board.

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Internal controls and action plans are then developed to mitigate the risk and reduce either the likelihood, consequence, or both. Committees are then responsible for the active monitoring and review of all risks which receive oversight from each respective committee.

Risk Management ensures that the Health Board focuses on the risks and concerns that may impact on the organisations ability to deliver its objectives. Whilst active risk management is performed daily at an operational level, the Health Board's risk management strategy and process ensures that the Board is informed, engaged, and assured about the approach that Health Board uses to identify and respond to perceived risks.

The approach adopted by the Health Board to strengthen the alignment between Board and Committee business and the Board Assurance Framework continues to embed and provide a foundation for Board and Committee business to be risk based and focussed on assurance needs. This approach will also help to ensure the correct business is directed to the most appropriate committee.

Assessment and Conclusion

Executive Engagement and Divisional Review

Following a review of all Divisional risks captured through the DATIX electronic risk management system has been undertaken and several 'themes' were identified. From this information the Health Board was able to determine 5 new risks and 1 re-framed existing risk. These risks have subsequently been approved by Executive Team and the Board for inclusion in the Corporate Risk Register.

Risk of Health needs/complexities of the population not being met	***Due to*** the Clinical Futures model of care not taking into consideration the evolving population needs
Risk of unsustainable provision of Primary Care Services	***Due to*** a range of factors including changes in professional working practices, impact of

	COVID and new demand e.g. impact of the Ukrainian refugee crisis.
Risk of an inability to deliver components of the Health Board's overarching strategy and key priorities	***Due to*** an essential reliance and involvement of Key Partners
Risk of clinically unsafe and inappropriate inter-site patient transfers and into communities	***Due to*** lack of availability of safe and appropriate transfer vehicles, staff and skill mix to facilitate the transfers.
Risk of an inability to staff acute sites appropriately and provide acceptable levels of care in line with best practice and guidelines.	***Due to*** Increased levels of patient acuity presenting
Risk of delays in discharging medically fit patients	***Due to*** partly due to delays in accessing packages of care from Partners -covered in part by CRR019 (unmet demand and ambulance delays) on CRR

OfW RL DATIX risk management module – progress

The most last reporting period has seen a lack of progress in relation to the National work being undertaken to devise an all-purpose electronic risk management system. However, more recently the National DATIX team has indicated that an updated version of the module should be available for Health Boards to test as a sandpit version in September 2022.

Once this has been completed, a update position in relation to the roll-out of this module will be reported to the Executive Team and the Committee with an accompanying plan to support implementation.

Risk Management Benefits Realisation Plan – Update

Significant Divisional engagement work continues to be undertaken, encouraging Divisions to cleanse data, discuss high risk areas at Divisional Management Teams and promote the use of the electronic risk management system as a business intelligence tool. A specific update on this work will be presented (as outlined in the Committee work plan) at the October 2022 meeting.

Current Organisational Risk Profile:

There are currently **26** Organisational Risk Profiles, of which **17** form Principal Risks due to the scoring being 15 or greater and form principle organisational risks. The following table provides a breakdown of the risks and level of severity:

High	**17**
Moderate	**8**
Low	**1**

A high-level breakdown dashboard of all strategic risks including, current score, target score, risk appetite level, risk treatment and trend since last reporting period is included at ***Appendix 1***.

Since the establishment of the Finance and Performance Committee, several risks that previously received oversight at ARAC have been transferred to FPC. Consequently, there are now 2 risk profiles that receive oversight from Audit, Finance and Risk:

- **CRR004 – Well-being of Future Generations Act and Socio-Economic Duty**
- **CRR034 – Health Board response to the Ukraine crisis.**

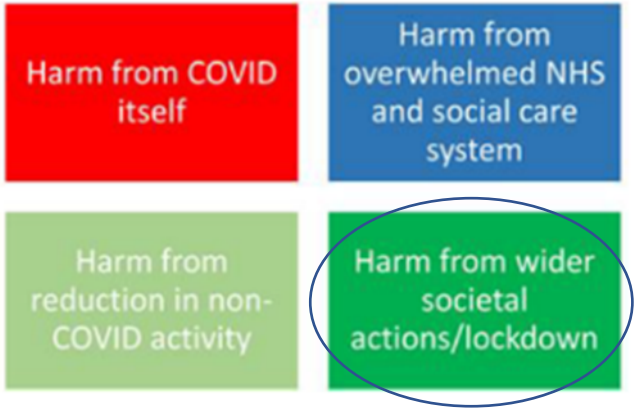
A breakdown and detail on these risks are appended to this report at ***Appendix 2*** and there has been no change to these risks since the last reporting period. The Committee is however asked to note that elements of the Ukraine crisis risk is covered in a new risk approved by the Board at its July 2022 meeting and relates to sustainability of Primary Care Services. This new risk is included as part of the corporate risk register overview and should be considered in conjunction with CRR034.

Recommendation
The Committee is requested to: • Note updates received and acknowledge that Executive risk owners have reviewed their respective risks. • Note the National position in relation to the OfW RL DATIX risk management module.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of New Terms	Not required.
Public Interest	Report to be published.

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="4">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2" rowspan="2">• This is an enabler risk and therefore impacts the Health Board's ability to achieve all objectives and strategic priorities</td><td colspan="4">CRR034 *this risk should be considered in conjunction with the new primary care sustainability risk*
Risk of disruption of provision of Health Board services
Due to the ongoing Ukraine crisis.</td></tr>
<tr><td colspan="4">Impact
Potential workforce, resource and financial implications in responding to the crisis and fulfilling expectations of Welsh Government due to the country being a 'super sponsor'.</td></tr>
<tr><td>High Level Themes</td><td>• Partnership
• Quality and Patient Safety
• Patient Outcomes and Experience
• Finance
• Public Confidence
• Reputational</td><td colspan="2">Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Audit, Risk and Assurance Committee</td><td>• Service Business Continuity Plans (BCPs)
• Service Contingency Plans
• Internal demand modelling data related to numbers of refugees incoming to the Health Board area.
• Welsh Government guidance on healthcare provision for asylum seekers/refugees.
• Internal bi-weekly meetings convened to report directly to Executive Team with</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td colspan="2">Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	escalations and by exception.							
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			3	5	2	5	1	5
Conduct analysis of Business Continuity Plans across sites and Divisions to ensure a state of readiness and ensure that this is communicated with key individuals across the organisation. Review and testing of Health Board Civil Contingencies Plans. Workforce colleagues identify and ensure support for staff who have family or friends in the Ukraine or Russia.		Ongoing Ongoing Ongoing	**15**		**10**		**5**	
Trend			**Executive Owner: Director of Planning, Digital and ICT**					
Mapping Against 4 Harms of COVID			**Update**					
			July 2022 A focus group has been established to meet monthly to discuss any potential risks as the crisis develops. This group will report to Executive Team by exception as and when required. The Community and Primary Care Division group meets weekly relating to the refugee workstream. A clear governance structure from Welsh Government has not been agreed however, it is anticipated that it will likely report to the regional Public Service Board (PSB). Structures in place for different aspects of the resettlement sponsorship schemes. Each Local Authority managing the process in their Borough the Health Board work with and across the Local Authority areas. Governance routes already established consist of: • Health Board Cyber security team liaise with the NCSC • Business Continuity into the Tactical Business Continuity Group. Health Board representatives from Emergency Planning Team form part of the membership of the Local Resilience Forum. The sponsorship routes have supported increasing numbers of refugees, with visas issued to support relocation to Wales. Each LA have been asked to identify suitable venues for refugee housing.				

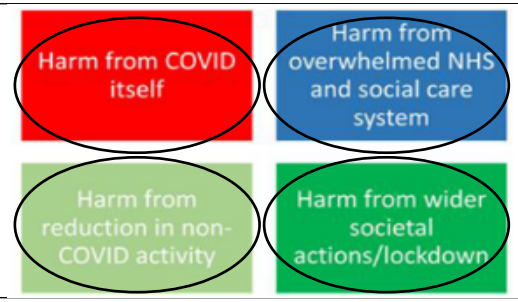
	There are 2 Welcome centres in the Gwent area, the use of Hotels across Boroughs, and refugees housed with families. The Health Board provides Health Assessment and screening for all refugees within agreed timeframes prior to individuals being registered with a General Practitioner in the local area.

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="2">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="2">CRR004 (Nov 2021) – (Reframed)
Risk of Non-compliance with relevant Legislative requirements.
Due to The Health Board does not meet its statutory duty under the Well-Being of Future Generations (Wales) Act 2015 or the Socio-Economic Duty.

TAKE OPPORTUNITIES TREAT

Impact
Negative impact on Health Board reputation and levels of public confidence would be low. If actions not taken to comply with the Acts, could potentially create sustained reliance on Health Care services in the future.</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Research, Innovation Improvement Value
Quality and Patient Safety
Patient Outcomes and Experience
Health Inequalities
Financial
Public Confidence</td><td>Risk Appetite</td><td>Moderate (cautious risk taking)
Risk Appetite
Level 3</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="2">Risk Score</td></tr>
</table>

Audit, Risk and Assurance Committee	Programme Board in place to ensure the duties in the WBFA are applied across the organisation. Each Division has developed and agreed wellbeing objectives which have been signed off by Board and published. Organisational wellbeing objectives and PSB(s) wellbeing objectives reflected within the IMTP and Divisional Plans.		**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			3	4	1	4	1	4
WBFA management arrangements to be reviewed post pandemic. Programme Board operations and wellbeing objectives to be re-set during 2022-23 to reflect maturity of WBFA arrangements. Development work is underway to incorporate the statutory obligations of the Socio-economic Duty to the corporate reporting templates of the Health Board to emphasise the importance of the Duty across the organisation.		Mar-23 Ongoing	**12**		**4**		**4**	
Trend			**Executive Owner: Director of Public Health and Partnerships and Board Secretary**					
Mapping Against 4 Harms of COVID			**Update**					

	Jun 2022: Pre-pandemic management arrangements to support adherence to WBFA requirements will be reviewed and re-set during 2022/23. This will reflect the post-pandemic position, as well as the ongoing prominence of the legislation in Wales. This will result in a re-statement of wellbeing objectives in the Health Board and a re-set of management arrangements. The Marmot Region programme of work through Gwent PSB is a significant demonstration of the Health Board's commitment to compliance with the Socio-Economic Duty.

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(June 2022 PQSO)** 	**PQSO**	**Director of Operations**
CRR002 Failure to recruit and retain staff across all disciplines and specialities leading to adverse impacts on delivery of care to patients across acute and non-acute settings and non-compliance with safe staffing principles and standards **(re-**	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles.	**No**	**Treat** the impact of the risk by using internal controls.	**(May 2022 Board)** 	**P&C**	**Director of Workforce and OD**

framed Jan 2022)								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Nursing**
CRR020 Failure to implement WCCIS leading to inaccessibility of essential patient information.	16	10	**High** level of appetite for risk in this area to innovate in the area of digital technologies. **Low** level risk appetite for the realisation of this risk and to maintain patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(June 2022 PQSO)** 	**PQSO**	**Director of Operations**
CRR007 Inability to reflect demands of an increasingly aging population. ***re-framed July 2022*** Clinical Futures model of care does not take into consideration the evolving needs of	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.	**(June 2022 PPHPC)** 	**PPHPC**	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships**

the population at this time								
CRR010 Inpatients may fall and cause injury to themselves.	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(June 2022 PQSO)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population,	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(June 2022 PQSO)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

for Mental Health support, in light of the COVID 19 pandemic.			reconfigure services and implement new arrangements.					
CRR026 Risk to the general population and patients already within our services, due to less than adequate surge capacity to address any further exponential increase in pandemic response. ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Operations**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**(May 2022 Board)** 	**ARAC**	**Director of Public Health and Strategic Partnerships and Board Secretary**
CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**

CRR016 Achievement of Financial Balance	16	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However, responding to COVID 19 implications and maintaining safe services take precedence.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 FPC)** 	**FPC**	**Director of Finance and Procurement**
CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PPHPC)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate. **Moderate** risk appetite with regard to innovation and developments across the Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence***	**(May 2022 Board)** 	**FPC**	**Director of Operations**

					should the risk be realised, is significant.			
CRR032 Failure to achieve underlying recurrent financial balance	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 FPC)** 	**FPC**	**Director of Finance and Procurement**
CRR033 (Dec 2021) Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR021 Welsh Language Act Compliance	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**P&C**	**Director of Workforce and OD**
CRR025 Well Being of Staff and normalisation of risk	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**P&C**	**Director of Workforce and OD**
CRR034 (April 2022) Disruption to Health Board services due to the Ukraine crisis.	10	5	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when reviewing regional responses to the crisis and how the Health Board and its Partners can work collectively to address and mitigate the risks.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**ARAC**	**Director of Planning, Performance and ICT**
CRR035 Sustainability of Primary Care Services due to	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PPHPC**	**Director of Primary, Community and**

increased demand, revised working patterns and continued response to Ukrainian refugee crisis.			innovative ways of providing Primary Care Services.		**Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.			**Mental Health Services**
CRR036 Inability to deliver components of the Health Board's strategy and key priorities where the involvement of key Partners is essential	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PPHPC**	**Director of Planning, Performance and ICT.**
CRR037 Clinically unsafe and inappropriate inter-site patient transfers and into communities	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PQSO**	**Director of Operations**
CRR038 Increased levels of patient acuity presenting resulting in an inability to staff appropriately and provide acceptable levels of care in line with best practice and guidelines.	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PQSO**	**Director of Nursing/Director of Operations**

CRR039 Delays in discharging medically fit patients partly due to delays in accessing packages of care from Partners - *__covered in part by CRR019 on CRR (unmet demand and ambulance delays)*__	20	10	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.		**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**NEW RISK**	**PQSO**	**Director of Operations and Director of Primary, Community and Mental Health Services.**

Audit, Risk & Assurance Committee

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

Executive Summary

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

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

The Audit, Risk and Assurance Committee is requested to

- Note the contents of this report.

- Approve the amendments to the following financial control procedures:
  Recovery of Overpayments to Employees
  Budgetary Control

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

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

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

Report Received consideration and supported by:

Executive Team		**Committee of the Board [Audit, Risk and Assurance Committee]**	

Date of the Report: 7th July 2022

Supplementary Papers Attached:

Appendix 1 –Recovery of Overpayments to Employees Financial Control procedure
Appendix 2 –Budgetary Control Policy & Procedure
Appendix 3 – Financial Control Procedures Status
Appendix 4 – Single Tender Action

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

Assessment and Conclusion

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

There is no further update in relation to this issue.

2. Financial Control Procedures (FCP)

The FCPs to be reviewed at this Committee as part of the regular programme of updates are below. The renewal schedule is stated in Appendix 3. The procedures are:

- Recovery of Overpayments to Employees
- Budgetary Control Policy & Procedure

The Capital Assets and Charges; Losses and Special Payments and Stores and Stock procedures will be presented at the October meeting.

A summary of the main changes is set out in section 3.0 below. The full revised FCP's are included as Appendix 1 and 2.

2.1 Recovery of Overpayments to Employees

This procedure sets out a process for recovering overpayments that is fair and takes due regard to personal financial circumstances of staff. It clearly sets out the responsibilities of Payroll Services, Corporate Finance, line managers, staff and the Counter Fraud department who are all involved in the process.

The main changes to the procedure are set out below and highlighted in yellow in the procedure document.

Paragraph	Summary of change
7.3.2	*Significant Overpayments* – Payroll will notify Corporate Finance of the issue within 10 working days of confirmation (previously no deadlines were set).
7.4	*Repayment of Debt and Repayment Terms* – in order to agree a repayment plan, the employee is required to provide documented evidence of correspondence with a recognised debt support service (no documented evidence was previously required).
7.5	*Payroll Query Process* – employee to contact Payroll with query. Payroll to reply in a timely manner, no later than 10 days (previously no process documented).

The document has been circulated for comment as follows:

- Head of Financial Services & Accounting
- Treasury Manager
- Payroll Services Manager
- NWSSP – Audit and Assurance Services

2.2 Budgetary Control

The Health Board has a statutory requirement to meet its financial duty to break even. Operationally that requirement is to provide services within allocated resources. One of the key mechanisms for ensuring this requirement is met, is a sound system of budgetary control.

This Budgetary Control procedure provides a framework for financial control and sets out the responsibilities from the Board down to the delegated budget holders.

The main changes to the procedure are set out below and highlighted in yellow in the procedure document.

Paragraph	Summary of change
2.1	Integrated Medium-Term Pan (IMTP) – reference to the Welsh Government's Citizen Centred Governance principles included
6.6	Budget Holders – responsibilities updated as per the revised Standing Orders (March 2021) wording
7.6	Changes to the Budget – clarification on Board notification and potential approval
8.0	Training – reference to the Finance Business Intelligence tool training included

The document has been circulated for comment as follows:

- Assistant Finance Director (Financial Strategy/Planning)
- Head of Financial Strategy
- Head of Management Accounting and Costing
- NWSSP – Audit and Assurance Services

3. Technical Accounting Issues

There are no new technical accounting issues to report to the Committee.

4. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of June. The Health Board has not achieved the target to pay 95% of the number of non-NHS creditors within 30 days of delivery of goods in June or cumulatively. A large number of the invoices paid outside of the target relate to Agency and Pharmacy homecare.

Category	Invoices	In Mth %	YTD %
Non-NHS	Value Number	94.0 91.7	95.0 93.6

The Resource Bank team are currently not able to process the volume of agency invoices within the timescale needed to achieve the required performance, and this makes up 50% of the invoices that breached the PSPP.

The Corporate Finance senior team are working extensively with and supporting the Resource Bank to help improve payment processing times. An action plan has been developed to tackle the backlog of invoices as well as improve processes for new invoices. Processing these invoices however will have a short-term adverse impact on the PSPP figures, due to their age.

The PSPP target has also been breached with regard to the issues with Pharmacy-Homecare invoices (11% of the total). There are currently 3 vacancies in the Pharmacy invoice processing team, which is having a significant impact on them being able to process invoices. The Senior Pharmacy team are working to try to recruit to these vacancies.

5. Single Quotation and Tender Actions – 25th March to 30th June 2022

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

There have been 10 requests submitted and approved during the period with a total value of £546,902.15 Ex VAT. Appendix 4 provides the full detail.

6. Payments in Excess of £100K

In May 2022, the process for paying the General Medical Services contractor payments was transferred from NWSSP – Primary care Services to NWSSP – Accounts Payables. This is following a similar move in February 2021 for the processing of the Pharmacy & Ophthalmic Contractor Services payments. These payments are now processed via BACS

through Oracle FMS. As such, these payments are included in the review of all payments made in excess of £100K.

There were no exceptional issues to report.

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*
Quality, Safety and Patient Experience Assessment	*Not applicable*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*No applicable*
Link to Integrated Medium Term Plan/Corporate Objectives	*SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant*
Glossary of New Terms	*FCP – Financial Control Procedure* *SFIs - Standing Financial Instructions* *SOs - Standing Orders* *NWSSP - NHS Wales Shared Services Partnership*

Summary Position on Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Recovery of Overpayments to Employees	22/23	Due for review		03-Apr-22	Aug 22 Audit Committee
Budgetary Control Policy & Procedure	22/23	Due for review		19-Jul-22	Aug 22 Audit Committee
Capital Assets and Charges	22/23	Due for review		19-Jul-22	Scheduled for Oct 22
Losses and Special Payments	22/23	Due for review		19-Jul-22	Scheduled for Oct 22
Stores & Stocks	22/23	Due for review		19-Jul-22	Scheduled for Oct 22
Engaging Off Payroll Workers	22/23	Not yet due		01-Dec-22	Scheduled for Dec 22
Accounts Payable	23/24	Y	Apr-20	02-Apr-23	
Capital Procedures and Guidance Notes	23/24	Y	Apr-20	02-Apr-23	
General Ledger	23/24	Y	Apr-20	02-Apr-23	
Patients' Property	23/24	Y	Apr-20	02-Apr-23	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	23/24	Y	Apr-20	02-Apr-23	
Purchasing Cards	23/24	Y	Apr-20	02-Apr-23	
Procurement Policy	23/24	Y	Jul-20	13-Jul-23	
Deployment of Medical Agency via a Neutral Vendor (Retinue)	23/24	Y	Jul-20	13-Jul-23	
Prepayment of Goods and Services	23/24	Y	Jul-20	13-Jul-23	
Patients' Travel Costs Policy	23/24	Y	Oct-20	22-Oct-23	
Cash and Bank	23/24	Y	Oct-20	22-Oct-23	
Petty Cash	23/24	Y	Dec-20	03-Dec-23	
Petty Cash - Mental Health	23/24	Y	Dec-20	03-Dec-23	
Accounts Receivable	23/24	Y	Feb-21	04-Feb-24	
Approval of Orders over £100K	23/24	Y	Feb-21	04-Feb-24	
Salary Sacrifice	24/25	Y	Aug-21	12-Aug-24	
Policy for Out of Area Referrals to Secondary Care	24/25	Y	Aug-21	12-Aug-24	
Overseas Visitors	24/25	Y	Feb-22	03-Feb-25	
Charitable Funds	25/26	Y	Apr-22	19-Jul-25	

Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
23/03/2022	Single Tender Request	ABU-STA-50041	Subscription to Online Database	£62,546.46	Wolters Kluwer UpToDate	Services	It offers synthesised and detailed expert medical "advice" to clinicians on treatment enabling a quick decision based on evidence. It is unique in offering this "advice" by qualified and experienced clinicians. It is widely used by nurses, allied health professionals, pharmacists as well as medical staff. It is available online through both NHS Wales PCs and through the personal devices of staff so it is immediately available at point of care. This makes clinical decisions quicker and safer, reducing the risk to the HB of poor or slow decisions. particularly by less experienced junior doctors or advanced nurse practitioners. It also means that staff in the community and remote areas would be able to access it. It also supports GP practices or in remote areas. Other Health Boards in Wales which have a subscription to UpToDate Anywhere on a multi year deal are: • Cwm Taf Morgannwg • Betsi Cadwalladr Cardiff & Vale Swansea Bay	Approved as there is only one supplier available who holds the copyright to UpToDate content.	Approved	23/03/2022	
28/03/2022	Single Tender Request	ABU-STA-50069	Development support of the Gwent Well-being Plan 2023-2028 to reduce health inequalities	£96,000.00	UCL Consultants Ltd	Services	Professor Sir Michael Marmot has over 40 years of experience in leading research on health inequalities, and his work is world-renowned. The proposal approved by Gwent Public Services Board is informed by studying Professor Marmot's work, including the cities and regions in England which are engaged with Professor Marmot and the Institute of Health Equity Team to address local health inequalities, including in light of the Covid-19 pandemic.	Required to ensure real business continuity	Approved	28/03/2022	
31/03/2022	Single Tender Request	ABU-STA-50110	Furniture & Equipment for the ABUHB Wellbeing Centre of Excellence	£27,329.69	COS Group	Goods	As this is an underspend, consideration has taken place and due to the winter pressures, Covid-19 and pressure to utilise Welsh Government underspend funding, the order could not be finalised in time. COS Group have agreed to provide all items and store these as part of a Vesting Certificate until the Wellbeing Centre of Excellence is opened in September, as there is no storage available at any ABUHB premises.	Approved due to the critical nature of the requirement and the impact on the service if the goods are not procured with the available funding.	Approved	05/04/2022	
07/04/2022	Single Tender Request	ABU-STA-50157	Lysis Buffer for COVID Testing	£236,160.00	E&O Labratories	Goods	Needed to maintain routine covid testing service – this is the only supplier providing the required volume and spec for this product. This is the only supplier for this buffer.	Approved as genuinely the only supplier in the market.	Approved	20/04/2022	20/04/2022
25/05/2022	Single Tender Request	ABU-STA-50467	Radiology Partnership Ltd	£50,000.00	Radiology Partnerships LTD	Goods	Service provider. Testing has taken place to ensure technical standards are met and Fuji are currently in the final stages of supplier agnostics to enable the sending and receiving of images to any service provider. The process will be the same, regardless of the external service provider. Within the contract with Everlight there is an exclusivity clause which states should Everlight not be able to meet NHS Wales demand in a given month there is the ability to source those services from another provider. However this is only allowable for a specific month where Everlight have advised that they cannot meet the requirements as set out within the client demand forecast.	Required to ensure real business continuity	Approved	31/05/2022	
23/03/2022	Single Quotation Action	ABU-SQA-50044	ACD Continued Works	£13,000.00	YMA (Dyna Mi Ltd)	Services	The Strategic Programme for Primary Care (SPPC) is an All-Wales Health Board-led programme that works in collaboration with Welsh Government and responds to A Healthier Wales. One of the key priorities identified for 2021/22, is the the Accelerated Cluster Development Programme (ACD) which is an ambitious Programme very much aligned with A Healthier Wales, the Care Model for Wales (PCMW) and the Programme for Government. The Accelerated Cluster Development Programme sets out a bold vision for cluster working in the future. The change required by the system is vast and Cluster Leads have set out their ambition to support the work necessary to service their communities.	Approved as genuinely the only supplier in the market.	Approved	28/03/2022	
24/03/2022	Single Quotation Action	ABU-SQA-50054	Digital Treatment and Recovery Programme	£15,000.00	Breaking Free	Services	Strengthening treatment and recovery services through digital innovation - substance use App Breaking Free Online is an evidence-based digital treatment and recovery programme for addressing substance use in community settings. Since 201 1, it has been used by community-based alcohol and drug services across the UK because it is proven to help service users overcome dependence on 75 different substances — including alcohol, New Psychoactive Substances (NPS) and prescribed medications of abuse. Due to its inherent flexibility, Breaking Free Online is currently being used by organisations to: Manage waiting lists — engagement tool that keeps service users motivated from the point of referral to the stan of structured treatment Reinforce Medication-Assisted Treatment — helps service users stabilize or detox from methadone/buprenorphine, manage cravings and regulate their emotions Augment telehealth/virtual care provision — overcomes treatment barriers such as stigma, social distancing, rurality, work or childcare commitments etc. Facilitate Computer-Assisted Therapy (CAT) — delivered by practitioners and clinicians in either one-to-one or groupwork formats Tailor intervention programmes — used to target hard-to-reach groups or specific cohorts of service users — e.g. women, crack/stimulant and NPS users etc. Support peer mentoring initiatives — enables peer supporters with lived experience to deliver structured interventions and strengthens their own resilience Strengthen continuing care approaches — aftercare tool that helps service users transition between services/treatment modalities	Approved as genuinely the only supplier in the market that can match all requirements.	Approved	28/03/2022	
25/03/2022	Single Quotation Action	ABU-SQA-50071	USW CBT Training	£19,616.00	University of South Wales	Services	The training delivered by USW will be tailored the developmental needs of current STaR workers Working in PCMHSS. This will support the delivery of evidence-based interventions to patients currently waiting on the PCMHSS low intensity wait list. An audit of the Low intensity wait list indicates Anxiety and low mood to be the predominant presenting issues. Training in interventions such as behavioural activation, anxiety management and worry management Is needed to ensure that STaR workers are delivering an intervention that is evidence based and prudent. Low intensity CBT is a feature of PCMHSS matched referrals received by PCMHSS. The STaR worker role is unique to PCMHSS and differs from the PWP role. STaR workers deliver low intensity intervention to individuals and groups. The need for CPD for STaR workers is paramount to the delivery of highquality inter,'entions to Patients referred into the service by GP's.	Approved as genuine need to retain a particular contractor for business continuity as tailored services for ABUHB	Approved	28/03/2022	
09/05/2022	Single Quotation Action	ABU-SQA-50385	PCC Workshops	£12,250.00	Primary Care Commissioning	Services	The Strategic Programme for Primary Care (SPPC) is an All-Wales Health Board-led programme that works in collaboration with Welsh Government and responds to A Healthier Wales. One of the key priorities identified for 2021/22, is the the Accelerated Cluster Development Programme (ACD) which is an ambitious Programme very much aligned with A Healthier Wales, the Primary. Care Model for Wales (PCMW) and the Programme for Government. The Accelerated Cluster Development Programme sets out a bold vision for cluster working in the future. The change required by the system is vast, not least in the professional collaborative area. PCC has supported the SPPC with background research on primary care models in England, including presenting to the team to develop thinking around the ACD model. In addition, they have developed draft collaborative guidance and draft guidance on managing conflicts of interest. All of which are included in the ACD toolkit - a resource used to support and inform ACD work. They have an understanding of the landscape in Wales and deep knowledge of the aims of the Community Infrastructure and Accelerated Cluster Development programmes of work which are unique to them due to the work they have undertaken over the last year. They have experience of running similar workshops in different Health Boards across Wales and are subject matter experts in their field.	Approved as genuine need to retain a particular contractor for business continuity	Approved	18/05/2022	
19/05/2022	Single Quotation Action	ABU-SQA-50408	Palliative Care Transport Service until August 1st	£15,000.00	ETS Medical	Services	Transport service between the GP Out of Hours Service, community pharmacies and patients homes within Aneurin Bevan UHB. The principle of the service is deliver pallitive care care medication to patients at their home. ETS have been providing the service for over 10 years. Currently no contract in place, however a tendering process is being undertaken to award a 4 year contract from the 1st Aug 2022.	Required to ensure real business continuity while new contract is set up.	Approved	31/05/2022	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Tuesday 2nd August 2022 Agenda Item: 4.1

Aneurin Bevan University Health Board
Counter Fraud Progress Report

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit Committee. It highlights the Counter Fraud work which has been undertaken by the Local Counter Fraud Specialist (LCFS) to date during financial year 2022/23.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	√		
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	√		
Executive Sponsor: Robert Holcombe – Director of Finance, Procurement and Value (DoF)			
Report Author: Martyn Edwards – Head of Counter Fraud			
Report Received consideration and supported by: Director of Finance, Procurement and Value			
Executive Team		**Committee of the Board [Audit, Risk and Assurance Committee]**	
Date of the Report: 20th July 2022			
Supplementary Papers Attached: Counter Fraud Progress Report			

Purpose of the Report
To update Audit Committee of work progress of Counter Fraud Team.

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

Assessment and Conclusion
This report will contribute towards the annual Quality Assurance Self-Review as evidence that ABUHB has complied with the aforementioned Functional Standards.

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

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

On behalf of

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Counter Fraud Progress Report

Martyn Edwards
Head of Counter Fraud
Aneurin Bevan University Health Board

Contents

1 Counter Fraud Staffing

With the departure of two LCFS from the team, the Fraud Team has functioned at a one-third staffing capacity during Q.1 of the current financial year. A recruitment drive has taken place in order to fill the two posts and one new LCFS has been appointed with a proposed commencement date of 25th July 2022. The new appointee is already an accredited LCFS so there are no immediate training and development requirements.

Due to shortage of applicants, the recruitment process was re-run and closed on 13th July 2022, following which, the selection/interview process continues.

2 Issues

The impact of the staffing deficiency is that it has had a capacity impact on the LCFS to undertake any Local Proactive Exercises or Risk Assessment work during Q.1 of the financial year.

3 Staff awareness

The fraud awareness programme undertaken by the LCFS is reaching its target audience and all mediums are being promoted and exploited in order to actively encourage fraud referrals. Eight (8) such referrals have been received during Q.1.

In ABUHB, for PADR purposes, Counter Fraud awareness input at Corporate Induction and the fraud awareness e-learning programmes remain mandatory requirements. Financial year to date, 361 members of staff have completed Corporate Induction which includes the fraud awareness input.

In addition to the aforementioned numbers, a further 55 members of staff have received awareness inputs at four sessions of the 'Taking the Lead' programme which is a programme for aspiring future NHS Senior Managers.

Furthermore, these numbers do not include uptake figures for the All-Wales Counter Fraud e-learning module which will be provided to Audit Committee once available.

The LCFS has redesigned and reinstated the Counter Fraud webpages on the ABUHB intranet following the predecessor webpages being disabled on the migration to the 'Pulse' system. These webpages promote fraud awareness, provide guidance on referrals and highlights the fraud referral form itself.

4 Fraud prevention activity

The LCFS has actioned the following alerts and fraud prevention notices during Q.1.

FPN H-001-22 – payment terminal fraud.
FPN H-002-22 – cyber enabled mandate fraud.
Alert notice 1616 – salary diversion fraud.
Iburn alert notice 2022-05-01 – bogus consultant.

National Fraud Initiative

The LCFS closed off on all data matches on the NFI, prior to the Cabinet Office formal closure of the 2020/21 initiative on 20th July 2022. No areas of concern were identified for ABUHB. The new data lift for the 2022/23 initiative, in which, the NHS is mandated to participate, will commence in October 2022.

5 Reactive work

A list of current investigations is detailed in Appendix (1)

Appendix 1

INDEX OF LCFS INVESTIGATIONS AS AT 15th July 2022

Case	First Ref	Health Body	Area	Subject	Status
1.	WARO/19/00145	ABUHB	NHS Staff	Falsify WLI claims.	CPS declined charging decision.
2.	WARO/19/00122	ABUHB	General Practitioner	Falsify information on application for Welsh G.P. performers list.	Subject has been interviewed under caution. CPS declined to charge. Subject has been suspended from practising by GMC pending fitness to practice hearing.
3.	WARO/20/00020	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Dismissed from employment on 21/10/2020 following disciplinary action. NMC sanction impending.
4.	WARO/21/00003	ABUHB	NHS Staff	Theft of medication.	Dismissed for gross misconduct on 10/08/2021 following disciplinary action. Police sanction Women's pathway. NMC sanction impending.
5.	INV/21/00267	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Investigation ongoing. Civil recovery of £28,328.68 implemented.

6.	INV/21/00276	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Subject interviewed under caution & prosecution file of evidence forwarded to CPS for charging decision. Defendant charged with fraud. Pleaded guilty at Merthyr Magistrates Court on 01/07/2022. Case referred to Merthyr Crown Court on 29/07/2022 for sentence. Financial recovery of £21,389.69 pursued.
7.	INV/21/00294	ABUHB	NHS Staff	Falsification of hospital appointments.	Investigation ongoing.
8.	INV/22/00060	ABUHB	Member of public	NHS compensation claim.	Investigation ongoing.
9.	INV/22/00110	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.
10.	INV/22/00123	ABUHB	NHS staff	False declaration on job application form.	Investigation ongoing in joint venture with Gwent Police.
11.	INV/22/00388	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Disciplinary and civil action impending.
12.	INV/22/00529	ABUHB	Member of public	Illegal supply of prescription drugs.	Joint investigation with Police, criminal charges to be proffered.

13.	INV/22/00690	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
14.	INV/22/00691	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
15.	INV/22/00692	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
16.	INV/22/00693	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Investigation ongoing. Financial recovery of £33,920.00 implemented.
17.	INV/22/00899	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
18.	INV/22/00925	ABUHB	NHS staff	Overtime fraud.	Investigation ongoing.
19.	INV/22/00926	ABUHB	NHS staff	Overtime fraud.	Investigation ongoing.

Aneurin Bevan University Health Board

Post Payment Verification End of Year Progress Report – 1st April 2021 to 31st March 2022

Executive Summary

The report is capturing 12 months of Post Payment Verification visits for the financial year 2021-2022 and covers Medical and Ophthalmic services. In the format of report, we are capturing the history of a practice of the course of their current visit and two historical pre-ceding visits to demonstrate levels of performance over a longer time.

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

Executive Sponsor: Director of Finance, Procurement and Value			
Report Author: Amanda Legge, Post Payment Verification Manager			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board [Audit, Risk and Assurance Committee]**	
Date of the Report: 20th July 2022			
Supplementary Papers Attached: Excel Report			

Purpose of the Report

The reports highlight the narrative on how practices have been performing over the current PPV cycle, and two previous visits that have been undertaken. It also demonstrates the overall performance of the University Health Board (UHB) against the national averages. Post Payment Verification 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).

Background and Context

To effectively respond to challenges identified within Primary Care and moving forward in 2021 with the Covid-19 pandemic, a review of opportunities have been considered during this time, to maintain an acceptable level of PPV, which would

continue to provide Health Boards with assurance that public monies are being appropriately claimed.

These decisions have been taken to protect our front-line services, to maintain colleagues' safety and to remove any pressure on primary care contractors and their teams during unprecedented times.

The paper is being produced for the Committee to review for information purposes and discussion.

PPV provides assurance in all contractor disciplines, except for General Dental Services. At certain times throughout COVID-19, cash flow to medical and ophthalmic contractors has been maintained based on historical claiming patterns, due to submission of claims for various enhanced services being suspended.

NWSSP reviewed how it was able to reinstate an agreed level of PPV within both the Ophthalmic, Pharmaceutical and Medical disciplines along with the Clinical Waste Audit.

Assessment and Conclusion

General Medical Services (GMS)

The visit plan runs on a 3-year cycle. Following review of the All-Wales visit plan and the inability to perform physical visits, we concentrated on our PPV arrangements within the GMS discipline. These visits can be completed remotely and would not be intrusive or place additional requirements on local front-line service provision. Remote access verification took place based on a sample of claims submitted from April 2019 to March 2020, due to the sudden decrease of claims from the point of lockdown in March 2020. It was agreed by the General Practitioner Committee Wales and Heads of Primary Care that PPV proceed with the GMS visits during the 2021-2022 financial year as part of the PPV three-yearly cycle, utilising 2019-2020 claim data from April 2021.

General Ophthalmic Services (GOS)

Pre COVID-19, the visit plan for GOS 2020-2021 was agreed by Health Board Audit Committees. However, ophthalmic practices were unable to remain open to the public for certain periods and this is a service where PPV teams did not have the ability to undertake reviews via remote access. We explored PPV remote access options, with full support from Optometry Wales, and have begun to carry out these visits via Microsoft TEAMS which is proving successful. Future visits will now be included in the 2022-2023 visit plan, and we are hoping to increase the number of contractors as we progress in this new way of working which is being encouraged by Welsh Government. We also continue to undertake the GOS quarterly patient letter programme across Wales to provide additional elements of assurance to our Health Boards.

Pharmacy Services (GPS)

Due to COVID-19, the Medicines Use Review (MUR) service was stopped in March 2020. In 2022, NWSSP is currently introducing a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and the Collaborative Working Scheme.

Other PPV work

- PPV have been conducting Bonus Payment checks (as requested by Welsh Government) relating to payments claimed and made to Primary Care Health Service staff in 2021.
- Provision of Additional Training Methods
- PPV Pilot - Checking eligibility of patients who qualify for Dispensing. Ready to roll this out nationally.

The additional reports submitted detail specific risks as outliers in a traffic light system, and provide the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.
The GMS statistics worksheet now separates the routine and the revisit averages. Revisits are generally higher percentages due to 100% of the claims being checked over a longer period.

- PPV have been conducting Bonus Payment checks (as requested by Welsh Government) relating to payments claimed and made to Primary Care Health Service staff in 2021.
- Provision of Additional Training Methods
- PPV Pilot - Checking eligibility of patients who qualify for Dispensing. Ready to roll this out nationally.

The additional reports submitted detail specific risks as outliers in a traffic light system, and provide the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.
The GMS statistics worksheet now separates the routine and the revisit averages. Revisits are generally higher percentages due to 100% of the claims being checked over a longer period.

Recommendation
The report is for assurance and review by the committee. We are proactive in our support, guidance and training we deliver to our contractors to aid with further improvements.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report details specific risks as outliers in a traffic light system, but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving.
Financial Assessment	N/A

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

We have representatives from every Health Board in Wales and have set up a newly reformed GMS working Group. These meetings are held bimonthly and are very successful. This is to keep communications open and transparent between PPV and Health Boards whilst also collaboratively working to review specifications and ensure standardised approach for PPV remote access samples.
Hold National and local counterfraud (CF) quarterly meetings to discuss the PPV work being carried out and any issues that we feel need to be raised.This establishes excellent working communications with our CF colleagues across Wales and avoids any duplication of work.
We are in the process of becoming an All Wales service. This will guarantee a more robust PPV team and ensure business continuity.
We have developed a video recorded guide to PPV to aid contractors and equip them with useful information in a simplified format/update FAQ documents.
To use technology to continue one-on-one training requirements from practices that request this as this was previously undertaken in person in the practice premises.
New 360 degree PPV questionairre released to capture feedback from our contractors after a PPV visit has taken place and the file is closed.
All PPV audit reports are sent to the Director of Primary Care for information purposes and for feedback.
Began PPV training/Roadshow events to Practice Managers across Wales, utilising technology to host these events as opposed to ‘in-person’ presentations.
Currently verifiying contractor Bonus claims and payments to NHS staff in Wales as required by Welsh Government.
We have re-established our quarterly meeting with ourselves, Primary Care, Counter Fraud and finance in our quarterly meetings. The idea behind this being that we can decide on appropriate actions from the appropriate division for all the practices in Amber and Red.
General Opthalmic Services, we can now complete remote access PPV visits after a successful pilot. We continue to utilise trend analysis data to write out to patients to ensure they are receiving the services that have been claimed in their names.
PPV has begun a Pilot working on 2 New services checks for Pharmacy from April 2022. These are the Collaborative working Scheme and the Quality and Safety Scheme.
PPV to roll out Nationally a pilot whereby patients are checked for their eligibility for dispensing.

Aneurin Bevan University Health Board

GMS PPV Progress Report: April 2021 to March 2022

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave (Routine & Extended)	4.12%
April 2021-March 2022 recovery amount	£7,842.92

UHB Claim error % Ave (REVISIT)	25.42%
April 2021-March 2022 recovery amount	£11,376.75

	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 1	Jun-14	REVISIT	28.00%	£609.63	Feb-18	Routine	1.04%	£55.57	May-21	Routine	212	0	0.00%	£0.00
Practice 2	Feb-18	Routine	14.86%	£1,146.47	Sep-19	REVISIT	8.48%	£2,270.22	May-21	Routine	255	23	9.02%	£1,077.43
Practice 3	May-14	Routine	6.12%	£927.55	Dec-17	Routine	1.25%	£17.90	Jun-21	Routine	205	5	2.44%	£50.15
Practice 4	Jul-18	Routine	9.20%	£686.75	Nov-19	REVISIT	24.14%	£8,302.34	Aug-21	Routine	92	8	8.70%	£201.39
Practice 5	Dec-14	REVISIT	0.00%	£0.00	Jul-18	Routine	1.35%	£148.05	Aug-21	Routine	213	11	5.16%	£217.39
Practice 6	Apr-18	Routine	10.86%	£1,112.36	Oct-19	REVISIT	13.43%	£10,390.63	Sep-21	Routine	255	39	15.29%	£2,340.12
Practice 7	Jul-14	Routine	2.16%	£320.33	Jun-18	Routine	2.21%	£263.66	Jul-21	Extended	382	2	0.52%	£118.94
Practice 8	Oct-18	Routine	6.31%	£225.95	Jan-20	REVISIT	17.86%	£148.86	Sep-21	Routine	48	0	0.00%	£0.00
Practice 9	Apr-18	Routine	3.52%	£283.24	Jun-19	REVISIT	13.33%	£472.95	Jul-21	Routine	183	7	3.83%	£533.42
Practice 10	Nov-13	EXTENDED	9.74%	£3,205.68	Dec-18	Routine	0.00%	£0.00	Sep-21	Routine	200	14	7.00%	£686.12
Practice 11	Feb-16	REVISIT	32.11%	£3,049.11	Aug-18	Routine	0.42%	£9.80	Aug-21	Routine	256	12	4.69%	£790.46
Practice 12	Nov-15	REVISIT	6.14%	£1,602.99	Nov-18	Routine	2.13%	£93.37	Sep-21	Routine	181	3	1.66%	£107.99
Practice 13	Jan-19	Routine	2.45%	£69.80	Mar-20	REVISIT	0.00%	£0.00	Oct-21	Routine	202	4	1.98%	£40.12
Practice 14	Jan-15	Routine	1.40%	£180.98	Oct-18	Routine	3.39%	£277.82	Oct-21	Routine	190	13	6.84%	£689.59
Practice 15	Dec-18	Routine	4.76%	£24.99	Feb-20	REVISIT	9.11%	£1,467.88	Dec-21	Routine	230	15	6.52%	£456.43
Practice 16	Feb-19	Routine	1.63%	£61.48	Mar-20	REVISIT	2.94%	£25.84	Oct-21	Routine	145	0	0.00%	£0.00
Practice 17	Aug-18	Routine	2.39%	£384.79	Nov-19	REVISIT	7.23%	£2,052.91	Jan-22	Routine	209	5	2.39%	£170.23
Practice 18	Dec-18	Routine	4.89%	£471.36	Feb-21	REVISIT	25.49%	£1,151.67	Jan-22	Routine	176	0	0.00%	£0.00
Practice 19	Feb-19	Routine	4.41%	£460.98	Mar-20	REVISIT	20.96%	£1,050.00	Jan-22	Routine	316	7	2.22%	£363.14

	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 20	Oct-18	REVISIT	5.10%	£1,056.14	Oct-20	Routine	18.97%	£1,530.23	Oct-21	REVISIT	643	137	21.31%	£4,936.95
Practice 21	Feb-19	REVISIT	5.44%	£424.83	Oct-20	Routine	5.33%	£195.33	Oct-21	REVISIT	266	30	11.28%	£826.20
Practice 22	Feb-19	REVISIT	4.39%	£883.12	Nov-20	Routine	10.81%	£700.46	Oct-21	REVISIT	110	100	90.91%	£3,027.00
Practice 23	Feb-20	REVISIT	0.00%	£0.00	Nov-20	Routine	5.30%	£248.91	Nov-21	REVISIT	186	14	7.53%	£283.22
Practice 24	Apr-17	Routine	0.00%	£0.00	Oct-20	Routine	7.91%	£487.30	Oct-21	REVISIT	136	23	16.91%	£1,018.90
Practice 25	Nov-18	REVISIT	15.74%	£2,490.13	Oct-20	Routine	9.22%	£1,168.63	Nov-21	REVISIT	946	43	4.55%	£1,284.48

GMS

	Health Board			All Wales		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	35	40	25	234	187	218
Amount of claims sampled	11,049	12,745	6,237	171,919	85,352	126,261
Claim errors identified	920	1,265	515	21,550	9,954	16187
Average claim error rate	7.12%	11.44%	9.23%	12.53%	11.66%	12.82%
Recovery amount	£42,735.66	£43,719.65	£19,219.67	£466,107.55	£232,012.10	£327,058.29

	Health Board - ROUTINE			All Wales - ROUTINE		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	23	26	19	129	122	138
Amount of claims sampled	6,016	5,075	3,950	62,694	27,804	42,436
Claim errors identified	337	260	168	3,015	1,635	2568
Average claim error rate	5.44%	5.51%	4.12%	4.80%	5.88%	6.05%
Recovery amount	£15,358.05	£13,165.93	£7,842.92	£85,165.13	£68,772.35	£74,982.07

	Health Board - REVISIT			All Wales - REVISIT		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	12	14	6	105	65	80
Amount of claims sampled	5,033	7,670	2,287	109,225	57,548	83,825
Claim errors identified	583	1,005	347	18,535	8,319	13619
Average claim error rate	10.34%	22.45%	25.41%	16.97%	14.46%	16.25%
Recovery amount	£27,377.61	£30,553.72	£11,376.75	£380,942.42	£163,239.75	£252,076.22

Aneurin Bevan University Health Board

GOS PPV Progress Report: April 2021 to March 2022

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	3.88%
April 2021-March 2022 recovery amount	£108.70

	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 1	Oct-13	Routine	0.00%	£0.00	May-17	Routine	3.00%	£61.25	Oct-21	Routine	103	4	3.88%	£108.70

GOS

	Health Board			All Wales		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	33	N/a	1	185	N/a	4
Amount of claims sampled	3,672	N/a	103	21,803	N/a	412
Claim errors identified	105	N/a	4	1,084	N/a	47
Average claim error rate	3.56%	N/a	3.88%	4.97%	N/a	11.41%
Recovery amount	£4,163.13	N/a	£108.70	£40,408.95	N/a	£1,777.37

	Health Board - ROUTINE			All Wales - ROUTINE		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	28	N/a	1	155	N/a	4
Amount of claims sampled	2,884	N/a	103	16,236	N/a	412
Claim errors identified	62	N/a	4	485	N/a	47
Average claim error rate	2.15%	N/a	3.88%	2.99%	N/a	11.41%
Recovery amount	£2,327.68	N/a	£108.70	£18,037.07	N/a	£1,777.37

	Health Board - REVISIT			All Wales - REVISIT		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Number of practices visited	5	N/a	0	30	N/a	0
Amount of claims sampled	788	N/a	0	5,567	N/a	0
Claim errors identified	43	N/a	0	599	N/a	0
Average claim error rate	11.44%	N/a	0.00%	10.76%	N/a	0.00%
Recovery amount	£1,835.45	N/a	£0.00	£22,371.88	N/a	£0.00

Internal Audit Progress Report

Audit, Risk and Assurance Committee

August 2022

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

The purpose of this report is to:

- highlight progress of the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the August 2022 Audit, Risk and Assurance Committee;
- approve the merger of the Access to Primary Care and Neighbourhood Care Networks audits; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2022/23 Internal Audit Plan

There are 27 individual reviews in the 2022/23 Internal Audit Plan including two to be reported from 2021/22 and provision for follow-up work.

The table below details progress against the 2022/23 Internal Audit Plan.

Number of audits in plan:	27
Number of audits reported as final	0
Number of audits reported as draft	1
Number of audits work in progress	6
Number of audits planning	8
Number of audits not started	11
Number of audits to be merged	1
Number of audits to be reported from 2021/22	2

The following report has been issued since the meeting of the Audit, Risk and Assurance Committee on 13 June 2022:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Waste Management	Reasonable

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

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reasonable assurance report issued since the last meeting on 13 June 2022.

Waste Management (reasonable assurance)

The audit was undertaken to assess the Health Board's compliance with relevant waste management legislation and guidance, and progress towards agreed

national and local waste reduction targets. In particular, the Welsh Health Technical Memorandum (WHTM) 07-01: *'Safe Management of Healthcare Waste'.*

We found the Health Board's supporting policy to be comprehensive, with detailed guidance included within the operational procedures. However, we raised recommendations within the following areas:

- the waste management policy guidance, operational control procedures and the associated intranet content should be reviewed, as the policy has now expired;
- a Waste Risk Register should be developed, with enhanced risk reporting processes;
- enhanced waste management training awareness should be implemented;
- there should be a consistent approach to the waste streams applied in public areas within the hospital sites;
- we identified non-compliance with waste management operational procedures across all sites;
- there should be a reintroduction of waste recycling provisions and targets across the Health Board; and
- enhanced monitoring and reporting arrangements, waste updates / assurance should be provided to the Board.

4. Merger of Audits

During our planning phases for the Access to Primary Care and Neighbourhood Care Networks (NCNs) audits we identified that there is a significant overlap in the fieldwork across each audit, through the rollout of Accelerated Cluster Development across the localities. This is a key initiative with the aim of improving access to primary care services. However, the NCNs are the key drivers within this process.

Consequently, there is a significant benefit to combining both audits, to minimise fieldwork and to ensure consistency with reporting. Therefore, we ask the Committee to approve this merger. If approved, we will still complete the key areas within each audit, but report as one overall audit.

5. Other Activity

The following meetings have been held/attended during the reporting period:

- monthly meetings between the Acting Head of Internal Audit and Director of Corporate Governance;
- advice on agency invoice processing within the Workforce and OD Division;
- monthly meetings with the Director of Finance, Procurement and Value;
- Audit, Risk and Assurance Committee pre-meeting with the Audit, Risk and Assurance Committee Chair;
- review and advice over financial control procedures; and
- liaison with senior management.

6. Recommendation

The Audit, Risk and Assurance Committee is invited to note the above and approve the merger of the Access to Primary Care and Neighbourhood Care Networks audits.

Appendix A: Progress against 2022/23 Internal Audit Plan

Review	Status	Rating	Summary of recommendations	Anticipated ARA Committee
Risk Management	Not started			May
Corporate Governance	Not started			May
Financial Sustainability	Not started			February
CF - Care Closer to Home	Not started			February
Clinical Audit	Work in progress			October
Urgent Care System	Not started			May
Access to Primary Care	Possible merger with NCNs audit			December
Neighbourhood Care Networks (NCNs)	Planning			
Mental Health Transformation	Not started			February
Dementia Services	Planning			May
Infection Prevention and Control	Planning			February
Use of off-contract Agency	Planning			October
Quality Framework	Planning			December
Discharge Planning	Work in progress			October
Integrated Wellbeing Networks	Not started			February
Agile Delivery	Work in progress			October
Review of Bank Office and Temporary Staff	Not started			May
Job Evaluation Process	Draft Report			October

Monitoring Action Plans	Not started			May
Follow-up of High Priority Recommendations	Not started			May
Benefits of Digital Solutions	Work in Progress			December
Cyber Security	Planning			May
Records Management	Planning			February
Management of the Robotic Process Automation (RPA)	Planning			February
IT Strategy	Work in Progress			December
Decarbonisation	Work in Progress			October
Tredegar Health and Wellbeing Centre	Not started			February
From 2021/22 Internal Audit Plan				
Children and Young People's Continuing Care	Draft Report			October
Waste Management	Final Report	Reasonable	10 Medium, 1 Low Priority	August
Medical Equipment and Devices	Timing of audit to be assessed from quarter three onwards			

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.

Waste Management
Final Internal Audit Report

July 2022

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	SSU-ABUHB-2122-02
Report status:	Final Report
Fieldwork commencement:	02/12/21
Fieldwork completion:	22/03/22
Draft report issued:	29/04/22
Draft report meeting:	25/05/22
Proposed final report issued:	27/05/22
Management response received:	16/06/22
Final report issued:	17/06/22
Executive Lead Agreement	05/07/22
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Director of Operations
Distribution:	Director of Corporate Governance
	Divisional Director of Facilities
	Head of Estates Maintenance and Operations
	Environmental Manager
	Health, Safety & Compliance Manager
Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement
NHS Wales Audit 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 Shared Services Partnership – Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The audit was undertaken to assess the UHB's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Overview

Reasonable assurance has been issued in this area.

The matters which require management attention include:

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

Other recommendations are within the detail of the report.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Policy & Procedures	Reasonable
2	Governance & Management	Reasonable
3	Contractual Arrangements	Reasonable
4	Operational Practice	Reasonable
5	Monitoring & Reporting	Reasonable

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Policy & Procedure updates	1	Design	Medium

2	Training Provision	2	Operation	Medium
3	Operational Practice - Waste Streams	4	Design	Medium
4	Operational Practice - Waste Storage	4	Design	Medium
5	Operational Practice – Waste Minimisation/ Reduction	4	Operation	Medium
6	Monitoring of audit recommendations	5	Operation	Medium
7	Monitoring and Reporting arrangements	5	Operation	Medium

1. Introduction

1.1 Welsh Health Technical Memorandum (WHTM) 07-01: '*Safe Management of Healthcare Waste'* provides a framework for best practice waste management, to help healthcare organisations meet legislative requirements as well as identify opportunities to improve waste minimisation and reduce the associated environmental and carbon impacts of managing waste.

1.2 Effective waste management also requires compliance with the requirements of various regulatory regimes, including environment and waste, controlled drugs, infection control, health and safety and transport.

1.3 Noting that waste arising from Covid-19 patients is designated as infectious clinical waste, specific guidance has additionally been developed in the last year ('Covid-19 waste management standard operating procedure').

1.4 The Welsh Government's waste reduction targets were set out in its 'Towards Zero Waste' strategy, first published in 2010 – with a target of 70% recycling / recovery rate by 2025, and for all waste to be recycled by 2050.

1.5 This audit assessed Aneurin Bevan University Health Board's (UHB) compliance with the relevant legislation and guidance, and progress towards agreed national and local waste reduction targets.

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

- Safety of UHB staff, patients, visitors, and contractors.
- Environmental damage.
- Non-compliance with legislation, risking financial penalties or prosecution.
- Failure to achieve mandated waste reduction targets.
- Reputational damage associated with negative publicity.
- Failure to achieve value for money for the UHB.

1.7 The Environmental Manager was assigned to cover managerial absence within another operational management role during the period from December 2020 – August 2021.

2. Detailed Audit Findings

Policy & Procedures: To ensure an appropriate Waste Management Policy and supporting procedures were in place.

2.1 The UHB's current Waste Management Policy was scheduled for review by September 2021; was therefore out of date at the time of the current review. Whilst comprehensive and generally in accordance with WHTM 07 – 01 requirements, and a legacy version of the Policy is on the intranet, the Policy was being reviewed and updated by the Environmental Manager.

2.2 The policy contents identified areas for enhancement in some instances to ensure full compliance with the WHTM requirements and best practice (**MA1**).

2.3 The UHB had developed a range of supporting Operational Control Procedural (OCP) documents, providing detailed guidance on waste management practices, in line with WHTM 07-01. The OCP review dates, in a number of instances, were dated 2015 and therefore showing as out of date at the time of this review. Whilst noting the same, management advised that the OCPs were reviewed biannually, but the review dates had not been incorporated within the OCPs (**MA1**).

2.4 Recognising the above, **reasonable assurance** has been determined.

Governance & Management: To ensure an appropriate governance structure was operating, budgets were appropriately monitored, risks recorded, monitored, and escalated, and training appropriately delivered.

2.5 The current Waste Management Policy(v4) states that the Chief Executive (CEO) is ultimately responsible for ensuring waste is managed in accordance with legislative requirements. The Director of Estates and Facilities is the nominated Director responsible for matters relating to the waste management, accountable to the CEO for ensuring that staff fully implement the Waste Management Policy and documented procedures.

2.6 The UHB's Environmental Manager is the assigned dedicated waste management operational lead. The Waste Management Policy includes the Estates and Facilities Division management structure chart, however whilst noting the same, the Executive Lead, Site Leads and Waste Management Administrative Officers/Assistants are not currently detailed within the same. (**MA1)**

2.7 The Board-level committee responsible for the oversight of waste issues and receiving reports on waste management is the Health and Safety Committee.

2.8 From an operational reporting level, the Waste Management Team is included within the Health & Safety Compliance Team, environment matters are reported and discussed, including Waste, in monthly meetings. We were provided with examples of meeting documentation from the Facilities Division Senior Management Board including the terms of reference stating that "The purpose of the Facilities Senior Management Board is to provide assurance to the ABUHB Executive Team that all aspect of estates and facilities services are being managed appropriately within the Division".

2.9 The Environment Steering Group previously acted as the main waste management forum however this is no longer operating. Noting the same, management advised that the Climate Change Adoption Group being newly established (and its associated Terms of Reference (TOR)) will assume waste management responsibilities.

2.10 In addition to the above, other groups were evidenced discussing waste management issues across the UHB including (but not exhaustive):

- Works and Estates Maintenance and Operations Finance and Performance Group/Estates and Facilities Finance and Performance Group.
- Food Waste User Group; and
- Individual site meetings.

2.11 At a national level, monitoring and reporting of waste management is overseen by the All-Wales Clinical Waste Consortium (CWC). The UHB regularly attends and participates in CWC meetings.

2.12 Budget management arrangements were found to be satisfactory. Documentation was provided of budget setting principles, budget allocation and budget holder accountability. Waste expenditure against the agreed budget was monitored throughout the period with the Business Partner Accountant.

2.13 The Environmental Manager advised that Risk Management processes were currently under review. (Refer to **MA7**). Risk assessments were undertaken in respect of Waste Compounds and the NHH Macerator (with a number of high-risk areas identified). However, the reporting/escalation of waste risks through localised risk registers, to the Facilities Risk Register and to the Corporate Risk Register was not identified. Limited reporting and scrutiny of waste management issues and risks at operational waste management meetings was observed.

2.14 Evidence was available that waste management training had been delivered to various staffing groups/locations. Whist training attendance documentation showed individual's names, OCPs covered and a date on the document tab, staffing groups were not recorded.

Whilst the Training Needs Analysis provided showed OCP training for some of the staffing groups identified in the WHTM 07 01 guidance, there would be benefit in formalising arrangements for the provision of environmental awareness / recycling training to staff across the UHB, to support the achievement of national / UHB targets (**MA2**)

2.15 Noting the above, **reasonable** assurance has been determined in this area.

Contractual arrangements: Assurance that waste contracts have been appropriately procured and were monitored against agreed performance targets. That appropriate controls operated in the payment of invoices.

2.16 The UHB's contractual arrangements for clinical waste (at both permanent sites and mass vaccination centres) were centrally procured and managed by NWSSP Procurement Services as part of a wider consortium of NHS Wales organisations. Contracts had recently been extended with the existing providers.

2.17 General waste/recycling and hygiene waste services had been procured via national frameworks. The UHB is planning to join the forthcoming All-Wales contract for general waste and recycling arrangements, which is scheduled to be tendered by NWSSP Procurement Services in 2022.

2.18 Contract performance (including delivery against KPIs) is monitored at both the CWC as well as within the UHB, using the UHB Management Programme system underpinned by regular site meetings with contractors/site staff. There had been an increased focus on performance during the past 18 months, to manage the service through the Covid pandemic. Continuing issues (NHS Wales-wide) with capacity and performance, which fall outside the agreed performance targets, were being discussed between the key parties at the time of review, we were provided with CWC meeting documentation, highlighting contract updates and performance issues. We noted good practice in the provision of data within the quarterly Consortium Report and, following the CWC meeting, Health Board representatives continued to collectively discuss (and record) contract performance and management issues with a sharing of ideas/actions to mitigate or alleviate pressures and site issues.

2.19 The UHB's "Management Programme (spreadsheet)" includes waste measurable targets, for recording, monitoring, and managing contract performance. Good practice was noted

in the frequency (and documentation) of site meetings with contractors. A log was maintained to record and monitor any identified contractor issues with actions to be taken and close off dates. Whilst, contract performance/issues were not reported to a Senior Management Board, we were advised this was due to be initiated over the forthcoming weeks.

2.20 Robust controls were also observed in the payment of invoices, to ensure payments were based on accurate charges and made in a timely manner.

2.21 Accordingly, **Reasonable Assurance** has therefore been determined, recognising the ongoing challenges associated with significant increase in clinical waste, associated with the ongoing Covid-19 pandemic, requiring removal and the performance of national contractors.

Operational Practice: A review of operational arrangements in key areas such as segregation, storage, safe handling, transfer etc. and associated record keeping, to assess compliance with the UHB's policy and procedures, WHTM 07-01 and relevant legislation. A review of waste reduction initiatives pursued by the Trust.

2.22 Operational practice was reviewed at two sites i.e., the Grange University Hospital (GUH) and Royal Gwent Hospital (RGH). The visits incorporated a review of waste management arrangements in areas including main entrances, wards, waiting areas, canteens, and the external waste compound.

2.23 Clinical waste volumes increased significantly across NHS Wales (including at the UHB) during the Covid pandemic, due to the inclusion of Personal Protective Equipment (PPE) etc. as infectious clinical waste. NWSSP: Specialist Estates Services (SES) published updated guidance ('Covid-19 Waste Management Standard Operating Procedure,' June 2021) stating that organisations should comply with the requirements of WHTM 07-01 i.e., disposal of non-infectious PPE in the domestic or offensive waste streams where appropriate.

2.24 It was evident that, unlike other NHS Wales organisations, the UHB substantially reduced its recycling during the Covid response (recognising that at this time, the UHB Waste Manager was seconded into a primarily operational role during the opening of the GUH during the pandemic). It is acknowledged that Waste recycling provisions and targets will be reintroduced across the UHB **(MA5)**.

2.25 Whilst considering the above, it was noted that whilst tiger bags were supposed to be provided in public areas for masks, inconsistency in their application was noted, with some orange bags in entrance areas, and also black/clear general waste bags in use **(MA 3).**

2.26 Additional areas of non-compliance were observed during the site visits including **(MA4)**

2.27 Whilst the Covid pandemic has inevitably adversely impacted on the volume of required waste disposal within the UHB, waste reduction initiatives details were provided, to support both UHB and Welsh Government targets. We noted examples of waste minimisation projects recorded and monitored in the Management Programme (v.27). In addition, waste minimisation/waste reduction initiatives were an integral part of the Environmental Manager's role with further supporting evidence and good practice, of a recent audit undertaken, (December 2021). Whilst some examples of good practice in waste minimisation were provided by management, it was not evident that a UHB-wide critical review has been undertaken in recent years. (**MA6**)

2.28 Noting the above, **reasonable** assurance has been determined in this area.

Monitoring & Reporting: That adequate arrangements were in place to record, monitor and report waste management activities, including incidents, compliance audits, costs, and performance against agreed targets. That reporting was appropriately directed at both operational and executive level.

2.29 Appropriate arrangements had been determined for the recording and investigation of waste-related incidents. No major waste related incidents had been reported to the Estates or Health & Safety departments during the past three years. The ISO14001 report (March 2021) additionally stated that "no environment incidents or complaints since the last visit were reported".

2.30 The UHB's waste audit processes are defined within the Waste Management Policy; Section 15 refers to waste audits to be undertaken, "*Waste Management Audits will be conducted by the Organisations' departments, wards and clinics as required evaluating compliance with waste regulations, Pre-Acceptance obligations and this Policy. The results of audits will be forwarded to the department/unit managers to identify good practice, non-conformances or areas requiring improvement."* The UHB participated in a number of audits each year covering aspects of waste management, including:

- Annual external audits as part of the ISO14001 Environmental Management System re-accreditation process;
- Annual / five-yearly (depending on waste tonnage produced per site) clinical waste Pre-Acceptance audits as required by WHTM 07-01; and
- Monthly internal site inspections.

2.31 Good practice was noted in the application of a recommendation "tracker" document, which was utilised to record /actions arising out of the various audits/site visit activities undertaken. The "tracker" included lead details, dates, non-compliance details, corrective actions and close off dates. Whilst noting the same, we were unable to identify external assessment non-compliance/actions from the ISO 14001 assessment (where three minor non-compliance areas were noted together with three carry forward items not actioned **(MA 6).**

We were aware that due to COVID 19/visiting hospital sites, some audits have been deferred.

2.32 Regular attendance at the Clinical Waste Consortium (CWC) by UHB's Environmental Manager was evidenced together with and provision of updates/data as part of the Consortium Report presented at the meetings.

2.33 The UHB's Health and Safety Committee is the Board level committee responsible for the overall oversight of waste issues within the UHB. No recent reporting to Executives on waste issues was evidenced. Other reporting/monitoring forums included:

- Facilities Division Senior Management Board;
- Works and Estates Maintenance and Operations Finance and Performance; and
- Estates and Facilities Finance and Performance.

2.34 With the exception of associated waste financial reporting, limited waste reporting/monitoring information was evidenced or considered at the above forums. Accordingly, recommendations have been made aimed at enhancing current monitoring and reporting arrangements **(MA7)**.

2.35 Noting the scope for improved monitoring and reporting arrangements, **reasonable assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Policy & Procedures (Design)	**Impact**
Welsh Health Technical Memorandum (WHTM) 7.1: '*Safe Management of Healthcare Waste,*' sets out the importance of a healthcare waste policy: *"To effectively manage healthcare waste, all those involved in the management of the waste stream should have access to an appropriate healthcare waste policy that identifies who is responsible for the waste and provides clearly written instructions on how it should be managed."* (6.2) The UHB's current Waste Management Policy (scheduled for review by September 2021) was under review with the Environmental Manager at the time of the audit. Whilst the policy was generally comprehensive and in accordance with the guidance provided by WHTM 07-01 (6.4), it was noted the following areas were not incorporated: • The Executive Board level Committee for the overall oversight of Waste Management and approval of the Waste Management Policy; • The governance structure, Committee/Groups from Executive Board level to Operational/Site Level in respect of waste management oversight and reporting mechanisms (including Board-level Committee responsibility and detail regarding relevant operational forums (inclusive of update/reporting requirements in respect of Contract assurance/issues and non-compliance identified from external and internal assessments/audits; Risk Management assurance/issues – Waste Risk Register scrutiny through to Facilities Risk Register scrutiny; Reporting of Top Risks, escalation when appropriate); • Detail of contractual arrangements, including contingencies, emergency arrangements (inclusive of testing of these); • The process for identifying improvement programmes; • Operational roles: whilst roles & responsibilities were included, they did not include reference to the management of waste from "cradle to grave" as recommended by WHTM 07-01.	Potential risk of: • Incomplete / out of date guidance available to staff, potentially not in accordance with current WHTM 07-01 requirements.

The policy was supported by a suite of operational control procedural (OCP) guides reflecting the current WHTM 07-01. Whilst comprehensive, in some instances, the review dates stated on the OCPs, indicated last reviewed in 2015. We have been advised that the OCP review dates had not been updated to reflect six monthly reviews undertaken. It was further noted that the UHB's intranet site contained a legacy Waste Management Policy dated 2010.	

Recommendations	Priority
1.1 Ensure that the Waste Management Policy has been reviewed/updated and reflective of the above findings. That the updated Policy is underpinned by formal Board Level approval with all key elements of WHTM 07-01 guidance incorporated. 1.2 Waste management operational control procedures review dates should be updated following each review. 1.3 Out-of-date policy / procedural documents published online should be updated.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
1.1 The Waste Management Policy will be reviewed/updated and formally approved by the Board.	Oct 2022	Environmental Manager
1.2 OCPs will be formally reviewed with associated record of actions.	Oct 2022	Environmental Manager
1.3 All online policies and procedures will be reviewed and updated where necessary.	Oct 2022	Environmental Manager

Matter Arising 2: Training (Operation)	**Impact**
WHTM 07.01 (6.33) highlights the importance of waste management training: *"A policy for the safe management of healthcare waste cannot be effective unless it is applied carefully, consistently and universally. This requires that all healthcare staff should be aware of the policy/procedures and that the policy is implemented by trained and competent people;"* and *"A training record will readily enable line managers to identify members of staff who are not receiving the appropriate level of training, and where such training should be focused."* The UHB's Waste Management Policy refers to training requirements, section 14, however does not stipulate the staffing groups recommended in the WHTM 07-01 guidance for waste management training. Copies of a sample of training completion certificates for the 2019 period were provided. Evidence of OCP training attendance records showed named individuals receiving training. The date of training was provided at the document tab (not the document header). The record showed training coverage in respect of several key OCPs covering waste management, however, did not state the staffing group of individuals trained e.g., not all the staffing groups identified within the WHTM 07 01 guidance for example were stated i.e., Pharmacists, Infection Control, Medical Doctors. The Training Needs Analysis record did not show dates or totality of all staff requiring training or additional training provided due to COVID. We were provided with a detailed spreadsheet to record NHS/CSTF Health, Safety and Welfare (3 years) training. This comprehensive record showed staffing groups, organisations, and expiry dates. Additionally, we did not evidence any mechanisms for providing/affirming general waste and recycling training across the health board i.e., to support the achievement of national waste reduction targets/decarbonisation strategy etc.	Potential risk of: • Staff do not receive sufficient training to safely handle waste; • Non-compliance with WHTM 07-01 requirements
Recommendations	**Priority**
2.1 Enhancement of the Waste Management Policy to include staffing groups as identified by the WHTM 07-01 guidance.	**Low**

2.2a The training needs assessment should be reviewed and enhanced, encompassing all relevant UHB staff groups to determine the level and frequency of waste management training required by each staff group (which could range from general guidance on waste segregation and recycling, to technical guidance on clinical waste handling and include additional training provided due to COVID).	**Medium**
2.2b Management should investigate options to provide waste management/recycling/green agenda training to all UHB staff.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
2.1 Staffing groups not recorded on OCP training evidence but recorded on induction training for Facilities and Clinical staff. To be recorded on all training sessions going forward.	Ongoing	Environmental Manager
2.2a Training needs assessments will be reviewed and updated where necessary.	Oct 2022	Environmental Manager
2.2b Provision of online training has been discussed and could be implemented within ABUHB, however we believe it would benefit from an all-Wales approach. This could potentially be coordinated via Welsh Health Environmental Forum	Ongoing	Environmental Manager

Matter Arising 3: Site Visits – Waste Streams	Impact
The NWSSP: SES guidance document 'Covid-19 Waste Management Standard Operating Procedure v2' (June 2021), states that Health Boards should comply with WHTM 07-01 in the return to business as usual after the initial Covid response, as follows: *"Where areas are COVID-19 secure, e.g., offices and food preparation areas, masks and face coverings can be discarded in the domestic waste stream if no longer required.* *Masks and face coverings worn by patients, visitors and non-clinical staff who have entered a clinical area should be discarded in the offensive waste stream if no longer required. Bins for these should be located at the entrances and exits where masks are given to those who do not have them.* *Clinical staff should dispose of surgical face masks in the offensive or infectious waste streams, depending on the procedures they undertook while wearing the mask."* During the GUH site visit, it was noted that bins in public areas (canteen/reception etc) labelled for mask / PPE disposal, contained a mix of both tiger waste bags and clear/general waste bags. Whilst noting PPE could potentially be disposed into either, providing it wasn't classed as infectious (i.e., from a Covid ward). At RGH, it was also noted that at the Belle Vue entrance that orange bags were also in use for PPE to be disposed. A consistent approach should be taken and applied by the domestic staff emptying the bins and replacing the bin bags.	Potential risk of: • Incorrect waste segregation, leading to over/under treatment of waste and potential associated financial penalties/ increased costs of waste disposal.
Recommendations	**Priority**
3. A consistent approach should be taken to the waste stream used for disposal of offensive (but non-infectious) PPE, in public areas within the hospital sites - based on official guidance and management decision.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
3. This is a recurrent issue across the country and every effort is made to ensure correct segregation through waste audits, spot checks and walkarounds by Environmental Team, Compliance Team, Senior Management and Divisional Director. These measures will continue to be employed along with enhanced communication.	Ongoing	Environmental Manager

Matter Arising 4: Site Visits: Operational Practices (Operation)	**Impact**
Operational practices were reviewed at two UHB sites i.e., the Grange University Hospital (GUH) and Royal Gwent Hospital (RGH). The visit incorporated a review of waste management arrangements in areas both within the site (main entrances, wards, waiting areas, canteens, waste storage rooms) and outside (waste compound, external storage areas). The sites were generally tidy and free from a build-up of waste at the time of the visit. However, the following issues were identified: • The waste compound gates at RGH (opposite the Belle Vue entrance) were open and unattended in an area adjacent to a public entrance at the time of the visit. It was noted this issue was also raised in the September 2020 audit by the Dangerous Goods Safety Adviser. It is clear therefore that this is a long-standing issue that has not been addressed. • During the GUH site visit, it was observed that the door to Disposal Hold 103-D1 had been left open when unattended (i.e., unlocked). Noting this is located off a public corridor, doors should always be locked when not in use to prevent access to clinical waste. • At the RGH, several bins were observed where the lid colours did not match the interior bin liner colour. There was also an absence of labels on the bins, or signage nearby, to instruct on the permissible contents. Whilst some of these bins were in ward areas, with staff 'presumably' trained in correct use based on bin liner colour, this may present confusion. Some mismatched bins/liners were also located in areas used by the public. • It was noted on the RGH site (Belle Vue waste compound) that paint and WEEE had been placed in a skip, incorrectly. • Waste must be packaged and labelled in receptacles that clearly identify the presence of sharps. During the GUH site visit, sharps boxes sealed for collection in several areas had not been appropriately annotated with the details of the department responsible.	Potential risk of: • Public access to clinical waste areas presents a health and safety risk. • Unsafe sharps storage and disposal; • risk to public health.

Recommendations		Priority
4. Staff will be reminded of the importance of complying with waste management operational procedures including (but not exhaustive): • the maintenance of secure waste storage areas; • the correct classification and disposal of waste; • the correct labelling of all waste items (including sharps).		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
4. As with Management Action 3 these are common, ongoing issues at all sites. Internal audits, ISO14001 audits (external), spot checks and walkarounds by Environmental Team, Compliance Team, Senior Management, Divisional Director and external auditors along with enhanced communications will reduce instances going forward	Ongoing	Environmental Manager

Matter Arising 5: Waste Minimisation/Reduction (Operation)	**Impact**
WHTM 07-01 (5.3) sets out that: *"the best financial and environmental option is not to produce waste in the first place. This is because whether waste goes for recovery, recycling, or disposal, it is still a product that the organisation has usually bought, handled, and is then having to pay for disposal of. Avoiding producing the waste at all reduces both buying costs and disposal costs;"* and *"Waste policies should include a programme to critically review the volume and types of waste that are produced, and to identify and implement practical steps to reduce waste volumes."* Whilst examples of good practice in waste minimisation were provided by management, it was not evident that a UHB-wide critical review has been undertaken in recent years. It was evident that, unlike other NHS Wales organisations, the UHB substantially reduced its recycling during the Covid response, this was additional compounded by the opening of the GUH during the pandemic. We also acknowledge that at this time, the UHB Waste Manager was seconded into a primarily operational role during the opening of the GUH). It is fully recognised that 2020-2021 has been focused on managing the Covid response, and time for such a review would not have been feasible and may not be for some time. However, the potential to undertake this work, in targeted areas, should be considered as part of future work programmes.	Potential risk that: • Waste is not minimised wherever possible at source.
Recommendations	**Priority**
5.1a Waste recycling provisions and targets will be reintroduced across the UHB.	**Medium**

5.1b A review of waste volumes and types across the UHB should be completed, to identify potential for waste minimisation in line with WHTM 07-01 (5.3).		
Agreed Management Action	**Target Date**	**Responsible Officer**
5.1a Due to the issues highlighted above, ABUHB was unable to review waste service and associated targets in recent years. Review to be undertaken.	September 2022	Environmental Manager
5.1b As above.	September 2022	Environmental Manager

Matter Arising 6: Monitoring & Reporting of Audit Recommendations (Operation)	Impact
WHTM 07-01 (6.9 – 6.23) provides detailed guidance and instruction regarding Waste audit, scope/procedures, frequency, and techniques. Section 6.12 "Audits play a vital role in demonstrating compliance with regulatory standards" and section 6.13 "Documented evidence from waste audits showing effective segregation demonstrates that the producer is complying with regulations". The UHB participates in a number of audits each year covering aspects of waste management, including: • Annual external audits as part of the ISO14001 Environmental Management System re-accreditation process; • Annual / five-yearly (depending on waste tonnage produced per site) clinical waste Pre-Acceptance audits as required by WHTM 07-01; and • Monthly internal site inspections. We were provided with a Tracker document utilised to record any non-conformities / recommendations reported from audits, inspections and site compliance activities. We were unable to identify the latest ISO14001 major non-compliance (October 2021) and carry forward minor non-compliance issues from the previous report (March 2021). Findings from the monthly internal site inspections were reported to the relevant Site Manager for action, recognising the lower-level nature of these issues (not resulting from formal external audits). In some instances, emails would be used to highlight action required. Pre-Acceptance audit non-conformities were not included in the recommendation tracker provided however pre acceptance audit details were recorded in the Consortium Report produced for presentation at CWC meetings.	Potential risk of: • Insufficient visibility of waste management issues at central forums; • Insufficient progress in actioning recommendations arising from non-conformities identified.
Recommendations	**Priority**
6.1a Recommendations / non-conformities arising from internal (pre acceptance audits) and external audits should be monitored via the central tracker. 6.1b Audit non-conformities, and progress towards actioning the same, should be reported to an appropriate forum.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
6.1a All non-conformities (NCs) and recommendations are recorded by a central tracker spreadsheet. At the time of the audit, the tracker had not been updated with the latest NCs. All NCs/recommendations will be recorded as soon as raised/published. This would be reviewed every 6 months as part of external ISO14001 audit.	Ongoing	Environmental Manager
6.1b Audit outcomes will be raised on an exception reporting basis to the Health & Safety Committee which has direct escalation to Corporate H&S and Exec Board.	Ongoing	Environmental Manager

Matter Arising 7: Monitoring and Reporting (Operation)	**Impact**
WHTM 07-01 (6.2) sets out that "to effectively manage healthcare waste, all those involved in the management of the waste stream should have access to an appropriate healthcare waste policy that identifies who is responsible for waste and provides clearly written instructions on how it should be managed". We were provided with the UHB Waste Management Structure Chart. The Chart did not include Executive Lead post, Waste Management Site Leads, Waste Team Administration staff posts. We were provided with meeting structure diagrams included in the Facilities Division Health and Care Standards Framework. This did not detail Waste Management meetings in respect of the above oversight Committee/Groups from an operational level to Executive Board level. We were unable to identify the site meeting roles and that of the Food Waste User Group as part of the Waste Management governance structure and arrangements. chart provided. The Waste Management Policy does not identify the Board level Committee responsible for the oversight of waste management, Committee/Group accountability and reporting mechanisms, and the approval of the Waste Management Policy. Cross reference to (**MA1**) In addition to the above, we reviewed a sample of waste monitoring and reporting meeting documentation from waste management oversight groups. We noted the following: • Health & Safety Committee: The Waste Management Policy does not define the responsible Board-level Committee for waste management nor defines accountability and reporting mechanisms/reporting requirements. The Health and Safety Committee had not received recent waste management reports/updates. (Refer to **MA1**) • There was minimal evidence of waste management updates/issues being reported to Facilities Division, Senior Management Board. We noted at the meeting on 24/11/21, the Group were updated, section 8 Risk, on ISO14001 non compliances, inclusive of the major non-compliance identified during the Lloyds assessment, October 2021. In addition, there was also the financial update. • At a more operational level, the Works and Estates Maintenance and Operations Finance and Performance Group. We could not identify specific waste management contract issues/performance or risk reporting. Best practice would ensure that key matters such as the management of waste contracts, Covid-related clinical waste management pressures, progress towards waste reduction targets and compliance matters being periodical.	Potential risk of: • Lack of clarity of oversight bodies, accountability and reporting mechanisms. • Governance arrangements are not properly embedded. • Insufficient visibility of waste management issues at central forums. • Poor management information, poor decision making.

• We reviewed a sample of meeting documentation from the above oversight groups, we found in some instances, oversight Group name differed on the agenda/minutes provided (Works and Estates Finance and Performance/Works and Estates Maintenance and Operations Finance and Performance); Names were recorded not job titles (to indicate representation/responsibility); Action logs at the end of minutes did not have timeframes. We were unable to identify reporting and tracking of External Provider recommendation progress/closure or Waste Risk/Top Risks updates. A localised Waste Risk Register is currently not in place.	

Recommendations	Priority
7.1a Waste Management monitoring and reporting arrangements should be enhanced (particularly through to Committee/Board levels), with appropriate scrutiny and challenge demonstrated.	**Medium**
7.1b Waste risk management processes and procedures should be enhanced to widen the scope of reporting of waste management issues, inclusive of the development of a localised waste risk register and top waste risks reports, with joined up mechanisms to incorporate contract performance issues, recommendation tracker updates etc.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
7.1a Environment to be a regular agenda item on Health & Safety Committee	August 2022	Environmental Manager
7.1b Local waste risk register with associated report to be created which will feed into Divisional Risk Register	August 2022	Environmental Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

Audit, Risk and Assurance Committee Update – **Aneurin Bevan University Health Board**

Date issued: August 2, 2022

Document reference: 2813A2022

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value for money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2021-22 Performance Report, Accountability Report and Financial Statements	Complete. The Auditor General certified the Performance Report, Accountability Report, and Financial Statements on 17 June 2022 and were laid before the Senedd the same day.
2021 Audit Plan	Completed; presented to the April Committee meeting.
Audit of Accounts Report	Completed and ISA 260 report presented to the June Committee meeting.
Charitable Funds: • 2021-22 Audit Plan • Audit of Charitable Funds financial statements	The planning for the audit of the Charitable Funds 2021-22 financial statements will take place in the Autumn. Dates have not yet been agreed with the Finance Team. We expect the audit of the Charitable Funds financial statements 2021-22 to be undertaken in the Autumn.

3 We plan to hold a joint post project learning (PPL) session between the Finance Team and the audit team in September to reflect on the 2021-22 audit, and to put in place agreed actions to further improve next year's closedown and audit experience. Following the PPL session, we will issue a draft Audit of Accounts Addendum Report to management and once agreed, the Report will be presented to the Audit, Risk and Assurance Committee.

Performance audit update

4 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work completed (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Finance, Audit and Risk Audit Committee
Structured Assessment 2021	Completed and findings to be presented to the Committee in February 2022.
Annual Audit Report 2021	Completed and presented to the Committee in February 2022.
Quality Governance	Completed and findings presented to Patient Quality, Safety and Outcomes Committee in June 2022.

Exhibit 3 – work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
Structured Assessment 2022	The structured assessment work will build on the baseline governance review by assessing the corporate arrangements in place at the SHA in relation to: • Governance and leadership. • Financial management. • Strategic planning, and • Managing the workforce, digital, resources, estates, and other physical assets. A copy of the Project Brief is available with this update.	Fieldwork in progress. Planned Date for Consideration: December 2022.
Review of arrangements for securing efficiencies Executive Lead: Rob Holcombe	This work will consider whether the Health Board's arrangements for securing efficiencies are robust, including the impact of new ways of working on planned efficiencies.	Fieldwork in progress Planned Date for Consideration: December 2022
Orthopaedic Follow up review Executive Lead: Leanne Watkins	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges and consider the impact of the pandemic and	Report being drafted.

Topic and relevant Executive Lead	Focus of the work	Current status and Finance, Audit and Risk Committee consideration
	orthopaedic service recovery. Therefore, reporting was moved to 2022.	
Unscheduled care arrangements Executive Lead: Leanne Watkins / Rhiannon Jones	This work has been carried forward from the 2020 Audit Plan and will initially look to provide a high-level whole system overview of the unscheduled care. The overview will be informed by the development of an interactive database covering all aspects of the unscheduled care pathway. Further work will then be undertaken on specific elements of unscheduled care pathway, with a likely focus on activities to signpost patients to the most to appropriate care setting, and to manage patient flow through the system.	Unscheduled Blog issued April 2022 alongside data tool. This review was replaced by work on Test, Track and Protect. The review is now recommencing. Date for consideration to be confirmed.

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Locally focused work	The precise focus of this work is yet to be determined.	TBC
All-Wales thematic on workforce	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely	TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
planning arrangements	to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	

Good Practice events and products

5 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

6 There has been one Good Practice Exchange (GPX) event since we last reported to the Committee on 7th April. We held a Responding to the Climate Emergency webinar on 16th May. The recording and resources from the online event can be found here. Details of future events are available on the GPX Website.

NHS-related national studies and related products

7 The Audit, Risk and Assurance Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts and Public Administration Committee at the Senedd to support its scrutiny of public expenditure.

8 **Exhibit 5** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 5 – Recent NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
The Welsh Community Care Information System update letter The key messages are summarised in **Appendix 1**	July 2022
Tackling the Planned Care Backlog in Wales The key messages are summarised in **Appendix 1**	May 2022
Unscheduled Care (Blog and Data Tool)	April 2022

Appendix 1 – Key messages from recent national publications

The Welsh Community Care Information System

9 The Auditor General wrote to the Chair of the Public Accounts and Public Administration Committee (PAPAC) on 1 July 2022 to provide an update, highlighting that the WCCIS programme is now at a critical phase following on from a recent 'Strategic Review' and with some key contractual milestones not far ahead.

10 Many of the issues highlighted in the Auditor General's report were mirrored in the findings of the Strategic Review, which recommended a series of actions to 'reset' and 'course correct' the programme.

11 The Welsh Government has recently announced further funding for national programme management to take this work forward. It will also provide further financial support to health boards and local authorities to support implementation.

12 Our latest update provides a detailed update on the main actions taken so far in response to our recommendations and on progress generally against key issues raised in our previous report on the Welsh Community Care Information System (WCCIS). These are summarised below:

- Relevant to our specific recommendations, the Welsh Government commissioned research to gather views from users and others about the performance and functionality of the system. The survey findings in June 2021 highlighted the system was having a more negative than positive impact on most users' ability to do their work. Preceding the Strategic Review mentioned above, there was also a programme assurance review which concluded in November 2021 and a further one scheduled for November 2022.
- Ongoing rollout has seen two more local authorities 'go live' with the system since our last report while one further health board has now signed a 'deployment order'. However, it remains the case that patchwork approaches to implementation mean that even where the system is live, it is not being used to its full potential or on a consistent basis. Our interactive data tool provides further detail on the overall roll-out position across the 29 organisations.
- Central support costs for the period to 31 March 2022 – excluding local costs to individual organisations and other opportunity costs – remain at around the £30 million expected at the time of my report, although the profile of those costs has changed. The Welsh Government has now committed a further £8.31 million for national programme support and support for health board and local authorities in accelerating implementation for 2022-23 to

2024-25. The Welsh Government has agreed that this figure may increase to up to £12 million if required.

- Key aspects of functionality continue to be delayed. Areas where work continues to be needed include Welsh-language requirements, mobile functionality and interfaces with other NHS Wales systems. As of June 2022, all these areas of functionality remain outstanding although mobile functionality is due to be piloted later this calendar year and most of the interfaces are also now expected by the end of 2022.
- System performance issues became particularly acute during Autumn 2021, but overall system performance has since stabilised. Significant performance issues during a planned upgrade resulted in the system being unavailable altogether for certain periods during October and November 2021. These issues continued to some extent into early 2022 before being resolved in February 2022.
- National data standards work has continued but is still not complete. Development of these standards is key to realising some of the benefits of WCCIS.
- The overall arrangements for reporting the benefits from WCCIS implementation, which have been the subject of discussion and review from the outset, have still not been resolved. Work is still ongoing to develop a suitable reporting framework. Annual reporting on the progress of the WCCIS programme has also not been completed as expected to date, although the Welsh Government has been receiving quarterly updates from the National Programme Team.

Tackling the Planned Care Backlog in Wales (May 2022)

13 Our Planned Care review describes the significant challenges facing NHS Wales both in terms of shorter-term recovery and the need for longer term sustainable planned care services. There were clearly issues in some key areas about the balance of capacity and demand for services before the pandemic and is exacerbated significantly since.

14 In February 2022, there were nearly 700,000 patients waiting and numbers of waits continue to grow. Over half of the people currently waiting have yet to receive their first outpatient appointment, and across Wales over 100,000 patients are waiting over a year for their first outpatient appointment. This may mean their care cannot be effectively prioritised often because effective clinical prioritisation can only take place during outpatients and diagnosis.

15 The report highlights that referrals reduced during the pandemic and this suggests that there could be a pent-up demand for services which may result in higher than average or more complex and acute referrals in the short to medium term. If even half of those missing patient referrals emerge, this could mean that recovery of waiting lists to pre-pandemic levels could take seven years. Some specialties and

services could recover more quickly, but others such as orthopaedics and eye care may take longer as these services have been under pressure for many years.

16 The Welsh Government made an extra £200 million available during 2021-22 to help recovery but NHS bodies could not use it all. They bid for and were allocated £146 million, but £12.77 million was returned to the Welsh Government at the end of March 2022. NHS bodies cited staff capacity, lack of physical space and limited private capacity to carry out planned care as barriers to spending the additional funding. While additional Welsh Government funding is going to be essential to tackle the backlog, this on its own, will not solve the problem. The NHS also needs to overcome some serious barriers, including the on-going impact of COVID on services, reducing the impact of emergency care on planned care service delivery and long-standing staff shortages and recruitment issues.

17 Our report makes five recommendations to the Welsh Government which focus on:

- Working with health bodies to set appropriately ambitious delivery targets;
- Producing a clear funding strategy including long term capital investment;
- Developing a workforce plan to build and maintain planned care capacity;
- Implementing system leadership arrangements to drive through the plan;
- Ensuring its arrangements focus on managing clinical risks associated with long waits, supporting patients while they wait, and delivering care efficiently and effectively.

18 While the recommendations are made to Welsh Government, health bodies across Wales also need to consider how they respond both to the issues identified in our report and locally required implementation of the recommendations. We are therefore seeking a written response from each health board and request that actions are tracked in routine recommendation monitoring arrangements and are reported to audit committees

19 Alongside our report, we have also published a waiting time which sets out the different waiting times by health board.

Audit Wales

24 Cathedral Road

Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Date issued: 25th May 2022

Structured Assessment 2022

Project Brief

Background

1 The Auditor General has a statutory requirement to satisfy himself that NHS bodies have proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources as set out in Section 61 of the Public Audit Wales Act 2004. To help in the discharge of this responsibility, the Auditor General undertakes annual Structured Assessment work at each NHS body that examines arrangements relating to corporate governance, financial management, strategic planning, and other factors affecting the way in which NHS bodies use their resources.

2 Our 2022 Structured Assessment work is taking place at a time when NHS bodies are continuing to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies are not only tackling the immediate challenges presented by the public health emergency but are also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. Therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

Audit approach

3 As in previous years, our work is focused on the corporate arrangements of NHS bodies for ensuring that resources are used efficiently, effectively, and economically.

4 Our structured assessment work will allow the Auditor General to answer the overall question: **Are the organisation's corporate arrangements supporting good governance and the efficient, effective, and economical use of resources?** The key lines of enquiry are set out in **Exhibit 1**.

Exhibit 1: key lines of enquiry

Are the organisation's corporate arrangements supporting good governance and the efficient, effective, and economical use of resources?

1. Is the organisation well led and well governed?
   - Does the Board promote and demonstrate a commitment to public transparency of Board business?
   - Are there proper and effective arrangements in place to support the effective conduct of business?
   - Is the Board (and its committees) operating effectively?
   - Does the Board and its committees receive timely, high quality information that supports effective scrutiny, assurance and decision making?
   - Does the Board promote and demonstrate a commitment to continuous improvement?
   - Does the Board promote and demonstrate a commitment to hear from patients / service-users and staff?
   - Do the leadership arrangements and organisational structure / design support effective governance?
   - Is there an appropriate and effective Board Assurance Framework (BAF) in place for managing the risks to delivery of organisational objectives?
   - Is the BAF underpinned by an appropriate and effective risk management system?
   - Is the BAF underpinned by an appropriate and effective performance management framework?
   - Is the BAF underpinned by an appropriate and effective clinical / quality governance framework?
   - Is the BAF underpinned by appropriate and effective information governance and information and cyber security frameworks?
   - Does the Board receive assurance that there are appropriate and effective systems in place for tracking progress to address audit and review recommendations and findings?

2. Is there an effective approach to strategic planning?
   - Does the NHS body have a clear vision and long-term strategy that is rooted in population health?
   - Is the long-term strategy underpinned by a long-term clinical strategy?
   - Does the IMTP satisfy Welsh Government requirements?

- Has the NHS body been able to produce an approvable IMTP in line with Welsh Government guidance and requirements?
- Are prudent healthcare and value based healthcare principles clearly evident within corporate strategies and plans?
- Do corporate strategies and plans identify and contain clear milestones, targets, and outcomes?
- Have corporate strategies and plans been developed in liaison with relevant partner agencies and stakeholders?
- Is there an effective approach to overseeing the development of corporate strategies and plans, and monitoring their implementation?

3. Is there an effective approach to financial sustainability?
    - Did the NHS body meet its financial objectives for 2021-22?
    - Is the NHS body likely to meet its financial duties in 2022-23?
    - Are financial planning arrangements robust?
    - Are savings and cost improvement plans designed to support financial sustainability and service transformation?
    - Are the arrangements for financial management and control appropriate and effective?
    - Are there appropriate and effective arrangements for accurate and timely oversight and scrutiny of financial performance?

4. Is there an effective approach to managing the workforce, digital resources, the estate, and other physical assets?
    - Is there an effective approach to managing the workforce?[1]
    - Is there an effective approach to managing digital resources?
    - Is there an effective approach to managing the estate and other physical assets?

5 Auditors will also pay attention to the progress made by NHS bodies to address outstanding structured assessment recommendations from previous years. Our work will specifically focus on open recommendations raised pre 2019 to determine whether they remain relevant. We will also consider outstanding recommendations from other relevant reviews.

[1] Please note that, as set out in our Audit Plans for 2022, auditors will be undertaking a separate review into workforce planning arrangements later in 2022.As a result, our structured assessment work in 2022 will focus primarily on arrangements in place at NHS bodies to support staff wellbeing.

6 Our work will be based on a review of relevant documentation, observations at Board and committee meetings, and structured discussions with the appropriate people at the NHS body. We will work with the Board Secretary to agree the precise timing of the work, who we need to speak to at the NHS body, and any information required to support our work that is not in the public domain. In the main, we will be undertaking our audit work remotely. If attendance in person is deemed necessary, we will agree this in advance with the Board Secretary and ensure all appropriate risk assessments are undertaken in line with current COVID-19 guidelines.

Reporting our findings

7 We will prepare a report for individual NHS bodies setting out local findings and any recommendations arising from our work.

8 If any immediate concerns emerge during our work, we will liaise with the Board Secretary to agree the most appropriate way of sharing these.

9 In line with Audit Wales arrangements for public reporting, we will publish the final report on our website once it has been formally considered by the relevant Board committee.

Timing of the work

10 The indicative timescales for the key stages of the work are shown in **Exhibit 2**.

Exhibit 2: timing of the work

Key stage	Timing
Set up	May 2022
Evidence gathering	May to August 2022
Draft report	End of October 2022
Final report	End of November 2022

Audit Wales contacts

11 Further information can be obtained from Andrew Doughton, Performance Audit Manager (andrew.doughton@audit.wales) or Nathan Couch Performance Audit Lead (nathan.couch@audit.wales).

Data Protection

Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation. Further information is set out in our fair processing notice attached at Appendix 1. We ask that you share this project brief with Board members, and anyone we intend to interview, to ensure they understand the purpose and scope of our review and how information may be used and shared.

Appendix 1 – Fair Processing Notice

This privacy notice tells you about how the Wales Audit Office processes personal data provided by you in connection with our Structured Assessment of NHS Trusts and Health Boards in Wales.

Who we are: The Auditor General for Wales examines how public bodies manage and spend public money, and the Wales Audit Office (WAO) provides staff and resources to enable him to carry out his work.

Data Protection Officer (DPO): Our DPO is Martin Peters, who can be contacted by telephone on 029 20320500 or by email at: infoofficer@audit.wales.

The relevant laws (legal basis): We process personal data in accordance with the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR). Our lawful basis for processing is the statutory powers and duties under the Public Audit (Wales) Act 2004, the Government of Wales Act 1998 and Well-being of Future Generations (Wales) Act 2015.

Purpose of processing: We are collecting opinions and information to help us carry out our Structured Assessment of health bodies. Some of this information may be about identifiable individuals, which would make it personal information, even though the purpose of our work is not in itself to collect information about identifiable individuals. The information collected will be used for this work and may also be used in our wider statutory audit work.

Who will see the data? The Auditor General and the WAO audit team will have access to the information you provide. We may share some information with senior management at the audited bodies involved, and our published report may include some information. We may share some data with the NHS Wales Audit and Assurance Service for the purpose of its internal audit and such information will be processed in accordance with the NHS Wales Audit and Assurance Service privacy policies.

How long we keep the data? We will keep the information collected, including your personal data, for a period of 6 years following publication of our report, or 25 years if published within a report, and we will hold your data securely in accordance with our Information Security Policy.

Your rights: You have rights to ask for a copy of the current personal information held about you or to object to data processing that causes unwarranted and substantial damage and distress. Contact the Information Officer, Wales Audit Office, 24 Cathedral Road, Cardiff, CF11 9LJ or email infoofficer@audit.wales.

Our rights: The Auditor General has rights to information, explanation and assistance under paragraph 17 of schedule 8 Government of Wales Act 2006 and/or section 52 Public Audit (Wales) Act 2004 and/or section 26 of the Local Government (Wales) Measure 2009. It may be a criminal offence, punishable by a fine, for a person to fail to provide information.

The Information Commissioners Office: If you require further information in relation to your rights under data protection law or are dissatisfied with how we are handling your personal data you may contact the Information Commissioner at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, or email casework@ico.gsi.gov.uk or telephone 01625 545745.

Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Aneurin Bevan University Health Board

Audit year: 2019

Date issued: May 2022

Document reference: 2861A2022

This document has been prepared for the internal use of 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 to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users. The Act comes into effect in 2023.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Aneurin Bevan University Health Board (the Health Board carried out between June and October 2021. To test the 'floor to board' perspective, we examined the arrangements for general surgical services.

Key messages

6 Overall, we found that **the Health Board has clearly articulated the corporate arrangements for quality governance and its key areas of focus for quality and safety. However, there remain weaknesses at a divisional and directorate level which could impact the flow of assurance from floor to board.**

7 The Health Board has articulated its annual key areas of focus for quality and safety and there are reasonable corporate and divisional arrangements for monitoring risk with good scrutiny and challenge by the Patient Quality, Safety and Outcomes committee on quality and safety risks it has been assigned. Arrangements for monitoring mortality and morbidity and national clinical audit are developing and performance in relation to responding to complaints, and arrangements for learning lessons are improving. The Health Board has a well-established values and behaviours framework, it encourages staff to raise concerns and there is collective responsibility for quality and safety amongst Executive Leadership. Corporate quality and safety structures and processes are clearly articulated and arrangements for monitoring quality and safety information are improving.

8 However, we found some gaps in flows of assurance on healthcare standards between operational and corporate structures. This indicates a need to ensure that the quality assurance framework provides clarity around how a 'floor to board' quality and safety assurance system operates in practice. There is also a need to review the extent that operational staff and management have sufficient capacity to effectively support quality governance. At a directorate level, arrangements for monitoring and reporting on key areas of focus for quality and safety are yet to be finalised and the monitoring and escalation of risk is not always effective. Whilst there are dedicated resources for quality improvement, the capacity of the team has decreased and was further affected by COVID-19. The arrangements for Health Board-wide and local clinical audit also require improvement. The Health Boards Putting Things Right policy is out-of-date and needs reviewing. There are opportunities for the Health Board to improve how it captures and learns from patient experience in respect of services it provides and services it commissions from other providers and more to do to ensure that staff feel comfortable to report concerns, and they receive feedback on actions taken.

Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Risk management R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should: • ensure there is appropriate scrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. • ensure that risk registers are completed and maintained across all directorates that identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.
Clinical audit R2 During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should: • complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide and local audits informed by areas of risk. This plan should be approved by the Patient Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely. • update and finalise the terms of reference for the Clinical Effectiveness and Standards Committee. • ensure there is sufficient resource and capacity for clinical audit at an operational level. • ensure systems for learning and good practice from clinical audit are embedded across the organisation.

Recommendations

Values and behaviours

R3 The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel:

- they are not treated fairly or given feedback when reporting errors, near misses or incidents.
- that the Health Board does not act on concerns they raise or take action to minimise future of occurrence errors, near misses or incidents.

Patient experience

R4 Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should:

- undertake work to understand why patient feedback updates are not regularly provided to work areas or departments.
- ensure there are systematic arrangements for collating and action upon patient experience information across the organisation and the services it commissions.

Putting Things Right

R5 The Health Boards Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.

Quality and safety framework

R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:

Recommendations

- complete its review of the quality and safety framework to ensure that flows of assurance are appropriate, and that the framework functions as intended.
- articulate the operational structures and processes for quality and safety within the quality assurance framework and how they align with the corporate structure to provide 'floor to board' assurance.

Resources to support quality governance

R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.

Coverage of quality and safety matters

R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:

- review the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements.
- ensure that other operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.

Detailed report

Organisational strategy for quality and patient safety

10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

11 We found that **the Health Board has articulated its annual quality and safety priorities, but it needs to improve how it monitors the delivery of these. Quality risks are appropriately managed at corporate and divisional levels but requires strengthening at directorate levels.**

Quality and patient safety priorities

12 **The Health Board has articulated its annual quality and safety priorities but there needs to be better alignment between operational quality priorities to the strategic quality aims. Monitoring and reporting on the delivery of those priorities need strengthening.**

13 The Health Board has articulated its approach to quality and safety through its Integrated Medium-Term Plan (IMTP) 2019-20 to 2021-22, Annual Plan 2021-22, and Quality Assurance Framework 2020-23. The Health Board's Annual Plan 2021-22 outlines its commitment to ensure that every individual 'has a positive experience'. To achieve this, the Experience, Quality and Safety element of the Annual Plan incorporates five key aims which replace the previous IMTP's quality priorities:

- enabling a safety culture
- a learning organisation
- a just culture
- data for quality and improvement
- a safe environment.

14 As part of its corporate planning cycle, the Health Board engages external partners, including the Community Health Council on priorities and challenges. Our discussions with staff suggest limited involvement from operational areas to help shape the Experience, Quality and Safety element of the plan.

15 The Health Board's delivery actions are designed to support achievement of its five quality aims. These delivery actions, however, lack clear target dates or milestones. Furthermore, there is no monitoring and reporting framework in place. We also found limited scrutiny and assurance by the Board and Patient Quality, Safety and Outcomes Committee (PQSO committee) on the key areas of delivery. This creates a risk that the committee might not be sighted on aspects where quality delivery aims aren't achieved or where progress is limited. Our 2021 Structured Assessment report also highlights weaknesses and made a

recommendation on the Health Board's arrangements for monitoring progress on the 2021-22 Annual Plan[1].

16 Both the General Surgery directorate and Scheduled Care division identify quality and patient safety priorities and monitor progress. The directorate and division revised their priorities in response to COVID-19. However, they haven't aligned their operational priorities with the Health Board's key delivery actions for quality and safety outlined in its Annual Plan for 2021-22.

Risk management

17 **The Health Board has defined its risk appetite for patient safety and experience and regularly reviews risks at Board, committee, and divisional levels. However, directorate level risk management arrangements need strengthening.**

18 The Health Board revised its risk management strategy, approach, and Board Assurance Framework (BAF) during 2021. This provides a greater focus on risk escalation and how it assists in achieving the Health Board's strategic objectives. It also places additional responsibility on operational areas to take greater ownership for managing risks to the delivery of local objectives.

19 The Health Board has defined its risk appetite and tolerance for patient safety and patient and experience as level 1 indicating a low risk appetite in this area. Ten of the twelve principal risks to the Health Board relate to quality and patient safety. Quality risks in the BAF and corporate risk register are appropriately assigned to the PQSO committee designated lead Executive Director.

20 Our observations of the PQSO committee indicates good discussion and scrutiny on the quality and safety risks. The Health Board's Quality and Patient Safety Operational group is a key forum in the quality and safety assurance framework. It provides assurance and advice to the PQSO committee and coordinates the management of quality risks across the organisation. Risk is a standing item on the group's agenda. This provides a platform for each division to escalate their highest risks and concerns in relation to quality and safety. In practice however, our review found limited scrutiny, challenge, cross divisional discussion or sharing of good practice around the risks discussed.

21 At an operational level, the Health Board's Scheduled Care division maintains and actively manages its divisional risk register. Quality and safety risks at this level are clearly articulated and scored with appropriate controls and risk owners identified. However, our work found gaps in the risk management arrangements at directorate level. A risk register for the general surgery directorate was not available for review during our fieldwork. Discussions with staff suggest that completion of directorate risk registers is inconsistent. This may impact on the quality of the divisional risk

[1] audit.wales/sites/default/files/publications/aneurin_bevan_health_board_structured_assessment_2021_english_0.pdf

register because it is reliant on risks escalated from the directorate level. We understand that the Scheduled Care division has recently established a quarterly meeting to review directorate risks, to improve the quality of these arrangements (**Recommendation 1).**

Organisational culture and quality improvement

22 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, compliance with statutory and mandatory training and wider quality improvement processes.

23 We found that **the Health Board has maintained a reasonable focus on quality improvement over the course of the pandemic. However, there are a number of areas that should be strengthened including clinical audit, addressing staff concerns and approaches for capturing and sharing patient experience.**

Quality improvement

24 **The Health Board's dedicated Quality Improvement team capacity has decreased over the past three years, being further affected by COVID-19. The Health Board has worked hard to develop its arrangements for monitoring mortality and morbidity and national clinical audit. However, local, and corporate clinical audit programmes require improvement.**

Resources to support quality improvement

25 The Health Board's Aneurin Bevan Continuous Improvement team (ABCi) currently consists of 9.79 whole time equivalent (WTE) staff (12 headcount). But compared to three years ago, resources have been reduced. The pandemic further impacted the capacity of the ABCi team with some staff redeployed to other roles within the Health Board.

26 The ABCi team provides training and support to operational teams. The pandemic is limiting usual training activity, but the team has continued to deliver in virtual settings where possible. The team deliver a range of quality improvement, analytics, modelling, and leadership training, such as 'Pocket Quality Improvement' and 'PocED Quality Improvement'. The IQT training has been superseded by the Improvement Cymru Improvement Practitioner Programme. Over the past three years however, the Health Board has provided an alternative to the bronze and silver IQT. The latest Health Board figures show that 4.7% of staff to have completed its IQT equivalent training.

Clinical Audit

27 Clinical audit is an important way of providing assurance about the quality and safety of services. At the time of our review the Health Board was updating its Clinical Audit Strategy and Policy. This will include requirements for divisions to develop their own clinical audit plans upon which a Health Board clinical audit plan will be based. At present though the clinical audit plan is not in place.

28 Positively, the Health Board has continued to deliver all mandated national clinical audits and provide regular progress updates to the PQSO committee. These updates identify learning and actions to be taken to address issues arising from the reviews. The Health Board's Medical Directors Support team (MDS team) comprises of 7 WTE (9 headcount) staff. The team supports divisions and directorates, by facilitating data collection, on national clinical audit, outcome reviews and local clinical audit. The team also support divisions with their development of data outputs, presentations, and improvement plans.
These improvement plans are then overseen by the Clinical Effectiveness and Standards Group. The Health Board is currently reviewing the effectiveness of its MDS team to maximise the support it provides to operational areas.

29 Arrangements to support sharing of clinical audit learning and good practice at an operational level are not yet effectively embedded or systematic. We also identified limited operational clinical audit resources to undertake corporate and local clinical audit work effectively and consistently.

30 In January 2020, the Health Board established the bi-monthly Clinical Effectiveness and Standards Group (CES group). This group provides a forum for senior clinicians to monitor outcome data relating to clinical effectiveness, patient safety and to monitor national and Health Board wide clinical audit activity.
The CES group's multi-disciplinary membership includes all divisions and is chaired by the Assistant Medical Director for Clinical Effectiveness. However, the pandemic has meant this group has been unable to meet as planned and there is variable participation. At the meeting we observed, there were no representatives from Scheduled or Unscheduled Care.

31 In addition, at the time of our review the CES group terms of reference were draft and there was some confusion about which version was in use. We were also informed that some elements required updating to reflect changes to the group's remit **(Recommendation 2).** CES group meeting agendas are well-structured with good presentations focussing on national clinical audits and other quality and safety related issues. There are discussions on some agenda items that lead to a focus on actions and solutions to address issues. However, there are opportunities to strengthen this further by encouraging this 'actions focussed' practice across all agenda items. Where actions are identified, it is unclear if the CES group regularly seeks further assurance from divisions to understand if the actions are delivered and sustained.

Mortality and morbidity reviews

32 Mortality and morbidity meetings provide a systematic approach for peer review of adverse events, complications, or mortality to learn from and improve patient care. In November 2020, universal mortality reviews were superseded by the Medical Examiner function. The Health Board anticipates that by May 2022, all inpatient and community deaths will be subject to Medical Examiner scrutiny.

33 The Health Board established a Mortality Review Screening panel in July 2021. This has multi-disciplinary and cross-division representation. The panel considers the need for further investigation to Medical Examiner referrals. If needed, the panel determines an investigation terms of reference and appoints an investigating officer. The panel reports investigation outcomes to the Health Board's Mortality Review Group and has recently published its first bi-annual Learning from Death report.

34 Shared learning is a crucial element of the five levels of mortality management. The Health Board's Learning from Death report demonstrates how the organisation is learning and improving its arrangements following investigation.
The improvements in prevention of COVID-19 nosocomial infection using a Rapid Assessment Tool provides a good example of this. Other learning following investigations include lessons from inter-site transfers, steroid prescribing, and advanced care planning. The Learning from Death report identifies communication as a commonly recurring theme and outlines several improvement actions. The Health Board now intends to introduce a systematic process for reporting outcomes of mortality and morbidity reviews to different Health Board forums.

35 The Health Board is planning on developing a Learning from Death Framework during 2022. This will bring together information from numerous sources including inquests, mortality and morbidity reviews, Putting Things Right complaints processes, and Medical Examiner scrutiny. It will focus on outcomes and improvements and further strengthen the assurance provided to PQSO committee.

36 Together, the Mortality Review Group, CES group and Deteriorating Patient and Resuscitation Group prepare a joint annual report. The aim of this is to provide collective assurance to the Quality and Patient Safety Operational group and PQSO committee on the arrangements for safe and clinically effective care.
Our review of the report found it to provide sufficient information for assurance and decision-making, demonstrating levels of compliance with healthcare standards and improvement actions for the next 12 months.

Values and behaviours

37 **While there is a well-established values and behaviours framework, the Health Board needs to ensure that staff feel listened to when they report errors or concerns.**

38 The Health Board's values and behaviours framework sets out its vision of a quality and patient-safety-focussed culture. It focuses on continuous improvement, openness, transparency and learning when things go wrong. Values and behaviours are embedded in workforce processes, such as recruitment, induction and performance appraisal and development reviews. They are also regularly publicised and referenced during meetings.

39 Our work revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. We undertook a survey of operational staff working across the Scheduled Care Division[2] (see results in **Appendix 2).** Of those responding, we found that 58 out of 83 staff agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. However, 39 out of 83 staff agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation (**Recommendation 3**).

40 The most recent NHS Wales Staff Survey[3] showed a minority but significant proportion of concerns relating to bullying, harassment, or abuse over the past year (16.6%, 15.2% and 9.6% respectively). Fewer than half agreed or strongly agreed that the organisation takes effective action if staff are bullied or harassed by members of staff or a member of the public (42.2%).

41 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. November 2021 figures show a 76%[4] overall organisation compliance with mandatory training requirements. This level has remained consistent since November 2020. Our survey of staff in the Scheduled Care division found that 42 out of 83 staff disagreed or strongly disagreed that they have enough time at work to complete any statutory and mandatory training.
The Scheduled Care division and General Surgery directorate have indicated that they are developing plans to ensure staff have access to training and time to

[2] We invited operational staff working across the Scheduled Care division to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. We had a response rate of 83 staff. Although the findings are unlikely to be representative of the views of all staff across the Scheduled Care division, we have used them to illustrate particular issues.

[3] The NHS Wales staff survey ran during February 2021 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 19%, compared to an all-Wales average of 20%.

[4] The Health Board is required to report compliance to the Welsh Government on a monthly basis. The target for compliance for all health boards is 85%.

complete online modules. Despite this, the Health Board remains concerned and is establishing a working group to further support mandatory training compliance.

42 Performance appraisal and development reviews aim to help staff understand what is expected of them and take responsibility of their own performance and development. Against a national target of 85%, the Health Board's compliance rate for appraisals in November 2021 was 59%. This is also broadly consistent with the compliance rate reported by the Scheduled Care division during our fieldwork of 50%. The Health Board is seeking to improve through its PADR strategic meetings and shared learning. The pressure on services may continue to affect PADR rates for some time.

Listening and learning from feedback

43 **Building on the lessons learnt from the pandemic, the Health Board now needs to reinvigorate its efforts to capture and learn from patient experience, staff feedback and independent review.**

Patient experience

44 Information on patient experience can provide a valuable insight into the quality of services received. Our work has found that the arrangements for obtaining feedback have been impacted by the pandemic.

45 It has not been possible for the Health Board's Person-Centred Care team to support divisions in capturing patient experience in the same way they would have prior to the pandemic. The Health Board has instead relied on patient experience surveys and third-party feedback. In August 2020, 96 patients provided feedback through a pilot scheme. While small in terms of numbers contacted, this innovative scheme enabled virtual inpatient 'buddying', where two members of the Person-Centred Care team would attend wards and connect patients to Community Health Council officers.

46 The Scheduled Care division and General Surgery directorate use questionnaires, complaints, and compliments, critical care follow-up clinics and patient stories to capture information. The division and directorate indicated to us that they seek feedback from patients and share learning. However, our survey found that 38 out of 83 staff disagreed or strongly disagreed that they receive regular updates on patient feedback for their work area or department.

47 The Health Board has arrangements for collating and acting upon patient experience information. However, our discussions with Health Board staff reveal that these arrangements are not systematic across the organisation or the services it commissions. A business case is being developed for the Health Board to procure the Once for Wales Concerns Management System. Its aim is to provide real-time feedback and 'ward to board' reporting functionality **(Recommendation 4)**.

48 At a corporate level, reports provided to both the Quality and Patient Safety Operational group and PQSO committee provide a good overview of patient experience activity alongside areas for improvement. The Health Board does not intend to update its Patient, Family and Carer Experience Strategic Framework which expired in 2019. However, it uses the 'what matters' principles and is awaiting the refreshed national approach to patient experience which aligns to the Quality and Engagement Act.

Concerns and complaints

49 The Health Board's Putting Things Right Policy outlines its arrangements for complaints, claims and patient safety incidents. The policy applies to all staff employed by or working with the Health Board and outlines their roles and responsibilities for dealing with concerns. The policy was due to be reviewed in 2018 and now contains out of date information **(Recommendation 5)**.

50 Against a national target of 75% of complaints responded to within 30 days, the Health Board achieved 69% compliance during 2020-21. This represents a year-on-year improvement from 2018 to 2021 and we understand that performance is continuing to improve. We were told, however, that the impact of the pandemic is resulting in growing complaints within the Scheduled Care division. The numbers of complaints are steadily rising due to service pressures and lengthy waits.

51 Staff training on 'putting things right' is well attended and receives positive feedback. The Health Board has also introduced a Complaints Co-ordinator Network meeting and a tracking system to monitor progress with corporate complaints. The Health Board uses learning from concerns, complaints, incidents, and redress to identify required improvements. These are reported in the annual Putting Things Right and Patient Quality Safety and Outcomes reports. For example, the latest report highlights aspects of clinical treatment, assessment, communication issues, and timeliness of appointments as the main themes arising from concerns and complaints.

Listening to staff concerns

52 The Health Board uses the all-Wales incident reporting policy, procedure and the Datix system for staff to raise concerns and support learning from staff experiences. This includes guidance on the responsibilities of all staff and the process for raising concerns, including whistleblowing. All staff have access to the system, however there are inconsistencies at corporate and operational levels around the levels of training provided on reporting concerns or near misses.

53 Our review found that there was an 'open door' policy amongst senior Health Board staff where staff concerns are confidentially brought to their attention. We were also informed of various other methods to understand staff concerns such as bespoke surveys, exit meetings, staff forums and the 'ask the Chief Executive' on the intranet. But our work suggests there is more to do to address staff

concerns and demonstrate where improvement action has been taken, or act to minimise future occurrence of errors, near misses or incidents. Our survey found that only 30 out of 83 staff agreed or strongly agreed that the organisation acts on concerns raised by staff and just over half of respondents (44 out of 83) agreed or strongly agreed that the organisation acts to minimise future occurrence of errors, near misses or incidents **(Recommendation 3)**.

Patient stories

54 Patient stories are used by the organisation at Board meetings, PQSO committee and various learning events. Patient stories featured regularly at Board prior to the pandemic. Since April 2021, patient experience and public engagement is a standing agenda item. While there have been difficulties in collating patient experience information needed over the last two years, there is an opportunity to return the frequency of patient story use to pre-pandemic levels. When used, patient stories are linked to agenda items.

55 The PQSO committee receives specific examples of patient stories as part of its assurance reporting in relation to listening and learning from feedback. Health Board staff have completed several digital patient stories. These include a patient's experience of COVID-19 in the Intensive Care Unit, and the experience of a patient within cancer services. However, it is unclear where these stories are presented. We also found limited evidence to indicate if patient stories are considered at divisional and directorate Patient Safety and Quality group meetings.

Patient safety walkarounds

56 Patient safety walkarounds provide independent members with an understanding of the reality for staff and patients, making data more meaningful and provide assurance from more than one source. The Health Board has recommenced the programme of walkarounds having paused them due to the pandemic. Independent Members commented positively on the walkarounds. They indicate that the walkarounds help to triangulate information, gain a sense of staff morale and an understanding of the day-to-day issues affecting staff.

Internal and external inspections

57 Our work indicates that the number of outstanding HIW recommendations has reduced over the last three years. The Health Board has made good progress in developing its arrangements for monitoring and disseminating findings and recommendations from Health Inspectorate Wales (HIW) reports. It maintains a detailed tracker which it uses to monitor progress in implementing the required improvements arising from HIW inspections across the organisation.

58 The Executive Team reviews the tracker quarterly prior to the PQSO committee meeting. The detailed tracker is not shared with the PQSO committee but doing so might help provide a greater level of assurance. The committee does however

receive updates on HIW inspections as part of its assurance reporting. Updates provide details of HIW inspections completed during the year, and both positive findings and areas for improvement.

59 The PQSO committee receives quality and safety related reports which may reference findings from Internal Audit reviews where these are relevant. At present though, Internal Audit reports that focus on quality and safety issues are not included on the committee agenda in their own right. This could leave some members less than fully sighted on quality and safety risks and limits opportunities to provide scrutiny and assurance.

Governance structures and processes

60 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

61 We found **collective responsibility for quality governance amongst the Executive Leadership of the Health Board and corporate structures and processes are working well. However, there are gaps in flows of assurance with a need to strengthen 'floor to board' quality and safety assurance.**

Organisational design to support effective governance

62 There is collective responsibility for quality and safety amongst the Executive Leadership of the Health Board. The Health Board's Clinical Executives have a collegiate and robust approach to quality and safety supported by the Assistant Director of Nursing for Quality and Safety, Assistant Director for Quality and Patient Safety and Assistant Director for Person-Centred Care. Together they provide additional senior capacity and focus from medical, nursing, and patient perspectives. The Health Boards' Director of Nursing will be retiring in July 2022 and therefore the Health Board will need to recruit to this role.

63 The Health Board's clinical executives and their teams attend weekly 'clinical huddle' meetings to discuss quality and patient safety matters. The executive team receive regular reports identifying issues and risks from these huddle meetings during its standing agenda item on quality and patient safety.

Quality and safety framework

64 In March 2020, the Board approved the Health Board's quality assurance framework. The purpose of the framework is to inform and support the Board and the PQSO committee in its focus on quality and quality improvement. The framework is mapped to Health and Care Standards and outlines the Health Board's quality assurance structure. The approval and implementation of the framework coincided with the COVID-19 pandemic which had an impact on progress to embed the approach across the Health Board.

65 The quality assurance framework articulates a structure which includes a range of committees and groups focussing on specific aspects of quality and safety. For example, the Health and Care Standard for 'safe care' structure includes overarching committees, such as the Health and Safety Committee supported by sub-groups including the Strategic Fire Safety Committee and Manual Handling Group. Each group is required to provide assurance to the Quality and Patient Safety Operational group and ultimately the PQSO committee and Board. The framework helpfully identifies areas which previously had not provided assurance. However, there are gaps in the flows of assurance from some sub-groups and in relation to some elements of the Health and Care Standards, for example, Communicating Effectively (Health and Care Standard 3.2).

66 The framework is reasonably comprehensive at a corporate level. But it doesn't fully articulate the operational structure and processes for quality and safety and how those align with the corporate structures to provide 'floor to board' quality and safety assurance. The Health Board recognises that elements of the framework and structure are not functioning as intended and have identified this as a key area for delivery in its annual plan **(Recommendation 6)**.

Patient Quality, Safety and Outcomes Committee

67 The Health Board's PQSO committee is responsible for providing assurance and advice to the Board in relation to quality and safety. The terms of reference for the PQSO committee were revised in April 2021 in response to changes made to the Health Board's governance structure. The changes aim to achieve a person-centred approach to care and recognise the need to become more outcomes focussed.

68 Our work found the committee is becoming more effective. We noted clear and concise papers and an increased focus on risk and outcomes. Independent Members commented positively on the quality of the committee meetings and were generally satisfied with the level and quality of assurance they receive. As part of our audit, we observed the committee on several occasions. We found good quality discussion, scrutiny, and challenge from independent members. There is multi-disciplinary involvement at agenda setting meetings ensuring transparency and balance in the coverage of quality and safety matters at the meeting.

Quality and Patient Safety Operational Group

69 The Health Board's Quality and Patient Safety Operational group is responsible for providing assurance and advice to the PQSO committee in relation to quality and safety. The group's bi-monthly meetings precede the PQSO committee. The group is chaired by the Director for Families and Therapies with representation from across all Health Board operational divisions and corporate departments. Health Board staff informed us that operational participation at the meeting has improved following the introduction of virtual meeting arrangements during the pandemic.

The Health Board intends to review the role of the Quality and Patient Safety Operational group within the Health Boards quality assurance structure to ensure that it is receiving and providing appropriate quality and safety assurance.

Divisional / Directorate Patient Safety and Quality Group(s)

70 The Scheduled Care Divisional Patient Safety and Quality group (DPSQ group) terms of reference indicates a responsibility to provide assurance on quality and safety to the Health Board's corporate groups and committees. However, our work found that the group does not provide a dedicated assurance report and there is a lack of clarity around the flows of assurance from divisional to corporate levels.

71 The DPSQ group meets monthly and is chaired by the Divisional Director for Scheduled Care. The groups terms of reference outline a multi-disciplinary membership. This includes both the divisional director and divisional nurse, medical and nursing leads for patient safety and quality, and senior representatives for Putting Things Right, Health and Safety. Whilst the proposed membership is appropriate, our work identified instances where certain members, for example a Health and Safety representative had not attended a meeting or provided an update for some time, leaving a gap in assurance. It was also unclear whether representatives from all directorates attend this meeting. Health Board staff indicate that meeting dates for the group are being revised to align with directorate audit days to improve attendance.

Resources and expertise to support quality governance

72 Corporately there are several teams working to support quality and safety issues in the Health Board. The Person-Centred Care Team and Putting Things Right Team, report to the Assistant Directors of Nursing for Person-Centred Care and Quality and Safety respectively. This is in addition to ABCi, Medical Director's Support Team, and Infection Prevention and Control Teams referred to earlier this report.

73 The Person-Centred Care Team (9.8 WTE, 12 headcount) provides a range of training and support to operational areas on patient surveys, developing patient experience metrics and digital patient stories. The team has expanded over the last three years through recruitment of an End-of-Life Companion Co-ordinator and Clinical Skills Trainer on fixed term contracts.

74 The Putting Things Right Team (11.9 WTE staff, 14 headcount) role is to provide training and support to operational staff, for example effective complaints handling and investigating officer training. The Health Board informed us that 150 staff are trained to investigate complaints and 101 staff trained to investigate incidents across the Health Board. There are currently no vacancies within the team and its size and composition has remained relatively constant over the last three years. However, there have been some changes to its structure resulting in recruitment and changes in personnel.

75 There is a dedicated team for Infection Prevention and Control (14.8 WTE staff, 17 headcount). They provide training and support to operational staff in line with the Health Board's infection prevention training strategy and has adapted in response to the COVID-19 pandemic. Recently, the Infection Prevention and Control Team has received funding to enhance the primary care aspect of its role. The pandemic has placed significant additional demands on the team, and this limits the amount of proactive infection and prevention control work it undertakes.

76 At an operational level, the Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. This includes managing concerns, risk management, infection prevention and control, quality improvement, Datix and health and safety. They also have designated leads for quality and safety. They assist with serious incidents investigations, support wards and departments in relation to the Datix system, attend quality improvement meetings and represent the division at meetings where there is a quality and safety focus. However, we found that some designated leads do not have protected time to fulfil several of these roles. **(Recommendation 7)**. In addition, the Health Board does not have designated leads for patient experience or a dedicated patient experience team such as a Patient Advice and Liaison Service (PALS). This contrasts with some other Health Boards in Wales. However, we understand that the Health Board is currently considering a model for the introduction of this service.

Arrangements for monitoring and reporting

77 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

78 We found that **the Health Board arrangements for monitoring quality and safety at a corporate level are improving, but the Health Board needs to review arrangements at an operational level to ensure it is receiving appropriate assurance on the quality and safety of its services**.

Information for scrutiny and assurance

79 The Board performance report and integrated performance dashboard provides performance information against the NHS Wales Delivery Framework measures including complaints and healthcare acquired infections. The redesigned Patient Quality, Safety and Outcomes report is more succinct, and outcome focussed. It includes quality metrics, including healthcare-associated infections, COVID-19, pressure damage and inpatient falls. It also provides greater clarity around emerging themes, areas of concern, mitigation, and good practice. Whilst the report is predominantly secondary care focussed, it includes wider areas of the Health Board's business such as Child and Adult Mental Health Services (CAMHS)

and Primary Care Mental Health. However, opportunities exist to strengthen reporting on the services the Health Board directly commissions.

80 At an operational level, the Divisional Patient Safety and Quality group receives presentations and reviews performance reports and dashboards with infection control, incident reports, concerns data and health and safety information. Some supporting papers are available in advance and attached to meeting agendas, but several are not. This may limit opportunity for attendees to review information in advance and provide sufficient scrutiny and challenge at meetings.

81 The four harms associated with COVID-19 remain a key consideration on the Health Board's BAF and information is routinely reported and escalated via a safety dashboard report to the PQSO committee. Whilst COVID-19 issues are included in various reports and papers for the Board, the removal of COVID-19 updates as a standing item on the Board agenda may limit opportunities to provide assurance.

82 The Health Board's annual plan includes requirements to refine its quality and safety dashboard quality indicators and increase the capacity and capability of divisions and its corporate teams to utilise data to support quality and safety.

Coverage of quality and patient safety matters

83 The PQSO committee's remit is clear in relation to oversight for quality and safety and its agendas are aligned to the main quality and safety risks within the Health Board. Agenda includes regular information around patient feedback within services and reports on external inspections and reviews. Health Board senior leadership are responsive to requests from the committee for additional information resulting from concerns identified at previous meetings. The chair of the Quality and Patient Safety Operational group presents assurances to the PQSO committee on the group's activities. Our review of the update reports found them to provide information on divisional quality and safety risks, and a summary of key matters arising from other items considered during the meeting. This is supplemented with additional information by the Quality and Patient Safety Operational group chair and senior Health Board officers as part of its presentation and discussion during committee meetings.

84 Operationally, the Divisional Patient Safety and Quality group uses a standardised agenda which covers key aspects of quality and safety. This includes infection prevention and control, serious incidents, safety alerts, complaints and concerns, divisional risks and Datix feedback to staff. The group also focuses on wider quality improvements. An example of this is its regular oversight of the theatre improvement programme which was established in response to 'never events' occurring within the General Surgery directorate. The Divisional Patient Safety and Quality group actively manages its action log which provides details on actions, completion dates, lead officers and progress updates.

85 The General Surgery directorate has recently established its own Patient Safety and Quality group, but it is in the early stages. At the time of our review, the group

did not have a terms of reference, standardised agenda, or report templates and whilst an action log is maintained, minutes of meetings are not taken.
The Divisional Patient Safety and Quality group is considering the introduction of standardised agendas, reporting templates and patient safety and quality plans and gaps in the flow of quality and safety information across its directorates. This should help to address some the inconsistencies in directorate approaches.

86 Our review of agendas and papers for the monthly assurance meetings with the Director of Operations indicate a focus on quality and safety, particularly around concerns, serious incidents, and infection control. However, these meetings stopped in March 2021 and have not resumed. We also note a focus on quality and safety at bi-annual reviews with the Executive Team. However, we found limited focus on quality and safety at the Scheduled Care divisional management team meetings with some meetings mainly focussing on finance, performance, and operational matters **(Recommendation 8)**.

Appendix 1

Management response to audit recommendations

Exhibit 1: management response

Recommendation	Management response	Completion date	Responsible officer
Risk Management R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should: • ensure there is appropriate scrutiny, challenge, cross			

Recommendation	Management response	Completion date	Responsible officer
divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. • ensure that risk registers are completed and maintained across all directorates that identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.	The form and function of Quality Patient Safety Operational Group is currently being reviewed, with the aim of strengthening oversight of Risk. ABUHB are in the process of introducing the OFWCMS with the Risk module part of a future phase of roll-out. This will be a driver for improving Divisional ownership of risk management and mitigation. A programme of Divisional awareness raising will be introduced across ABUHB to strengthen risk management processes. The responsibility of Divisional Directors will be reinforced in terms of maintaining registers and ensuring appropriate mitigation.	June 2022 October 2022 May 2022	Executive Director of Therapies and Health Sciences Director of Clinical Governance Director of Clinical Governance

Recommendation	Management response	Completion date	Responsible officer
Clinical audit R2 During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should: • complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide and local audits informed by areas of risk. This	The Clinical Audit strategy and policy are currently under review and will be ratified by June 2022. A Digital Clinical Audit Platform has been procured to support the delivery of Divisional, Directorate and Corporate Clinical audit plans designed to provide assurance around areas of high priority.	June 2022	Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
plan should be approved by the Patient Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely. • update and finalise the terms of reference for the Clinical Effectiveness and Standards Committee. • ensure there is sufficient resource and capacity for clinical audit at an operational level • ensure systems for learning and good practice from clinical audit are embedded across the organisation.	Complete ABUHB will undertake a review of resources and capacity available to support the completion of the National Clinical Audit programme. The Clinical Standards and Effectiveness Group is the forum where Clinical audit is discussed and presented to ensure scrutiny and assurance. Bi-annual reporting to the PQSOC takes place to provide assurance of clinical performance and the development of action plans to address requisite improvements. A review of the	N/A August 2022 June 2022	N/A Executive Medical Director Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
	membership of the group will be undertaken to support improved Divisional representation.		

Recommendation	Management response	Completion date	Responsible officer
Values and behaviours R3 The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel: • they are not treated fairly or given feedback when reporting errors, near misses or incidents.	The ABUHB Value Framework has been refreshed recently. There is clearly a need to remind managers and leaders to ensure feedback to staff who have raised concerns and this will be reinforced through Divisional Triumvirates for cascade.	October 2022	Executive Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
• that the Health Board does not act on concerns they raise or take action to minimise future occurrence of errors, near misses or incidents	A review of concerns raised by staff and the actions taken will be conducted to provide assurance.	October 2022	Executive Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
Patient experience R4 Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should: • undertake work to understand why patient feedback updates are not regularly provided to work areas or departments. • ensure there are systematic arrangements for collating and acting upon patient experience	A business case is in-development for the procurement of 'Civica' as part of the OFWCMS. If supported this will strengthen the ability to capture live patient experience which Divisions and Directorates will own, strengthening feedback. (As per response above)	September 2022	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
information across the organisation and the services it commissions.			

Recommendation	Management response	Completion date	Responsible officer
Putting Things Right R5 The Health Boards Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.	The PTR policy will be updated with an extension to the date in light Welsh Government are reviewing the PTR policy aligned to the Quality & Engagement Act implementation.	June 2022	Executive Director of Nursing

Quality and safety framework R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should: • complete its review of the quality and safety framework to ensure that flows of assurance are appropriate, and that the	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF.	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
• framework functions as intended. • articulate the operational structures and processes for quality and safety within the quality assurance framework and how they align with the corporate structure to provide a 'floor to board' assurance.	The revised Quality Assurance Framework will include the operational structures and processes.	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
Resources to support quality governance R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.	A review of roles for QPS across Divisions will be undertaken with the aim of implementing a consistent approach (this will include time for leads to undertake their role effectively).	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
Coverage of quality and safety matters R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional			

Recommendation	Management response	Completion date	Responsible officer
Management Team meetings. The Health Board should: • review the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements. • ensure that other operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.	The patient, quality and safety structures for each Division will be reviewed and outlined in the revised Quality Assurance Framework (see R6). Divisions will be reminded to ensure a robust focus on patient quality and Safety through Divisional and Directorate meetings.	October 2022 May 2022	Clinical Executives Clinical Executives

Appendix 2

Staff survey findings

Exhibit 2: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	19	32	12	11	8	-	82
2. I am satisfied with the quality of care I give to patients	25	28	10	12	6	2	83
3. There are enough staff within my work area/department to support the delivery of safe and effective care	5	17	16	18	27	-	83
4. My working environment supports safe and effective care	15	25	11	16	15	1	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
5. I receive regular updates on patient feedback for my work area / department	11	21	13	18	17	3	83
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	14	35	18	4	5	7	83
7. My organisation acts on concerns raised by staff	7	23	16	16	17	4	83
8. My organisation encourages staff to report errors, near misses or incidents	18	40	13	6	5	1	83
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	11	28	24	9	4	7	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Managing patient and staff concerns							
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	11	33	20	10	5	4	83
11. We are given feedback about changes made in response to reported errors, near misses and incidents	8	26	17	18	10	4	83
12. I would feel confident raising concerns about unsafe clinical practice	18	31	15	10	7	2	83
13. I am confident that my organisation acts on concerns about unsafe clinical practice	12	32	21	11	6	1	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Working in my organisation							
14. Communication between senior management and staff is effective	2	27	16	18	20	-	83
15. My organisation encourages teamwork	7	35	22	11	8	-	83
16. I have enough time at work to complete any statutory and mandatory training	4	25	12	25	17	-	83
17. Induction arrangements for new and temporary staff (e.g. agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	7	31	23	5	10	7	83

Archwilio Cymru
Audit Wales

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail:
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.